Health care resource allocation: is there a role for the capability approach?

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Introduction

• Health is an intrinsic capability
  – Sen refers to the freedom to avoid premature mortality and morbidity, and it appears in many lists, notably Nussbaum’s

• Considerable research around capabilities and the health domain
  – Determinants of capability, (mental) health, quality of life, measurement, functioning, conversation factors, social justice, equity

• But we wish to focus on capabilities and their role in health care resource allocation
  – How could it be applied, what are some of the issues to be overcome?
Health care resource allocation

• All resources (labour, land, capital, knowledge) are scarce
  – Necessary to make decisions as to how to use these scarce resources
• How do we make such choices and how can the capabilities approach help?
• Two resource allocations approaches
  – In a market system, price provides an efficient means of resource allocation
  – In a non-market (e.g. health care) system
    • Questions as to the objective, is it efficiency or equity
    • Questions as to the decision maker, who decides the allocation
    • Questions as to the criteria, what attributes are important
• The objective, the decision maker, the criteria are all key to operationalising the capability approach to inform resource allocation
Efficiency or equity?

• Efficiency: maximisation of ‘benefit’; utilitarian ethic; distribution is irrelevant
• To measure efficiency we first consider what is effective. In health this is heavily dictated by clinical effectiveness
  – Health and disease, but mostly disease
  – Move towards health related quality of life and wellbeing more generally (extra welfarist approach – QALY)
• A capability focus would be an explicit move from disease to health/wellbeing AND a move away from functioning
  – Utilising a capability approach would change the notion of benefits, efficient allocation might be about cost per unit of capability (what is a unit of capability?)
• Equity: just distribution; based on need? age? lottery?
  – “From a policy perspective it is … important to specify precisely what is meant by equity, equity of what and among whom, in order to derive appropriate policy conclusions for pursuing equity goals” (Birch and Abelson, 1992)
• Equity in the capability context means that we would not only look to maximisation, fundamentally change the current approach to evaluation
Decision maker?

- Often the decision maker is the funder/budget holder
- Extra-welfarism (in part informed by the capability approach) resulted in a move away from individual preferences to public preferences, to reflect the fact that this was a decision to influence the community (with an associated opportunity cost)
- Notably Sen specifies that capabilities and freedoms need to be important to the individual, but the decision maker should decide the weights, expert centred
- Also issues of procedural fairness with respect to this decision making
  - consistency/transparency/accuracy
Criteria/Attributes?

• Sen deliberately underspecified the approach
• Numerous lists exist (Nussbaum, OCAP, OCAP-18), and more recently instruments have had preference weights attached such that they can be used in an economic evaluation
  – ICECAP suite of instruments
• But Sen argues that capabilities are person and culture specific, so can a generic instrument be applied?
  – A different list of attributes or just different weights attached to these attributes?
• Preference weights reflect individual choices, but they do not address the issue of equity and social preferences
  – Sen’s agency goals – goals deemed important but not focused on one’s own wellbeing
What is the problem?

- Poor health, preventable disability, premature mortality (‘inequalities in health’)
- The CA addresses this problem by showing how social choice plays a great role in health and its distribution. Healthcare is one important social determinants of health.
  - How do we apply the CA to the social choices in relation to the multiple dimensions of health?
  - How do we apply the CA to the specific domain of health care?
  - The above two have to be consistent.
What is the problem in health economics?

• Resource allocation / rising costs
  – Effectiveness (defer to science) **
  – Efficiency
  – Equity
  – Cost-containment (??)

HE is used to adding equity considerations after measurements of health states and efficiency calculations. Where efficiency creates losers.
Applying CA to HE

• Measure benefits in cost-benefit analysis in terms of capabilities.
  – What then does a health capability look like?

• Other principles
  – Equity
  – Impartiality (objective assessment)
  – Liberty
  – Individuals
Equity

• Multiple dimensions
  – Causes
  – Need
  – Likelihood of benefit
  – Few or many (non-trivial cases)
  – Non-health consequences
  – Experience of disease and dying
  – Persistence through generations
  – Process
Questions for discussion

• Capabilities as an outcome measure in economic evaluation is fine, but to inform broader decision making and resource allocation is a step too far?
  – What is the set of capabilities?
  – How do we value them, and who should value them?
  – How do we anchor them for comparison with say QALYs?
  – Should they be used in a maximisation framework?
  – Is equity in a capability context too multidimensional to be workable?
Further Reading


