Capability to Health, Health Agency and Vulnerability

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One of the defining features of the capability approach (CA) to health as it is developed in Sridhar Venkatapuram's book *Health Justice* is its aim to enable individual health agency. Furthermore, the CA to health hopes to provide a forceful tool to assess social and political conditions for what we may call their health capability *enabling* content. Applying a CA to health will allow us to identify and criticize those social conditions that hinder individuals in their attempts to realize capability to health (CH). We may then be able adjust social policies with a view on improving capability to health, or so is the hope.[1]

The ability for agency, and access to the means of agency is often contrasted with another concept – namely, individual vulnerability. Some argue that if we are vulnerable, we may be hindered in our ability to make decisions that are in our best interest. I am interested here specifically in the *liberal* discussion of vulnerability, in which the concept of vulnerability is developed and assessed through the lens of individual autonomy. Those writing in this vein worry that vulnerability may pose harm to individuals because it may stifle the possibility of developing a sense of self. Yet in order to be effective agents who take health enabling decisions in our lives, we need to know who we are, what our goals are and what we stand for – we need a sense of self.[2]

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[1] A similar link between the CA and health policy has earlier been made by Jennifer P Ruger. 2010. *Health and Social Justice*, Oxford : Oxford University Press.

[2] To be sure, human vulnerability plays a central role in the CA more generally. There is a nuanced difference between the *liberal* concept of vulnerability as challenge to autonomy and vulnerability as it is used in the capabilities literature: the liberal concept of vulnerability is not tied to the idea of freedom as it is in the latter, but instead, at least some kinds of vulnerability describe a state in which we can not know who we are. This account of vulnerability is prior to the concern discussed in the capabilities literature since we need to know who we are before we can know what specific freedoms are vital to us. I would like to thank an anonymous reviewer for pressing me on this point.

Moral philosophers derive from the fact of individual vulnerability moral obligations to protect the vulnerable. Kant had already identified the relevance of vulnerability in moral reasoning: "[o]n Kant's view the combination of agency and vulnerability constitutes the circumstances of justice". [3] It is therefore not surprising that the concept of vulnerability has received increased attention in the wake of a sharper focus on the conditions of justice from a health perspective. In this vein, some have discussed vulnerability in the context of health care settings[4] or when lacking access to health care.[5]

My motivation to assess Venkatapuram's proposals through the lens of the liberal concept of vulnerability is to assess his moral claims. I want to investigate the broader relationship between capability to health and individual vulnerability. In particular, I am interested in the question whether the CA to health can indeed solve the challenge that individual vulnerability may pose to health capability. This is an important question in light of the argument proposed in 'Health Justice'. If I understand it correctly, then the central point of Venkatapuram's book is twofold: the first step suggests that health should be understood as 'achieving vital goals' (72), making health into a 'meta-capability'. [6] In a second step, this understanding of health should help recognize 'the entitlements to the capabilities of achieving these vital goals' as 'basic political principles grounded in freedom and equal dignity' (72). The argument then suggests that such an understanding of health and its social conditions should lead us to accept 'the health of citizens' to be 'the first priority of social justice, and one of the most basic values of society' (72).

A closer analysis of what I will call 'the background conditions of vulnerability', however, shows that such a strong moral claim is not warranted for *all* types of individual vulnerability that may stand in the way of taking health-enabling decisions. This leads me to

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[3] Onora O'Neill. 2000. *Bounds of Justice*. Cambridge : Cambridge University Press : 138.
[4] Samia Hurst. 2008. Vulnerability in research and health care; describing the elephant in the room? *Bioethics* 22 : 4.
[5] Christine Straehle. 2014. Ethical Reflections on Who is At Risk: Vulnerability and Global Public Health. Garrett Brown, Gavin Yamey, Sarah Wamala, *The Handbook of Global Health Policy*. London:Wiley-Blackwell : 195-207.
[6] Sridhar Venkatapuram. 2011. *Health Justice*. London : Polity Press. All further page references in the text refer to the book under discussion.

say that when analysed through the lens of liberal vulnerability, health should not be considered a meta-capability. To be sure, conditions of vulnerability need to be taken into account when designing public and social policy, but they don't suffice to justify the claim that health as a meta-capability should be the driving concern of such policy. Background conditions of vulnerability are a fact of human life, but they are not immediately justice relevant. Moreover, I want to say that the faith put into the CA is overstated: even if we were able to design social policies that pursue the meta-capability of health, we need to acknowledge background conditions of vulnerability as a possible limit to CH because they will inevitably affect individual health agency. Put differently, background conditions of vulnerability may prohibit individuals from taking health-enabling decisions about their lives. We may bemoan this fact, but it is not clear that we can alleviate the burden on individual decision-making by focusing social policy more sharply on health.

I will first summarize Venkatapuram's conception of the link between agency and background conditions of health decisions. I will then tie this conception to a discussion of two kinds of vulnerability, 'circumstantial vulnerability', on the one hand, and 'background conditions of vulnerability', on the other. If I understand the CA to health correctly, it aims to address both of these since both pose potential problems to health agency. I believe, instead, that only the first set of vulnerabilities can directly guide us in designing public policy that enables CH; the second kind, I want to argue, simply underlines the need to take individual vulnerability *into account* when thinking about individual agency, but it doesn't warrant the strong moral claim for health as a meta-capability.

Capability to health and individual agency

The capabilities that the CA is interested in are those that help individuals to 'be and do what they have reason to value' (115). It seems therefore intuitively plausible to accept that health should be considered an important capability. We can safely assume that all human beings have reasons to value being healthy, however this may be defined, simply for the benefits that come from being healthy, and because of the costs and burdens that are

associated with not being healthy.[7] These costs need not only be material ones, but may also take other forms: think of the emotional costs to a person and her circle that are associated with mental illnesses such as depression or bipolarity. To characterize health as a *meta*-capability suggests that health is not only one among several capabilities that individuals should have access to, but, instead, that health is what we may call an *enabling condition* for many other choices and decisions in an individual's life.[8]

The meta-capability to health, in turn, depends on several conditions: the biological endowments and needs each person has, the social and physical environment in which she lives, and her individual behaviours (pg 74 and *passim*). 'A person's capability to be or doing something is determined by the independent or interactive roles of all these four factors' (116). To illustrate the kind of interaction Venkatapuram has in mind, recall the example of a depressive person: we can imagine that such a person may have considerable biological and social endowments, yet that she has difficulty converting them into the kind of beings and doings that constitute health (121).

Venkatapuram thus argues that we need to consider not only what we may call the *external* factors that influence a person's health – many of which have been subject of debates over the social determinants of health – but also what we may call *conversion* factors of health. Health depends on individual agency insofar as individuals make choices about how they use and benefit from the endowments they have, and how they navigate the social and physical environment in which they live.[9] This is an important further step in our thinking about conditions of health and enabling health in particular. Yet I want to argue that one

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[7] Some capabilitarians don't subscribe to such an instrumental understanding of health, holding instead that health is intrinsically valuable. On both accounts of the value of health, it is important to assess individual capability for health agency. I therefore don't explore the distinction further.

[8] To be sure, Venkatpuram discusses the basis on which we should value CH in detail and the argument from subjective benefit is closely scrutinized (Chapter 4). My aim here is not to enter into this discussion; rather, I hope to draw out possible limits of the application of the CH. I therefore simply accept the premise of the moral value of CH.

[9] For a detailled and helpful discussion of health agency, see Ruger 2010, chapter 6. See also Jennifer P. Ruger. 2007. Rethinking Equal Access. Agency, quality and norms. *Global Public Health* 2(1) : 78-96.

problem when designing policy aimed at fostering the CH arises not simply from individual variations in conversion factors, but also from background conditions of vulnerability that we experience in specific health contexts. Later on, I will discuss public health screening programs as an example of social policy aimed at enabling health agency. I will explain that for such programs to be health-enabling, they need to be free of charge; however, I will also show that despite such programs aimed at providing individuals with relevant information about their health, they can't overcome background conditions of vulnerability. To make sense of this argument, I will now explain the concept of individual vulnerability.

Individual vulnerability

The idea of vulnerability as a fact of individual life is ubiquitous in public discourse. The idea of vulnerability is referred to when discussing the need for protection of young children, or old people, organ sale, assisted suicide or surrogacy arrangements, to name but a few of the instances when we can hear about it. The moral relevance of vulnerability has several sources. First, moral philosophers support the claim that we have a special obligation to protect the vulnerable. Bob Goodin, for instance, argues that we ought to protect those whose interests we can easily harm, those "whose vital interests are particularly vulnerable to our actions and choices." [10] Vulnerability according to Goodin ascribes moral obligations to those who have "the capacity to produce consequences that matter to another"[11] and where these consequences affect the interests of another. The concern for individual vulnerability can be further motivated, of course: we can propose egalitarian arguments (Mackenzie 2013) as well as Kantian conceptions of respect for another (O'Neill 2000), or Venkatapuram's own concern for equal dignity as reasons why we should be concerned with individual vulnerability.[12] All of these approaches support the

[10] Robert Goodin. 1995. *Protecting the Vulnerable*. Chicago : University of Chicago Press : 111.
[11] Ibid : 114.
[12] Venkatapuram acknowledges his intellectual debt to the work of Martha Nussbaum and Amartya Sen. Representatively, see Martha C. Nussbaum. 2011. *Creating Capabilities. The Human Development Approach*. Cambridge (Mass.) : Harvard University Press.

claim that individual vulnerability should be the subject of moral reasoning.[13]

Second, we should be concerned with individual vulnerability because to be vulnerable may mean a challenge to individual agency. One definition of vulnerability that reflects this concern is to say that "to be vulnerable means to face a significant probability of incurring an identifiable harm while substantially lacking ability and/or means to protect oneself."[14] The particular concern then is that individuals may come to harm but may be unable to take decisions and/or implement them to effectively protect themselves. In particular, the harm we should be concerned with is harm to our interests. Later on I will make a distinction between *welfare* and *agency* interests, and the moral obligations that derive from them.

The moral obligations vulnerability gives rise to have long been cast in the language of rights: "at least some rights are grounded in certain *vulnerabilities….* The vulnerabilities that spawn rights are those that are significantly tied to what we shall call *interests.*"[15] The link between vulnerabilities and rights then justifies the claim that "vulnerabilities arising from negligence are constitutive of what might be regarded as *an abuse of rights*."[16]
We can thus hold in a further step that a person's vulnerability generates moral obligations to protect her interest; she has a right for her interests to be protected and not to be harmed.[17]

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[13] For extensive discussion of the *political* relevance of the concept of vulnerability when discussing capabilities, see Catriona Mackenzie. 2013. The Importance of Relational Autonomy and Capabilities. Catriona Mackenzie, Wendy Dodds, Sue Rogers (eds.) *Vulnerability – New Essays in Ethics and Feminist Philosophy*. New York : Oxford University Press.
[14] Doris Schroeder and Eugenijus Gefenas. 2009. Vulnerability: Too vague and too broad? *Cambridge Quaterly of Healthcare Ethics* 18 : 117.
[15] Rom Harré and Daniel N. Robinson. On the Primacy of Duties. *Philosophy* 1995 ; 70 (274) : 513-532, 517.
[16] Ibid : 518.
[17] Many capabilitarians prefer the language of 'freedoms' rather than interests. See Amartya Sen. 1999. *Development as Freedom*. New York : Anchor Books. The difference is one of nuance rather than scope. Interests are based on our assumptions about human functioning as is the language of freedom proposed by Sen. Yet to speak of interests also allows us to discuss the needs of those who are not agents yet, or no longer. We have welfare interests even when we our capacity to agency is fundamentally in question. Second, if our goal is to

So far then, I have discussed how the moral assessment of liberal individual vulnerability aligns with the concern for vulnerability in the CA to health. I believe that they also align in their appeal to social policy. Both approaches argue that we need to identify the source of vulnerability because it will help us designate those responsible to fulfil the moral obligations that arise from vulnerability. Vulnerability thus becomes an action-guiding concept in designating *specific* obligations and assigns them to *specific* duty holders. If a specific vulnerability arises from a set of social public policies - for instance, if, a specific public policy renders an individual unable to take health-enabling decisions - then the burden of the rights protection lies with public policy makers to change the policy in order to enable health agency.

Circumstantial vulnerability

This scenario is one that we can best describe as 'circumstantial vulnerability'. Circumstantial vulnerability is indeed the kind that is most problematic from a social justice perspective, and especially so if we can change the circumstances that lead to such vulnerability. The kinds of circumstances I have in mind are the specific conditions that frame individual decisions about the protection of the interests in health. Here an important distinction may be warranted to illustrate where the liberal vulnerability and capability approaches diverge. Some people live in circumstances that would allow them to make decisions that promote and further their interests even though they may choose to act in ways that seem to outside observers to go against their interests. What is relevant for my purposes here is that the circumstances are such that they *could act* in ways that would promote their interests. An example that comes to mind is a well-endowed and talented person who chooses to use debilitating drugs. The liberal concept of vulnerability would have to assess, first, what health enabling decisions are possible in such circumstances. Yet a liberal approach is, second, also concerned with individual agency interests more broadly. Agency interests can be defined as "individual values, principles and beliefs, which the

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make access to the basic capabilities a political claim and one on a global scale, then the language of interests mirrors some debates in the literature on human rights where interests are accepted as the basis of human rights claims against states. See David Miller. 2012. Grounding Human Rights. *Critical Review of International Social and Political Philosophy* 15 : 407-427.

individuals in question pursue and which may form the subject of setbacks."[18] Liberals want to allow for individuals to experiment with their lives even if this may imply that they act against their objective health interests. Here a liberal vulnerability assessment may arrive at the conclusion that these kinds of circumstances should not be subject to social policy intervention, whereas a capability approach to health agency may justify intervention.[19]

There are, however, also circumstances that make it difficult if not impossible to promote and protect one's agency and welfare interests, circumstances that make it difficult if not impossible to take health-enabling decisions about our lives. If this is the case, both liberal accounts and CA accounts hold that circumstantial vulnerability poses a moral problem and generates moral responsibilities. In other words, in some cases of circumstantial vulnerability, we can see the intersection between the CA to health and the liberal concept of vulnerability. To illustrate such circumstances, think of screening programs for some cancers. Screening programs are often offered for sections of society simply as a precautionary measure based on the statistical evidence that certain segments of society are more prone to particular kinds of diseases: mammogram programs for women over 50, or prostate cancer screening for men of the same age. In most developed rich countries, these tests are made available free of charge.[20]

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[18] Angela Martin, Nicolas Tavaglione, Samia Hurst. 2014. Resolving the Conflict : Clarifying 'Vulnerability' in Health Care Ethics. *Kennedy Institute of Ethics Journal* 24 (1) : 56. The authors continue this definition with a quote from Amartya Sen: 'A person's agency aspect cannot be understood without taking note of his other aims, objectives, allegiances obligations, and – in a broad sense – the person's conception of the good.' 55.

[19] "Health agency entails a more specific form of human agency that relates particularly to one's health…. Health agency thus also embodies a conception of the good – of optimal health functioning- as a valuable goal. Part of developing health agency involves developing this value through self-scrutiny, self-actualization, and recognition that health is the right choice. In other words, the idea of enhancing health agency, as defined here, is inconsistent with a notion of aiding someone to continue or maintain an addiction to drugs." Ruger. 2010, *op. cit.* 146.

[20] The notable fact here is that these tests are offered free of charge even though there is no concern for the health of the greater public since cancers tests aim to determine non-communicable diseases. In other words, even though danger of infection across populations is not given, governments assume the responsibility to provide for a section of society that is vulnerable to be affected by a disease.

Now, imagine instead a scenario in which such tests were not offered free of charge but that, instead, individuals could only access them for a fee. For most, this might not pose a hurdle and they could simply pay for such a test. For some, however, charging for the test may pose an insurmountable problem and they may have to forgo being tested. The resulting harm to a person's interest in making health-enabling decisions is the result of a *specific circumstance*, a constraint that is put into place by the requirement to pay for such a test.

This should give us moral pause: first, because individuals who experience this sort of circumstantial vulnerability are not so vulnerable because of an "absolute lack of capabilities and resources; rather it is that they possess fewer capabilities, powers or resources than others."[21] What is at issue here is that health as a non-positional good, i.e. a good whose value is defined independently from our value in the labour market and our concomitant socio-economic status, becomes a positional good, i.e. a good, the absolute value of which depends on our "standing in the distribution of the good".[22] Yet because of its fundamental value for individuals, health is not supposed to be a positional good. Alternatively, if health is a positional good for the advantages it confers to its holder, and all else being equal it is at least supposed to be equally accessible to all in society. Otherwise, the promise of moral equality is put in jeopardy. This is the case in the scenario just described: charging for tests that allow individuals to make health-enabling decisions puts into question equal dignity. If we are concerned for all to be able to make health–enabling decisions, all those sharing comparable characteristics, being in the relevant age-group, say, should have access to the means necessary to make them regardless of their position in the socio-economic sphere.

Second, circumstantial vulnerability is morally problematic because its specific instantiation, like that due to lack of access to funds for provision of health care are *generated* by such constraints: without imposing a fee for such tests, we could speculate

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[21] Onora O'Neill. 2000. *Bounds of Justice*. Cambridge : Cambridge University Press : 95.
[22] Harry Brighouse and Adam Swift. 2006. Equality, Priority and Positional Goods. *Ethics* 116 (3) : 471-497, at 474.

that there is no such vulnerability. The specific vulnerability here derives from the harm to our agency interests. The problem inaccessible screenings programs pose is that they make it impossible for those not screened to convert their endowments into health-enabling decisions because there is no foundation on which to *take* a decision. If access to relevant information is barred we can't exercise agency.

Considering this type of circumstantial vulnerability, therefore, I agree with the argument for health as a capability that should guide social and public policy. Individuals should as far as possible be able to make health-enabling decisions about their lives, and their capability to do so should be promoted and certainly not be hindered by adverse circumstance that are due to public policy. So far, then, we can say that when thinking about *circumstantial* vulnerability, the CA to health and a liberal vulnerability-based analysis work alongside to define moral responsibilities and designate those who hold them. Both approaches demand social policy to address circumstances that hinder individuals from taking health-enabling decisions and create conditions of health agency.

However, another kind of vulnerability that may equally hinder individuals from taking health-enabling decisions can't be addressed effectively within the CA to health. I refer to this kind of vulnerability as a *background condition of human life*. Even though this kind of vulnerability may thwart our individual behaviour against realizing our capability to health much like circumstantial vulnerability just described, it is not obvious that we can address it through public and social policy.

Background conditions of vulnerability

The kind of vulnerability a newborn or a young child experience is a simple background condition of the life of a newborn or a child, even though we need not assume that their interests will be harmed. The idea of human vulnerability in these cases tries to account for human limitations and attempts to capture the "fragility of human life, action and

achievement."[23] Moreover, the idea of human vulnerability in this sense simply underlines a general interest all human beings share, which is an interest in their *welfare*. Welfare interests are those interests that can be said to contribute, benefit and further our well-being.[24] They apply to all and ought to be taken into consideration when generally thinking about our moral obligations.

Toddlers and children are not expected to take health-enabling decisions about their lives, of course. Yet I believe that some background conditions of vulnerability also apply to adults, in particular when thinking about the challenge of taking health-enabling decisions. The example I want to offer now is a person as a patient. The vulnerability a patient experiences derives from a different source: patients are those who depend on others to provide them with the necessities of life, in very dire cases, or at least with means to bring their lives to the kind of comparable standard of others who are not in the patient setting. This, we could say, defines their welfare interests. These interests can only be satisfied if we pay special attention to the needs of an individual patient.

Recall that I want to argue that some background conditions of vulnerability challenge our capacity to make health-enabling decisions but that the provisions of the CA to health can't address these kinds of vulnerability through the means of social public policy. Some background conditions of vulnerability, in other words, escape the attempt to assure health agency. This claim can be supported by taking a closer look at the background conditions of vulnerability that a patient experiences. I will first explain what *precisely* distinguishes the background condition of a person as a patient from that of a person without need of medical attention (1). Second, I will identify what precisely shapes the vulnerability within these background conditions so that it hampers a patient from being able to make health-enabling decisions takes (2).

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[23] O'Neill, Onora. 1998. Vulnerability and finitude. In E. Craig (Ed.), *Routledge Encyclopedia of Philosophy*. London: Routledge. Retrieved November 01, 2014, from http://www.rep.routledge.com.proxy.bib.uottawa.ca/article/L113SECT2

[24] Angela Martin, Nicolas Tavaglione, Samia Hurst. 2014. Resolving the Conflict : Clarifying 'Vulnerability' in Health Care Ethics. *Kennedy Institute of Ethics Journal* 24 (1) : 55.

(1) Most commonly, we describe a patient as a person who lacks in well-being. Patients, in other words, experience a very specific instantiation of the human fragility that is shared by all. Patients are those who realize that something in their body demands attention. Most minimally, we can say that a patient is a person who realizes, through her own observation or that of others, that she is not able, temporarily unable, or no longer able to function as she may wish. Second, a patient is a person who, when realizing this, aims to address this inability. Note that I take both the body and attention here in the largest sense. Note also that this realization is not measured against a 'norm' of ability or some such externally imposed criterion. What matters from the perspective of health agency is the range of options that a person considers available when thinking about her body. A patient is constrained by the demands of her body in what she can do.

The background condition of patients is comparable to that of newborns and toddlers I have mentioned above. We can say that all patients are more vulnerable *qua* patients – they are vulnerable to not being able to protect their welfare interests. They have to rely on others in a very specific sense to have their welfare protected. This is a question of degree of course: it ranges from pointed interventions like setting a broken limb, to longer-term interventions in the case of psychotherapy, to maybe permanent interventions as in the case of pain-management. As with the case of newborns and toddlers, this need not cause a moral problem– as long as welfare interests are protected as much as possible, as long as a person as patient is helped as much as possible to restore well-being, I believe it fair to say that no harm has been done.

(2) Recall the two steps of my argument. So far, I have explained that background conditions of vulnerability don't pose a moral problem; they do not warrant the strong moral claim proposed by the CA to health. I want to argue that this is the case *even if* the background conditions of vulnerability impede individual agency interests. Recall, now, the example of breast cancer screenings. In recent years, mammogram programs have come

under scrutiny from pubic health officials and doctors alike for reasons of 'overdiagnosis'[25]: the worry is that for many, the sensitive technology used will detect tumours that will then be treated even though the tumour itself would likely not have posed a risk to the health of the patient. Earlier, I argued that such tests should count as prime examples of enabling individuals to exercise health agency. However, the worry about overdiagnosis also illustrates to what extent individual agency interests can be hampered by the background condition of being a patient. Once diagnosed with a tumour, women have to take action; they have to decide between intervention and non-intervention, and in the case of deciding for intervention, they have to decide what kind of intervention, what level and extent of invasiveness even though to take such a decision is near impossible for them as patients. Even with careful preparation by doctors and oncologists, all we know are the probabilities involved in the development of the tumour, but not the specifics of the development of the specific tumour.

Here we see a challenge to the premise assumed so far that welfare and agency interests intersect. Following the CA to health, our agency interests contribute and support our welfare interests. We are meant to take decisions to further our well-being. The worry about overdiagnosis, however, suggests that this conversion is not always possible. Knowing more about different types of cancers, their development over time, success rates of different treatments or overall survival rates are meant to help us make health-enabling decisions, yet this is not so. We simply have no way of knowing how best to protect our welfare by having more means for agency.

Note that neither our agency interests nor our welfare interests are restricted by circumstances that are due to public policy. In fact, it is not clear what protection any policy however well-meaning could offer. Moreover, there is no specific moral obligation and no addressee for a moral obligation that we can derive from this vulnerability even though it affects both sets of our interests. To be sure, doctors ought to provide women with the available information about the reliability of mammograms and cancer development. But

[25] Independent UK Panel on Breast Cancer Screening. 2012. The benefits and harms of breast cancer screening : an independent review. *The Lancet* 380 (9855) : 1778-1786.

this obligation does not mirror the vulnerability that comes from being a patient and having to take a decision. If we accept this, then I believe that we also need to accept the limits of the CA to health. A background condition of vulnerability, even though it hampers capability to health, doesn't warrant the strong moral claim proposed by the CA to health to define health as a meta-capability that should guide social policy. Nothing in our designing social policy could change the challenge to health agency in a scenario like this.

This raises the question if Venkatapuram's thesis of health as a meta-capability is indeed warranted. Instead, background conditions of vulnerability may make the case for other capabilities to be agency enabling and equally worthy of protection. Nussbaum has developed a list of capabilities, many of which may prove important to protect welfare and agency interests.[26] For instance, think of the possibility to control one's environment as an important capability to promote our sense of who we are and our agency interests. What seems obvious from the example of cancer screenings, then, is that simply focusing on health agency as providing patients with more information may not actually promote welfare interests. In fact, this example raises a further question, and one that illustrates the liberal concern for agency interests: health may not be what we believe defines us. Instead, we may want to choose how we live our lives in the specific context in which we find ourselves. This may be the context of having been diagnosed with cancer. We may wish to emphasise our emotions and relations to others rather than focus on treatment, or we may wish to forgo treatment simply because we don't believe that the medical environment is one that we can control and that will protect our welfare interests.[27]

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[26] Martha C. Nussbaum. 2011. *Creating Capabilities. The Human Development Approach*. Cambridge (Mass.) : Harvard University Press.

[27] I would like to thank one of the anonymous reviewers for leading me to this conclusion of my example. One striking example how focussing on health rather than wellbeing and welfare more broadly can stifle individual agency is illustrated by Atul Gawande. 2014. *Being Mortal*. London : Profile Books. In his analysis of elder care, he criticizes the focus on medical intervention rather than genuine discussions between health care providers and elderly patients to identify what their specific interests and hopes for well-being are and what kind of intervention would realize these hopes rather than simply adressing a medical problem.

Conclusion

Venakatapuram's 'Health Justice' makes a strong case to conceive of health as a meta-capability that should guide social policy. In some cases, the claim to carefully scrutinize social public policy is supported by applying the liberal concept of vulnerability. If health agency is impeded by circumstances that can be affected by social public policies, we have a moral obligation to change such policies. A concern for the CH and a concern for liberal vulnerability then result in similar action-guiding principles. If, on the other hand, the vulnerability in question is due to background conditions of life, to design health as a meta-capability does not address the gap between welfare and agency interests. If we want to assure that individuals can hold on to their sense of self and their agency interests, making health a meta-capability neglects other capabilities that identify us as who we are and what we stand for. Instead, we should revert to the encompassing list of capabilities that should be protected by social public policy.