

**DEVELOPING AN INDEX OF
CAPABILITY FOR HEALTH AND
SOCIAL POLICY EVALUATION FOR
OLDER PEOPLE: THEORETICAL
AND METHODOLOGICAL
CHALLENGES**

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SUMMARY

Current UK policy suggests that greater integration between health care and social care for older people is desirable. Given this aim, previous qualitative work has developed attributes for a new measure focusing on quality of life (rather than health-related quality of life) for older people. Five attributes of importance to older people were found: attachment, enjoyment, security, control and role. Further, capabilities, rather than utility, seemed to be the focus of the older persons' concerns. This work concluded that further development of this measure should focus on developing an index of capability.

This paper focuses on theoretical and practical challenges involved in developing an index of capability. These are examined in three areas: attribute development, valuation and anchoring. First, conceptual attributes developed in the previous work must be "re-written" in lay language and developed into levels. Second, valuing these dimensions requires a theoretical reconciliation between Sen's view that preferences should not inform values and the concern to base policy on the views of those directly affected by interventions. Issues such as whose views are important, and how many values any one individual can provide, are also examined. Finally, concerns related to the anchoring of an index of capability are considered, ranging from "is anchoring necessary and/or desirable?" to issues about the practicalities of such anchoring.

This paper discusses these theoretical, methodological and practical challenges using fieldwork with 19 informants and a quantitative pilot study with 30 respondents to illuminate the issues and to indicate how the issues have been resolved.

INTRODUCTION

Current UK policy with respect to the provision of health and social care for older people suggests that greater integration is required between these two areas.^{1;2}

Economists' attempts to assist such resource allocation decisions, however, are very strongly focused upon the measurement of health, with the use of proxies for health, life expectancy, and health-related quality of life measures (in particular the Quality-Adjusted Life Year (QALY)³), dominating the empirical economic evaluation literature. Given the concern for closer integration, however, previous work by this research team has concentrated upon the development of attributes for a new measure clearly focusing on quality of life for older people, rather than health-related quality of life or influences upon quality of life.⁴

This previous work used in-depth interviews with older people to find out what was important to them in terms of their quality of life. Although discussion initially concentrated upon factors influencing quality of life (activities, relationships, health, wealth, surroundings and religion/faith/spirituality) further probing and analysis suggested five conceptual attributes were important to these older people. These five attributes were attachment (incorporating feelings of love, friendship, affection and companionship), role (incorporating the idea of having a purpose or 'doing something' that is valued, either by the individual and/or by others), enjoyment (incorporating notions of pleasure and joy, and a sense of satisfaction), security (incorporating ideas of feeling safe and secure, not having to worry and not feeling vulnerable) and control (involving being independent and able to make one's own decisions).⁴

Importantly, the previous study also suggested that the quality of informants' lives was limited by the loss in *ability* to pursue these attributes.⁴ So, for example, it is not poor health in itself which reduced quality of life, but the *influence* of that poor health upon each informant's *ability* to achieve the attributes outlined above, that was important.

This finding led the authors to link the work with the extensive literature on capabilities,⁵⁻⁷ associated particularly with the work of Amartya Sen,⁸⁻¹¹ and to interpret the five conceptual attributes as a set of functionings, the capability to achieve which

appeared to be of importance. The previous work concluded that further development of this measure would be focused on developing an index of capability rather than a preference-based utility measure.⁴

It should be stressed at this point that developing such an index of capability was not a starting point of the original research, but rather one which emerged from careful consideration and analysis of the qualitative data. Consequently, whilst an index of capability seems to most closely reflect the values of the older people interviewed, the purpose of the research is firmly situated within the economic evaluation paradigm within health care research, with the measure ultimately aimed at being a potential outcome measure for economic evaluation.

There are a number of challenges, therefore, faced by this research in terms of reconciling the notion of an index of capability with accepted norms within both health care and health economics. These include theoretical and methodological challenges associated with the development of attributes (dimensions), with the valuation of those attributes, and with anchoring the resulting valuations. In part these challenges arise because the literature on capabilities, whilst extensive, remains largely conceptual. Even where empirical work has been conducted, it has tended to focus on assessing the extent to which countries appear to perform more or less well if some measure of functioning is used rather than measures of national income.¹² Little evaluative work has been conducted⁶ and, apart from the development of the human development index,¹² the area remains largely conceptual.

This paper explains the process by which the set of five conceptual attributes has been developed into an index of capability. The paper draws on two empirical studies, one a further qualitative study with older people, and one a quantitative pilot study. These are described in detail in the body of the paper. The paper is structured around three challenges which were faced in this research, each of which is split between theoretical problems and methodological problems faced by the research. The three challenges were defining attributes, valuing attributes and anchoring values, each of which is discussed in turn. The paper ends with a more general discussion.

CHALLENGE 1: DEFINING ATTRIBUTES

Theory

As previously indicated, the attributes for the measure were derived using qualitative work with older people themselves. This makes the process of the development of attributes for this index very different from the processes usually used in, and indeed recommended for, developing important attributes in the work of other capability researchers.⁶ Attributes are more commonly arrived at by a process of development by a single researcher or group of researchers, followed by debate by the wider research community.⁵ There is currently much concern in the capabilities literature with the issue of whether a single list of capabilities could, or should, be developed, with Sen and his supporters suggesting that a single list should not be endorsed^{5;6;13;14} on the grounds that “no one set will do for every evaluation” (Alkire,¹³ p.119), but others such as Nussbaum suggesting that the approach is weakened by the lack of a single list.⁷

Interestingly, only five attributes were developed from the original qualitative research, whereas the lists of attributes or dimensions in other work on capabilities tends to be much longer.⁵ (The exception being the Human Development Index which has just three dimensions: national income, literacy and life expectancy.¹²) This seems to have arisen for two reasons. First, the attributes derived in the original work were obtained in the particular context of older people in a developed country in the early 21st century.⁴ Attributes related to survival, sometimes referred to as “basic capabilities”⁶ such as the capability for nourishment, were never discussed by any informants,⁴ but such attributes are commonly found in the lists of capabilities provided in the literature^{5;7} and Sen notes that some of the basic capabilities will feature in most lists.¹⁴ Second, as part of the analysis of the qualitative data, there was a clear emphasis on deriving separate and mutually exclusive attributes, in a way which does not seem to have been pursued across other work. Indeed, despite the emphasis on the difference between means and ends in the capabilities literature, some capabilities (for example, health) are seen as being both ends in themselves and means to achieve other capabilities.⁶ Because of the

potential for double-counting the benefits of an intervention where both means and ends are included in the same index, it was felt to be important in this research to arrive only at end-points. Care was taken to ensure that these end-points were comprehensive so that, for example, omitting health did not result in the omission of the element of health that is an end in itself, which is conceptualised as an element of enjoyment. The list of attributes developed here, therefore, may look somewhat different to lists developed by other research teams for other purposes.

Methodology

The attributes that emerged from the initial qualitative work were attachment, role, enjoyment, control and security. These conceptual terms were defined by and had meaning to the researchers,⁴ but clearly were largely described in terminology that would not be meaningful either to older people themselves or to policy makers. In terms of using an index based on these attributes for policy evaluation in health and social care, it is clearly more helpful if people can understand the meaning behind the conceptual labels so that they can indicate for themselves to what extent an attribute is attainable in their lives.

The research was thus faced with the methodological issue of ensuring that the terminology used in the eventual index of capability represented the conceptual attributes, whilst expressing the attributes in language that would be meaningful to the eventual users of the index. It was therefore necessary to “translate” the conceptual labels into lay language, ensuring that the language used evoked the same meaning for informants as the conceptual labels evoked for the research team. Any “translation” process also had to maintain the mutually exclusive nature of the attributes.

It was decided that a second stage of qualitative work, using iterative techniques to constantly refine the language used, would be the best way to proceed. Semi-structured interviews were therefore conducted with 19 of the informants interviewed during the earlier work (from two out of three of the original locations). Informants were approached and asked if they would be willing to take part in a further interview.

Informants who gave consent were visited in their own homes. All interviews were tape recorded, again with consent, and transcribed verbatim.

The research team began by brainstorming for potential lay terminology that might represent each of the conceptual attributes. The attribute “security” will be used here as an exemplar, as this was the term which, in the event, was most difficult to clarify. A number of different ways of expressing this concept were initially thought of by the research team, including: security, not feeling vulnerable, having money or support so you don’t have to worry. It was not clear what would be the best way to proceed in terms of clarifying language and two different techniques were therefore tried. The first was to use cards upon which were listed various “descriptors” associated, by the research team, with the five conceptual attributes. Informants were asked to sort these cards so that they were linked with the conceptual attributes, described using lay language. The second task was to ask informants to describe what particular terms meant to them. The second technique proved to be more effective, in that informants were not constrained by the research team’s descriptions, and so that was used for the majority of informants.

Analysis was ongoing throughout the research, with a small number of interviews being conducted and then analysed before going on to the next few interviews. Analysis used the techniques of constant comparison^{15;16} and the writing of accounts to elucidate the different areas. So, with the security exemplar, initial interviews produced the following meanings for the use of the terminology “vulnerable”:

“... I see vulnerable as being if you’re out after dark... vulnerable to things that may or may not happen...” (Male, age 77)

“...vulnerable to me almost implies danger, you know, somebody’s going to come along and cosh you on a dark night... But it’s not what we’re trying to say I don’t think. You’re trying to say vulnerable in the sense that you’re not going to be able to cope and you’re not going to be left not to cope... Whereas the idea of vulnerability that comes immediately to me is being mugged.” (Male, age 76)

This term was therefore abandoned as it was clearly evoking the wrong meaning for at least some informants as was the term “security” which for one early respondent evoked a focus on national security:

“At the moment I’m looking at the blackest scene to think we’re certainly going to have a huge conflagration throughout the world... We’ve got America that’s deciding... I think of the bigger picture.” (Male, age 70)

An alternative terminology tried was “money or support so you don’t have to worry”. Here, again, the interpretation did not work however, as money was immediately focused on by informants to the exclusion of other aspects of security:

“Just as long as I have enough to see me through...” (Female, age 73)

“...financial support to me is sort of like state benefits you know or something like that” (Female, age 66)

A fourth terminology tried was “not having to worry about things”. This also evoked a concern only with finances for some people, but for some people, the use of the word “worry” conflicted with their own self image, making it difficult for them to identify with the terminology:

“... you get natural worriers, you know, people who worry “oh, did I lock the door before I came out?” and they’re not happy unless they go back...” (Male, age 77)

“I am not a worrier, I’ve never been a worrier because I always think ‘what’s the good of worrying, it’ll either come out or it won’t’... so I think that is a lot to do with me individually.” (Female, age 85)

Adding the notion of the future seemed to deflect people’s thoughts away from current monetary concerns, however, so the terminology “thinking about the future without having to worry” was tried and seemed to evoke meanings closer to those envisaged in the original concept:

“... to know that you’re going to be able to live reasonably securely, secure in health, financial security and probably emotional security” (Male, age 70)

The use of the terminology of “worry” was still not completely evoking the right responses, however, and so the terminology finally settled on was “thinking about the future without concern”:

“when you know a lot of people that’s elderly that can’t do things for themselves, they’re bound to be concerned aren’t they? Never ‘avin’ nobody go in there...”

(Female, age 66)

“I often think just briefly, ‘Well who’s going to look after me?’ Cos the family are too far away.” (Female, age 74)

“I can only think about the future with a lot of concern, and that is purely two things I put in that category. One, of course, is the most important, which is your health. And the other is finance. Because as time goes on, it’s not getting any easier.” (Female, age 69)

Changes were made to the interview schedule after each small group of interviews, such that topics for which saturation had been achieved (that is, the research team were satisfied that the terminology had been established with the meanings of the terms being clear to respondents) were no longer considered. The final set of terminology was:

- Attachment – “love and friendship”
- Role – “doing something that makes you feel valued”
- Enjoyment – “enjoyment and pleasure”
- Security – “thinking about the future without concern”
- Control – “independent”

CHALLENGE 2: VALUING ATTRIBUTES

Theory

Much of the work in outcome valuation in health economics currently is based on the elicitation of people's preferences for different (health) states. There are clearly, however, different theoretical bases for these valuations. Welfarists using cost-benefit analysis tend to be concerned with the estimation of monetary values for different options as an expression of the individual utility associated with an intervention or policy change. Non-welfarists using cost-effectiveness analysis with the QALY as the unit of benefit, tend to be concerned with the estimation of the value of a particular health state, sometimes by the population and sometimes by the patient, sometimes on the grounds that this is an estimate of "health-related utility" but at other times being concerned mainly with preferences for different health states. Both groups, however, have a clear concern to avoid the use of health care professionals or policy makers as the group whose values should be elicited and there would be little support for the use of researchers' values to be incorporated within a measure.

This tradition within health economics, therefore, seems somewhat different to the tradition within the capabilities literature, where deciding on values is explicitly not linked to individual preferences. As Cookson notes in his paper on the application of the capability approach to health economics, "Sen explicitly rejects the use of either choices or desires to value capabilities" (Cookson,¹⁷ p.821) and, as Cookson further notes, Sen's approach is based on value judgements. Cookson suggests a way around the problem of reconciling the two approaches, which is to think of the views elicited from a population as representing their value judgements, rather than their preferences.¹⁷ This use would imply that it is possible to obtain information from the relevant population about their value judgements, and to use this as evidence for the choice of values given to each of the different dimensions.¹⁷ Essentially, then, the values obtained from a population would provide evidence for the final value in the capability index but the final value in the capability index would not be bound by these final values. Of

interest then, of course, is how one would move from evidence of values to the final values to be used.

Sen is concerned that the capability approach should not rest exclusively on mental states such as happiness, with moral judgements also needing to be incorporated into an index of capability.⁶ Much of the capability approach is concerned with democratic debate and deliberation – particularly for the development of “lists” of capabilities, but also in relation to the values and weights that these capabilities have. Indeed, in a recent paper Sen refers to “the need for open valuational scrutiny for making social judgements” (Sen,¹⁴ p.157) It is not clear, however, how the “processes of public reasoning and democracy are going to take place, and how we can make sure that minimal conditions of fair representation are guaranteed.” (Robeyns,⁶ p.106) One option for this work, therefore, might be to elicit value judgements from the population for whom the index of capabilities is to be used – here older people in the UK – but then to decide on a final set of values using a more deliberative approach. This deliberative approach could involve a set of focus groups including older people, health and social care decision makers, charities concerned with health and social care for older people, and so on. These groups could discuss the values elicited from the older people and, taking into account any other concerns, could then decide on a set of values for use in policy appraisal. Reasons for divergence from the set of values obtained from older people directly could be detailed such that the final set could be justified.

This two stage approach, of first eliciting older people’s values, and then using this as evidence within a process of deliberation and debate seems to be an approach which both fits in with the expectations within health care and health economics, that the views of patients and the public are more important than those of health care professionals and policy makers, but allows for the democratic deliberation that is valuable in the capability approach for ensuring that people’s (possibly poor) expectations do not drive public policy.

If this is the approach to be taken, what method of eliciting value judgements would be most appropriate? Standard approaches within health economics would include willingness-to-pay (as a method for valuing health outcomes in monetary terms), methods associated with QALY measurement including standard gamble and time

trade-off, and the newer methods of Stated Preference Discrete Choice Modelling.¹⁸ Willingness to pay explicitly links values with money which, it is felt here, is inappropriate for an index of capability. Time trade-off requires values to be obtained with reference to the state of death. Although this is helpful for QALY measurement, it may or may not be for developing an index of capability (see section below), and hence time trade-off was rejected on these grounds. Questions have been raised about the ability of standard gamble techniques to address observed 'idiosyncratic context dependent risk behaviour' on the part of respondents.¹⁹

Discrete choice modelling is potentially a useful method for eliciting values because it imposes few prior assumptions about the way in which these values are constructed, although the method is grounded in random utility theory.²⁰ Discrete choice experiments can take a number of forms. Pairwise comparisons are the most common in health economics, where choice sets are of size two and respondents are asked to choose between two scenarios (alternatives) in each pair. Best-worst scaling²¹⁻²³ is another form of SPDCM, where respondents are presented with choice sets of size one and asked to identify the best and worst (most and least attractive) attribute within that scenario. The only assumptions made are that respondents can choose the best and worst from a set of attributes, but that they can and do make errors.

Methodology

Having decided on a design for taking forward the valuation of the index of capability, a number of methodological issues presented themselves. These were examined during the second stage of qualitative work described above, and during a pilot discrete choice experiment which was conducted by 4 interviewers with 30 respondents in one area of the UK. Respondents taking part in the pilot had not previously taken part in the qualitative work. Interviewers were briefed prior to the pilot and de-briefed by telephone following its conduct. Interviewers were also asked to write on the paper copy of the questionnaire all comments made by the respondents, as well as to include their own perception of any difficulties in the interview.

The first methodological issue was that the five attributes, now in lay language, had to be rewritten as a series of levels, and as capabilities rather than functionings. This latter problem was of particular concern in that it would potentially make the statements that older people had to consider more unwieldy. For example, if the attributes had been written as functionings rather than capabilities, the top level for enjoyment may have appeared as “You are completely independent” rather than its eventual expression as “You are able to be completely independent”. The latter is clearly more difficult to read and understand than the former, but the aim here was to focus on capability rather than achieved functioning¹³ so it was important to check during the qualitative work and at the pilot stage that informants appeared to be able to comprehend the terminology used and to ascribe meaning to these different levels of capability for the attributes given.

In general this appeared to be the case and, although it took them a short amount of time to get used to the terminology, informants did not appear to have particular difficulty with the phrasing of the attributes in terms of capabilities. They were able to describe what particular levels and capabilities meant to them. For example, in response to the independence highest level as described above, one informant stated:

“I would take it that I can completely look after myself with no outside help from anybody on every aspect of my life.” (Female, age 69)

And in relation to the love and friendship lowest level attribute (“You cannot have any of the love and friendship that you want”) the informant stated:

“...because all my friends are dying and I haven’t the ability to make new friends, as real friends, you know, as bosom pals... I mean I can be friendly with people but I can’t make them part of me as I did with these people that I loved so dearly.” (Female, age 81)

A second methodological issue concerned whether informants could work with the notion of choosing a best and a worst option from each of the scenarios. Again, this was examined during the qualitative work, and also during the pilot. From both pieces of work it was clear that respondents took a while to grasp what they were being asked to do, but most grasped it within one or two scenarios. It became apparent in the pilot, however, that a number of respondents had difficulty for some scenarios in identifying a

best and a worst aspect of the scenario presented. This tended to be when all aspects of the scenario were very good (when identifying a “worst” attribute was difficult) and when all aspects of the scenario were very bad (when identifying a “best” attribute was difficult). This difficulty was noted in text comments for at least one scenario for 7 of the 30 pilot respondents, and for eleven of the 28 respondents who completed the pilot survey there were data missing for one scenario, and for one more data were missing for two scenarios.

A third methodological issue concerned the number of best-worst scenarios that older people would be able to cope with in a single interview, bearing in mind that this group of respondents potentially includes a number of members who are frail and experiencing health problems. Linked to this issue – as well as to the resources available – was the feasibility of looking at interactions in the design, rather than just main effects. For 5 attributes each with four levels, 16 scenarios need to be completed by older people to estimate main effects. To estimate main effects and all first-order interactions, in the order of 50 or more scenarios would need to be completed. This was not considered feasible, and a blocked design (giving different subgroups different versions of the questionnaire) was not possible given the resources (and hence maximum sample size) available. However, utilising a small main effects design (one where the number of parameters to be estimated is relatively large relative to the number of scenarios) can have adverse implications for statistical precision. In the event, therefore, the main effects design obtained was used in conjunction with its foldover, to produce two statistically equivalent orthogonal sets of 16 scenarios. With the resources available for this survey, it was not possible to consider interactions, but future work may be important in this area.

The pilot discrete choice experiment was used to determine whether older people were able to cope with completing 16 scenarios. Out of the 30 interviews undertaken, only two had to be stopped. The first was stopped because the respondent “seemed unable to imagine herself in any other situation” and the second because the respondent was unable to read the scenarios for himself and thus had to try to memorise them. Neither of these respondents contributed any data to the analysis. On average the pilot interviews took around 37 minutes.

CHALLENGE 3: ANCHORING VALUES

Theory

One aspect of the valuation of health outcomes for the purposes of health economics is the desire to combine information about quality and quantity of life. This is because interventions in the health field frequently impact on either quality or quantity of life, or upon both, and there is a desire to be able to compare across interventions that provide these different benefits.²⁴ There is however a question about the meaning of anchoring at death as is done within the QALY and what it means to include death on the same scale as quality of life: is the absence of life the same as the absence of health? Or, in this case, is the absence of life the same as the absence of capability?

This index of capability thus faces the question about how to deal with potential mortality resulting from an intervention. The capabilities literature does not suggest anywhere that capabilities should be combined with length of life and, indeed, the inclusion of basic capabilities such as the ability to be well-nourished as important capabilities⁸ suggests that the potential for mortality is taken account of through a different mechanism and more indirectly than it would be in traditional health-related utility indices.

Theoretically, there seem to be three options for the question of anchoring. The first is to not anchor the index of capability by including death. It could be argued that capabilities are incommensurate with life, and that such anchoring should not be done.

A second option is to work with the terminology developed for the capability index: this terminology incorporates the notion that *You are unable to have... (attachment, security, role, control or enjoyment)*. It could be argued, potentially, that being unable to have any of these capabilities is, in essence, equivalent to death. Anchoring of the index at death thus happens by default and by definition. Indeed, it is noted in a paper concerned with the Human Development Index that survival is a prerequisite for enjoying other capabilities.¹²

A third option is to work with the notion of how people value the different scenarios with the different levels of capability, by asking them to consider each scenario and decide whether or not they would value the state as being better than being dead or worse than being dead.

Each of these options is a viable way forward and no decision has yet been taken about which is preferable, because it is an area where debate and discussion would be extremely beneficial in informing how the index is developed. It is an area that could be considered both by professional groups and by older people themselves, and will be taken to the sorts of focus groups proposed in terms of valuing attributes. It was, however, important to build the opportunity of achieving the third option into the survey of older people's values and that is the subject of the next section.

Methodology

The most obvious method for achieving the third option within the discrete choice questionnaire was to ask, for each scenario, whether the respondent would prefer death to the scenario described. There was initially concern, however, about the ethics of asking such a question to frail older people who might find it extremely upsetting. Within the later qualitative interviews, however, the issue did arise spontaneously when informants were asked to identify the best and worst attributes from very severe states:

Interviewer: ...imagine yourself in this situation, where you can't have any of the enjoyment and pleasure that you want, you cannot have any of the love and friendship that you want, you are unable to do any of the things that make you feel valued and you are unable to be independent and you can only think about the future with a lot of concern.

Informant: That's dreadful, dreadful. I should want to die (Female, age 81)

It was, however, felt that the question "would you prefer to be dead" was a difficult and potentially unethical question to ask informants, and did not wholly fit with the capabilities approach, where the aim is to find out about values rather than preferences

per se. Instead, therefore, an alternative formulation of the question: “would you say this was a life worth living” was explored with a small number of informants towards the end of the qualitative work and used in the pilot. The question did not appear to cause difficulty in the interviews in that informants were not upset by it and could provide some answer to the question. When the question was used in the pilot interviews it became apparent that twenty respondents never described a scenario as being a life not worth living, whereas the remaining eight were happy to identify a number of scenarios as being lives not worth living. There is a suggestion from the qualitative work that this may have to do with the views of some people that all life is intrinsically worthwhile:

“...if it’s the only life then we would have to accept it with grace but it would be a lot of grace on my part.” (Female, age 71)

DISCUSSION

Cookson suggests that “unfortunately, it is not possible at present to directly apply the capability approach to economic evaluation.” (Cookson,¹⁷ p820). This is for two reasons, one being concerned with the difficulty in obtaining agreement about the relevant list of functionings, and the second being concerned with estimating capabilities. This work seems to go some way to addressing these difficulties but many questions remain. In particular, there are questions about whether it is possible to reconcile the notion of an index of capability with, first, the sorts of purposes for which such an index is required in health and social care in the UK, and second, with prevailing views about whose views matter for these purposes.

There are clearly further challenges associated with some of the solutions proposed here: if values are to be adjusted during deliberation and debate, on what basis will this be done? Who should be included in such deliberation and debate – for example, should the views of the young be sought because of the problem of potentially reduced expectations among older people?

A further issue concerns the use of an index of capability within economic evaluation in health and social care. One option would be to use such an index essentially as a QALY replacement – as a means of retaining a single measure of outcome for such evaluations, but with that measure covering more than just health in that its concern is quality of life more broadly, and capability rather than utility. Whether this index could be used in such a way depends on a number of factors. First, it depends on the decisions taken finally about combining survival with capability. If the decision is taken to not anchor the index at death, then the measure would be unlikely to become a substitute for the QALY. Second, it needs to be remembered that the attributes developed in this work are for use among older people. To develop an index of capability relevant to a wider population would certainly require additional early development work, for example, additional qualitative research among younger sub-groups of the population.

A second option for using such a measure would be as one of a number of outcome measures along the lines of a cost-consequences approach.²⁵ This might well fit better with both a non-welfarist approach to economic evaluation²⁵ as well as the capabilities approach. As Alkire states “Sen argues that no one principle – for example, efficiency maximisation – suffices for normative economic problems. Rather, a plurality, not only of informational ingredients, but also of combining principles, should be considered” (Alkire,¹³ p.124).

We would welcome discussion on all these topics from participants at HESG.

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