

Health Needs Assessment

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Abstract

This chapter begins with a consideration of the technical processes used for conducting health needs assessment. The ways to plan the exercise, assess the structure of a given population, examine the effectiveness of potential interventions and conduct evidence syntheses are described. The complexities of health systems are noted. The relationship between health needs assessment and health economics is then examined. The philosophy of utilitarianism and its influence on health economics is explored. Cost utility analysis and its links to studies of quality of life are described. The important relationships between equity and efficiency are considered. The chapter then proceeds to explore the political and philosophical issues attaching to health needs assessment particularly health inequalities and the issues of justice, fairness, and equity. This leads to an elaboration of the concept of justice derived from the work of Sen. Using ideas about the importance of human capabilities an argument is developed about the relational approach to understanding justice. The relational as against the individualistic position is found to provide a novel and useful way of describing health need and of attempting to meet that need. It also provides a set of precepts about the ways that services might be configured.

Key words

Health needs assessment, health economics, utilitarianism, capabilities theory, health inequalities, justice.

Introduction

The idea of health needs assessment is, on the face of it, straightforward. In theory it ought and could inform the planning and provision of health services in any jurisdiction. It is a simple formula; measure health, assess need and orient services accordingly. In an uncomplicated world the assessment of health need and health-care need would be a tool for tackling inequalities, a pre-requisite for the allocation of resources and the first step in planning and evaluating care¹.

In practice however, as we will show, this neat and tidy formula raises some fundamental problems about the appraisal of, and the response to, health needs. The apparently straightforward approach requires us to confront some of the most vexing problems of definition and measurement in health and public health. Terms like health, health-care, need, equity, equality, fairness and justice, among others, have to be considered in detail². They turn out to be far from simple or straightforward.

Needs assessment has been defined as a process which takes 'a population-based, epidemiological and public health approach to the planning of health interventions'. That means using data about population patterns of health to do rational planning in order to meet the particular needs of all, or parts, of the community, taking account of equity, efficiency and affordability. In principle this approach to needs assessment might be used as the basis for planning in any health system³. It aspires to 'maximize the appropriate delivery of effective health interventions or care ...in an evidence based way ... [to] maximize equity'⁴.

However, 'need' is a slippery idea, which is not easily defined. Two broad approaches to assessing need will be outlined. The first is a very practical approach, which emphasizes measurement and tends to focus on the needs of sub-sets of populations and rarely tries to assess need in whole populations except in emergency situations⁵. In this view there are several levels of need; sub sets in the population, groups of people with specific conditions, or a population using a particular service for example. Both

individuals and families will each generate different profiles of need. The second, broader and more political and philosophical approach to need, operates mostly at the level of total populations or whole societies and is concerned with broader questions of justice, fairness and equity. We explore both of these approaches and identify some of the tensions between them in this chapter.

Epidemiological health needs assessment.

We begin by focusing on the more practical approaches. In this view assessment of need must include an assessment of the effectiveness of interventions to meet identified health needs⁶. The assumption is that the relative total need can be measured sufficiently by just a few factors such as standardised mortality or morbidity rates. It emphasises quantification and objective comparative measurement. This type of needs assessment is usually dependent on existing or available data, it seldom involves generating new information from primary research because this would be too expensive and take too long. Health needs assessment tends therefore to be based pragmatically on the routine data sources that are there already⁷.

There are a number of distinct steps. It begins with clear problem definition. To do this, two questions need to be considered. What do we want to find out about the population, and how can we go about finding it out? A series of further questions can then be asked to help clarify the process: why is this assessment needed now, who will be affected, what would the consequences be of doing nothing, how much time is available, how can the results and the recommendations be presented to maximal effect, are sufficient resources available, and how will the needs assessment be itself assessed and evaluated?⁸.

A detailed project plan identifying the component parts of the exercise should be prepared. Central to the exercise will be an epidemiological assessment which will determine how many people in the population need care and at what level and what services are available for them. It is important to identify the denominator population, that is the total population or relevant sub-

population because otherwise it is very difficult to interpret prevalence (total number of cases) and incidence (new cases in a given time period)⁹.

Collecting data like this tends to be more straightforward in developed countries. In less developed countries data systems tend not to be so reliable, although where data systems are less than optimal other options may be available¹⁰.

Details of the structure of the population need to be built into needs assessment; the age, ethnic, occupational and geographical contours of the local population and the patterns of health inequalities will need to be assessed and described¹¹. The level and severity of the diseases of interest need to be examined at this stage too, along with an assessment of the prevalence of relevant risk factors - for example levels of smoking, physical activity and alcohol consumption. In a population with a significant number of Afro Caribbean people an assessment of sickle cell disease might be a particular focus of interest, in a mining community chest disease might command attention. The absolute number of people suffering from the condition, and the degree of severity can then be calculated¹². If assumptions have to be made in the absence of data and proxy variables are used, these must be made explicit.

The next stage is to develop an assessment of the clinical effectiveness of interventions for the condition or conditions of interest. There are a variety of ways of assessing effectiveness. However, if we are concerned to determine the clinical effectiveness of a medicine, or some other kind of intervention, we will get a more accurate assessment if we use evidence in which a control is used and potential biases are minimized. If this is so, we can be reasonably sure that the observed size of the effect is a consequence of the intervention not some other biasing factor. Some commentators suggest that using only evidence drawn from the top of the evidence hierarchy to assess clinical effectiveness is the way to do this¹³. The evidence hierarchy is a device which categorizes studies according to the methods they have used and the degree of bias which is associated with the methods. Randomized controlled trials (RCTs) and the meta analyses of the such trials rest at the top of the

hierarchy as these methods are deliberately designed to eliminate bias and offer the greatest certainty that the observed relationship between the independent and the dependent variable is the consequence of that relationship, not some other factor.

It is possible to make an assessment of the effectiveness of interventions by examining clinical trial data for its quality or bias. So it would be quite appropriate, but very time consuming, for someone conducting a needs assessment, who is interested in the effectiveness of particular treatments, to examine RCT findings directly. An easier route is to use the evidence of effectiveness which has already been appraised for its quality in Cochrane reviews. These are produced by the Cochrane Collaboration, a world-wide network of reviewers conducting quality appraisal of primary intervention studies. Alternatively data examined by the National Institute for Health and Clinical Excellence (NICE) who conduct clinical and cost effectiveness analyses of new technologies, treatment pathways and preventive interventions in the UK can also be consulted. The assessment of effectiveness is based on a set of principles which collectively are known as Health Technology Assessment¹⁴.

After the effectiveness analysis is complete a synthesis of the evidence is then undertaken of the epidemiology in the local population, incidence and prevalence, underlying risk factors, treatments and interventions ranked according to effectiveness, along with evidence of cost effectiveness and actual costs (see below). These will, of necessity, be imprecise, but if assumptions are made explicit they will suffice as a starting point for needs assessment¹⁵.

Once data have been collected on the local population of interest, the next stage is to compare locally derived data with data from other places in a *comparative* needs assessment. This allows an appraisal of the degree to which local provision is consistent with what might be expected on the basis of the comparisons. This is sometimes difficult because rates of interventions vary both within and between countries, but the process is about putative

differences between the observed and the expected values rather than exactness. It is important to consult with stakeholders at this point and genuine community participation is important. . Rapid needs assessment may come into play where statistical and other data are unavailable¹⁶ . All of this is brought together in a “case for change “document” which will outline what is in place, what ought to be done, what stakeholders believe should be done and what the community want done. Costed options are essential to inform redistribution of resources. The final step is to act on the needs assessment and implement a plan.

Health systems are complex socio-technical arrangements consisting of people, cultures and practices, organizational structures, equipment and technologies. Health systems are constrained, because whatever the system, the resources to fund them are finite. Because of finite resources it is not possible to do everything, to fulfill every need or to adopt every new drug, procedure or device. At the same time demand for health services rises because expectations of what medicine can achieve increase. People, especially in advanced societies, frequently think that they deserve or have some entitlement to – that they *need*- the best and most up to date medicines and procedures. The availability of a medicine therefore often creates the demand *and* the need for it – patients want it and doctors want to use it. All of this adds to the demands on the resources in the system.

Health systems have to adapt to constantly evolving set of inputs in the form of new medicines, medical technologies and approaches to medical and surgical interventions. Decisions have to be made about the adoption and use of these new things. In addition, the health needs of populations are complex and change. For example the age and ethnicity distributions of populations alter. Not only do populations change, but health systems themselves also evolve. Needs assessment, is one means of deciding how to allocate scarce resources to prioritise and tackle need in the face of these complexities. A needs assessment provides a basis for decision making, which will include local knowledge and understanding of the nature of communities, their socio-demographics and physical environment. Health needs assessment consists

of a range of techniques to assess and meet need in a rational and systematic way against this background of complex and changing systems, population diversity, evolution and increasing expectations and demand. An understanding of the social environment and the social relationships within those environments is essential to successful implementation of needs assessment.

Later in this chapter we explore some of the difficulties attached to this approach. However, it is very important to remember that applying rational principles in this way arose from an understanding that the operation of an unmanaged system in which historical patterns of supply, the generosity of benefactors, the preference of medical practitioners to live in attractive areas, and their wish to provide services that were consistent with *their* interests led to very unequal and inefficient distribution of resources. So whatever the imperfections of the rational approach, it was born out of a desire to do things better and more fairly.

Health economics and needs assessment

Over the last several decades, two important techniques have come into general use to assist the allocation of resources in the face of scarcity in health systems; health technology assessment which helps to assess effectiveness of interventions and cost utility analysis in health economics, to help assess cost effectiveness¹⁷. We have already discussed health technology assessment above in the context of assessments of effectiveness. We now turn our attention to the contribution of health economics.

The discipline of health economics has been profoundly influential in the approach to health needs assessment outlined in the previous section. It is possible to trace a link between the ethics that govern economic thinking and the techniques and tools that economists develop and apply. Trends and momentum for change in advanced health systems are also important because health economics has over the years operated with changing concepts of need, and approaches to, and techniques for measurement, assessment and evaluation of health programmes and interventions. There

have also been some important new ideas to challenge conventional orthodoxies¹⁸.

As a starting point we look to Utilitarianism – which is the ethical basis of the discipline of economics. It is a theory that holds that the proper course of action is the one that maximizes utility, specifically defined as maximizing happiness and reducing suffering. Utilitarian ideas grew out of the writings of Jeremy Bentham. Bentham had legal training and wrote on a wide range of subjects connected with creating conditions for common or social good and living in harmony. He spent much of his time travelling and tried to interest various heads of European states in his ideas. One Bentham idea that illustrates his thinking related to prisons. He suggested a surveillance system called the ‘panopticon’. The theory of ‘panopticon’ is that prisoners behave appropriately in a prison setting if they believe that someone they could see in a watch tower holding a gun, could see them at all times. This idea seems at first rather odd as a model for social good. But Bentham theorised that the armed guard would only need to make their presence felt for a short time, and after that prisoners would behave as if the armed guard was there, and would not know if in reality the guard had disappeared. He argued the ‘panopticon’ principle of surveillance of behaviour that conforms to social norms could be applied successfully to engender harmonious living among social groups and communities in society as a whole – the threat of the use of force, rather than the actual use of force.

Utilitarian ideas, theories and techniques are concerned with the common good or the greatest happiness of the greatest number¹⁹. Utilitarianism in allocation of resources for the common good of society has much to commend it. But the tools and techniques do tend to favour the *status quo*. They do not challenge or on the whole try to amend existing resource allocations that might be considered to be unfair or unequal. Utilitarian tools and techniques if applied without critical reflection implicitly approve existing resource allocation and aim to improve social welfare starting from that point. They make what might be viewed as conservative changes to re-allocate

resources, so that at least one person is made better off and nobody else worse off²⁰ .

Utilitarianism, or the greatest utility of the greatest number, is the ethic that still guides economic thinking, tools and techniques and is also central to the ethic of health needs assessment. However, at the end of the nineteenth century, the future direction of economics as a discipline was influenced by the introduction into mainstream economic theories of mathematical thinking from the physical sciences and engineering. The concerns and subject matter of economics moved from a focus on questions of political economy, for example, generating free trade between countries for maximising the common good and how the growing population would feed itself, to more narrowly-focused, 'scientific' questions, for example, how to maximise utility in buying goods and services and how to maximise profits²¹ .

Economics moved away from broad questions of how resources should best be applied for the good of society - a mix of value judgement on social welfare and observation of facts, to empirical testing of hypotheses using data – more akin to a version of laboratory experiments. For example, economists became very interested in the relationship between unemployment and inflation and used empirical testing of data to test hypotheses concerning these variables.

A new more scientific language and a range of tools and techniques emerged from economic theories which tended to distance itself from the messy details of complex behaviour. The legacy of these changes still survives within economics. A quick perusal of the main economics journals today reveals numerous articles containing strings of equations to test hypotheses, as well as outlining the intricacies and new derivatives of different economic techniques and tools and how to apply them rigorously. In addition, the need within the economics discipline to find mathematical solutions to applied problems has guaranteed survival of the basic assumptions of the economic way of thinking i.e. people, firms and institutions are perfectly rational and behave predictably, as if, they have perfect information and control over

environment and events. In economics people are assumed to be equal and social/cultural and environmental/place variations between them are not acknowledged explicitly. So when health needs assessment is defined as rational this is the underlying rationality.

Health economics has developed particular techniques and tools, in particular the Quality Adjusted Life Year (QALY)²². This is steeped in utilitarianism - allocating resources efficiently for the common good - in this instance fair allocation of health technologies and other interventions in the face of finite resources. Economic thinking is predicated on the notion that most resources are scarce and have limits, but demand on those resources is potentially infinite. This creates choice and opportunity cost meaning that once resources have been allocated and used they cannot be reallocated and used again in another way²³. Health has been characterised as a multidimensional, dynamic concept subject to changing human expectations and revision over time²⁴. The economics of health has therefore also developed over time to reflect these changes. Since the Second World War, successive generations of theorists have sought to embrace new ideas about health. For example, economic, social and psychological aspects of health have been included to reflect changing expectations, the nature of health systems, stage of economic development and passing time²⁵. From the late 1980s in developed countries, definitions of health broadened considerably to reflect the notion that wellbeing is inseparable from and crucial to health, and in turn, both are influenced by society as a whole²⁶.

An important idea that has been used in health economics in this regard is quality of life (QoL)²⁷. Various instruments have been developed to measure QoL²⁸. The best QoL measures detect the cultural factors that influence health perceptions, including the health of others in the individual's community or group, the nature and severity of illness, demographic characteristics and social environment²⁹. Debates about Quality of Life measures have ranged over whether QoL should be measured at all³⁰, how it should be measured if it has to be³¹ and how QoL measures might be applied³². QoL is a hotly

contested concept. However it has been applied successfully to measure the outcome of health interventions and very importantly in units of common currency using the QALY. A distinction is made between the concepts of quality of life and health status. QoL measures try to capture current broad definitions of "health"³³, while health status measures include socio-economic dimensions as well as physical factors. Quality of life relates in addition "to how a person feels and functions in his or her everyday life"³⁴.

The Quality Adjusted Life Year (QALY) itself is used to assess cost effectiveness of interventions. A QALY is a number indicating the size of health gain from an intervention. QALYs are conceptualised by first imagining years of life lived in perfect health with a perfect QoL. The QALY is constructed by combining estimates of life years saved (Life Years) by the intervention with values for utility of different health states (Quality Adjustment). It is created by combining quantitative information of length of survival with 'softer' information of patient perceptions of quality of life³⁵. The essence of the QALY is that people will trade-off length of life for quality of life - they would rather live shorter lives with full quality of life than longer lives in which quality of life is poor. QALYs are the outcome measure used in cost utility economic evaluation. Cost utility analysis provides a standardised form of economic evaluation that focuses particular attention on the quality of the outcome produced or averted by investment in health programmes.

Cost utility analysis and the QALY have been widely used around the world in the assessment of the cost effectiveness of new drugs and of other types of clinical interventions. But it has proved less well suited to assessing preventive public health type interventions. The literature identifies a number of conceptual, methodological and practical difficulties in evaluating the effectiveness and cost-effectiveness of primary prevention interventions³⁶. There are difficulties of producing evidence of cost-effectiveness for public health guidance and methodological difficulties associated with applying health economic techniques to public health interventions³⁷. These difficulties and issues spring from the focus on efficiency within economic evaluation techniques to the exclusion of the determinants of health and inequalities in

health, which are central preoccupations in public health.³⁸ This is important because as we will show, health needs assessment is itself premised on principles of economic efficiency as well as the principle of equity. And so the same problem that applies to the application of simple cost utility analyses to preventive interventions also applies more broadly to health needs assessment.

Equity, efficiency and health economics

Health systems may be characterised by the way they organise, finance and deliver resources to attempt to balance competing health and wellbeing objectives. Equity in the distribution of resources is the main objective of a health system where citizens have *entitlement* and equal access to the means of achieving good health and wellbeing according to health *need*. Efficiency in the allocation of resources- where the cost of good health and wellbeing is minimised and the benefits maximised- is often prioritised by governments over equity in order that the overall *cost* of a health system as a proportion of GDP, is controlled. Efficiency and equity are generally viewed as competing objectives that most health systems fail to reconcile because both objectives cannot be optimised at the same time – creating an equity-efficiency trade-off. This in turn raises concerns about justice and generates philosophical arguments about where the balance between efficient resource allocation and equitable distribution of health resources to meet health need, should lie. Early forms of health needs assessment and similar approaches - social audit and rapid appraisal - attempted to establish the size of different health needs and to prioritise and allocate resources *pro rata* on that basis.

Health economists were critical of the early needs assessment approaches for a number of reasons. They argued that the allocation of resources according to the size of a problem can be very misleading; not all needs can be met and resources are finite. Therefore measuring need gives no guidance concerning resource allocation to meet those needs and offers no rules by which resources can be allocated across programmes and interventions.

Specifically, no attention is given to costs and benefits of treatments, only to the size of problems³⁹ The practice of needs assessment changed in response to these arguments⁴⁰ During the early 1980s, the way of thinking in health economics gathered momentum in relation to the wholesale recasting of 'need' as a concept- seeing the fulfilment of the size and volume of health needs as in direct opposition to the objective of maximising health status through the efficient allocation of healthcare resources.

Economists argue that the size of a health need – how many people have a certain disease at levels of severity - says nothing about how to maximise efficiency in the allocation of resources, so that the ratio of marginal benefit to marginal cost is equal across all interventions⁴¹ . Health economic techniques and tools were directed at inefficiencies in the allocation of healthcare resources and 'the need for healthcare' defined as 'capacity to benefit' from healthcare became recognised as a key aspect of health status. As a consequence, the health intervention needed in any given circumstance is a function of factors such as the level of prevailing resources, the availability and effectiveness of health interventions, and the perspective and values of those making the assessment. Over time notions of health need have come to be defined as a result of momentum in economic discourse and debates and the development and proliferation of common currency quality of life measures that reflect the outcome and efficiency of interventions to improve health and wellbeing.

Health economics, it is argued, provides a way of thinking logically through the problems of setting priorities for health improvement as well as offering the techniques of Programme Budgeting and Marginal Analysis (PBMA) to support decision making in resource allocation. Programme budgeting can be used as an information framework to allow health services to be disaggregated into programmes which have relatively homogeneous outputs⁴² . The information in any programme budget will include cost or expenditure data together with an indicator of output from a programme. Services are ranked on the basis of ratio of marginal benefit to marginal cost. Marginal analysis provides rules for deciding how resources should be moved between sub categories of a

programme. In terms of allocative efficiency, the concept of opportunity cost figures prominently in these techniques, where the benefit foregone is in health status.

Health systems and the equity-efficiency trade-off

We next examine the relationship between equity, efficiency and cost describing debates about resource allocation in Beveridge and Bismarckian health systems. These systems take their names respectively from William Beveridge whose report was used as the basis for the policies which helped establish the Welfare State in Britain⁴³ and Prince Otto Von Bismarck who set up the first schemes of national insurance in Germany in the 1880s⁴⁴. We outline the ways theories of justice underpin equity-efficiency trade-offs, explaining the background to the emergence of new policy concepts and techniques of assessing, measuring, evaluating and prioritising efficient and equitable allocation of resources. The nature of the determinants of health and the role of physical and social environment in the improvement of community health outcomes are considered with respect to equity, need and efficiency.

Healthcare is financed and provided free at the point of use by government through taxation in Beveridge-type health systems. Beveridge health systems differ from Bismarck-type systems in which healthcare is financed by multiple employer-based insurance schemes and taxation in which providers are privately rather than publicly owned. Both types of system however face the same problem of increasing demand in the face of finite resources to fund the systems. In recent decades, some reformers of health systems and health policies have attempted to create market incentives within the system to control overall healthcare expenditure, increase quality, bring down prices and increase choice⁴⁵ - for example, providing a choice of provider for healthcare treatments and services as a way of taking some people off waiting lists. However, the economic and social trade-off is that this comes at a price - leaving those who cannot afford to move to languish on the longer waiting list.

Alternatively, other systems that prioritise access and provide universal coverage to meet health need provide a narrower range of healthcare services because price signals to reallocate resources within the system are absent. An equity-efficiency trade-off occurs and this can create a dash from central decision making to localism where the allocation of resources is determined by local decision makers. Much of the tension in the balance between efficiency and equity however, can be traced to expectations and changes over time in the common understanding of what constitutes good health and wellbeing in communities and countries. Inevitably, these understandings are related to stage of economic development, economic performance and historical Gross National Product (GNP).

The political and philosophical approach.

At the heart of the approach to needs assessment outlined so far is a relatively one dimensional idea of need. There is an altogether different approach in the philosophical literature which defines need as a dynamic, politically and ideologically value-laden idea. In the political and philosophical view the starting point is *unmet* health needs. It is argued that unmet need creates unfair deficits in the distribution of health and wellbeing among communities and populations - deficits that society should take steps to address. In this view, need is described as something that is likely to be dynamic over time as technologies, expectations and availability of services change. Measurement of need will therefore vary in different contexts, such as, in the clinical setting and at the population level. Needs assessment planning would therefore involve considerations of allocative efficiency along with social values⁴⁶.

But here the argument changes gear because morbidity turns out not to be a good guide to unmet need! We may posit that one person's need is greater than another's because there is a greater degree of morbidity – they are sicker. This in turn implies that one health state is more deserving than another because of the extent of the disease. It also assumes we can accurately measure the differences in disease states. This however may be a

false premise because degrees of illness in a strictly biological or pathological sense, even if they can be measured accurately and meaningfully compared, tell us nothing about an individual's quality of life with different degrees of morbidity and therefore their needs in a social or psychological sense. Some people cope extremely well with illness and have a relatively good quality of life while others seem to be rendered incapable of normal social functioning with relatively minor ailments. The subjective experience of illness and an individual's response to it significantly affects their expression of need. It is difficult to measure need solely by assessing biological morbidity in any absolute sense⁴⁷.

There is a still more difficult issue relating to health differences in populations. All health systems, and by definition all health needs assessment, have to confront the systematic differences in the pattern of health in populations. The health of individuals varies, and the health of groups of individuals also varies; so men and women, age groups and ethnic groups show *average* differences in life expectancy and patterns of disease. The health of one country varies compared to other countries; within countries there are differences between individuals and groups. These variations occur because of biological inheritance, because of differential exposure to factors which cause disease and because health services are not uniformly or equally spread between individuals and populations. In any case, individuals make widely different use of available services especially preventive ones. Some people die relatively young, while others live to a ripe old age. Some people live life with multitudes of health problems and disabilities, others lead lives of a good quality and die peacefully in their beds in their nineties. So as a starting point the demands placed on health systems of these different individuals and groups vary. If we are trying in some way to meet the health needs or demands of various individuals and populations on what basis should we do it?

A straightforward answer is that we should seek to measure the needs of individuals or populations and we should allocate provision to meet the need accordingly, as that would be the fairest way to do it. But that in turn raises several questions – how exactly would we measure need? Could we do it in a

way that was accurate and precise and more importantly could we do it in a way that was fair? And fair exactly to whom? To the people in need or to the people who are not in need and whom we might call upon to fund the needs of others in greater need than them. But why should those not in need, subsidize those who are in need? Is that fair? The answer as to whether one thinks it is fair will be dictated by a political preference as well as general ideas about fairness which would in turn be influenced by other ideas about ethics, morality, duty, responsibility and liberty for example. Is it fair to have one's income taken away to fund the needs of others? Not forgetting that some people's health needs are generated by the choices that they themselves have made in how they have lived their lives, whether they have chosen to smoke, to excessively consume alcohol and food and to take drugs or engage in sexual practices which might expose them to risk of infection. These people have health needs, but whose responsibility is it to meet those needs? Again the answer will be influenced by other value positions.

Patterning of health differences

There is another very important dimension at play here which, we have not so far explored; this is the *patterning* of health differences, which removes the discussion from the level of the individual to the level of the social or population. The differences in health experience and health outcomes, the differences in access to services, the differences in exposures to risks and even the differences in behaviours which are health damaging are not distributed randomly or evenly in the population. Health experience and health outcomes are strongly patterned by social position. In short, on whatever measure used to assess health status, be it mortality, morbidity or self-defined health state, the measures follow a strict social gradient. Those who are better off *on average* enjoy better health, live longer, make better and more appropriate use of services and generally get a better deal out of health systems. Moreover, this applies under whatever arrangements for the funding of services operate. It holds true in market systems like the United States, it holds true in social insurance systems as found in much of Western Europe and it holds true in societies where care is free at the point of use like the

United Kingdom. This is called the health gradient - and is one of the most enduring and vexatious characteristics of contemporary health systems⁴⁸.

Comparative data for the UK and the USA illustrate the gradient. They show similar patterns of graded health differences measured by income for, among other things, self-assessed health, diabetes, heart disease, and lung disease⁴⁹. The gradient is described in many texts, reports and papers⁵⁰. The shape of the gradient varies; it tends to be steeper in societies with very heterogeneous populations and rather gentler in societies which are more socially homogeneous; but only by degree. Health differences linked to social position remain an enduring and structural feature of contemporary developed societies. In both developing and low income countries the same features of health inequities apply although the shape of the gradient tends to be more curvilinear. In some developing and low income countries a small affluent elite enjoy good health outcomes and the majority of the population are in a less desirable situation⁵¹.

In broad terms the state of the contemporary world is one where health differences, however measured, prevail across all societies and also between societies. There are absolute health differences between rich and poor societies and between rich and poor people and those not so poor, in all societies⁵². So here we encounter a major problem with the apparently rational calculus of health needs assessment. Whether health need is expressed in terms of health status or outcome, need (including subjective expression of need) varies systematically across the population and there are considerable health inequalities. It can be, and often is argued that the needs of the most or the relatively disadvantaged are paramount and therefore resources should be deployed in such a way that they meet those needs first. All that would remain to be done would be to find a technical solution to the measurement of need.

In addition to the health gradient there are two other ways of looking at health differences called health disadvantage and health gaps⁵³. Health disadvantage simply focuses on differences, acknowledging that there are

differences between individuals, distinct segments of the population, or between societies. It is a descriptive and non-judgmental approach. The health gaps approach, in contrast, focuses on the differences between the worst off and everybody else, often inviting the conclusion that those who are not the worst off enjoy uniformly good health. The gap approach also invites the conclusion that this state of affairs is wrong or unfair.

A gap approach and a gradient approach lead to rather different solutions. Conceptually, narrowing health gaps look to actions which will improve the health of the poorest regardless of the rest of society. Such an approach would be one which achieved both an absolute and a relative improvement in the health of the poorest groups. The health gradient approach takes, as its starting point in contrast, the acknowledgement that the penalties of inequities in health affect the whole social hierarchy even though they increase from the top to the bottom.

Gaps and gradient approaches lead to quite different assessment of need and how to meet those needs. It may seem counter intuitive, but if policies or actions only attempt to target the needs of the neediest at the bottom of the social hierarchy, there will be little or no impact on health inequalities across the rest of society⁵⁴. This is because inequities in health will still exist, the social determinants continue to exert their malign influence and the health needs of the majority of the population remain unattended to. The alternative approach advocated by the Marmot reviews for example and WHO⁵⁵ involves a consideration of the whole gradient in health inequities rather than only focusing on the health of the most disadvantaged. An effective policy is one that meets two criteria. It is associated with (a) improvements in health (or a positive change in its underlying determinants) for all socioeconomic groups up to the highest, and (b) a rate of improvement which increases at each step down the socioeconomic ladder. In other words, a differential rate of improvement is required: greatest for the poorest groups, with the rate of gain progressively decreasing for higher socioeconomic groups. It locates the causes of health inequity, not in the disadvantaged circumstances and health-damaging behaviours of the poorest groups, but in the systematic differences

in life chances, living standards and lifestyles associated with people's unequal positions in the socioeconomic hierarchy⁵⁶. The significant caveat is that where the health gap is both large and the population numbers in the extreme circumstances are high, a process of prioritizing action by beginning with the most disadvantaged would be the immediate concern.

From health inequality to health equity

The gradient leads to some other questions. Does it matter that there are patterns of inequalities in health? Why should we seek to remedy this state of affairs? Why use the instruments of health service provision to deal with this problem? Why conduct needs assessment to try to change the gradient? After all, all societies demonstrate a gradient to some extent. Even though health differences are clear, a case can be made that over the last century and a half, things have improved for nearly everyone - at least in the developed West. Rates of infant mortality are at an historic low and life expectancy has never been greater. Furthermore, while *average* patterns of morbidity and mortality in different social groups and populations may be clear, there are wide variations between individuals. In short, not all well to do people live to a healthy ripe old age, and not everyone who is disadvantaged dies young. To be human is to know that we will eventually die and that the manner and timing of our death is in almost all circumstances beyond our control whether we are rich or poor. So is it the case that patterned average differences in *early* and largely *preventable* death and suffering are unfair and unjust just because they are theoretically preventable – particularly when there is no necessary inevitability that relatively disadvantaged people should die earlier than anyone else? There is no straightforward answer.

A number of writers have explored the theme of injustice in this context. The World Health Organisation (WHO) has had a long standing interest in the matter. The World Health Organisation's Commission on the Social Determinants of Health used a series of definitions to clarify things which were based on the work of Whitehead⁵⁷ and Solar and Irwin⁵⁸. A distinction is made between health inequality and health inequity. Health inequality is defined as *health differences which are not avoidable or preventable, are not*

the consequence of human actions and activities, but are based on genetic or constitutional individual differences, age or biological sex. These are sometimes also referred to as variations⁵⁹. Health inequity, in contrast, is defined as *unfair and avoidable or remediable differences*. Health equity in turn is defined as *the absence of unfair and avoidable or remediable differences in health among social groups*⁶⁰. The italics highlight the difference in definitions. It is particularly important to note that the difference in definition between inequity and inequality is not used universally and many writers and commentators use the two terms as synonyms. Also the distinctions between individual differences which are based on human biology and differences arising from interaction between an organism and an external man-made hazard are in reality difficult to draw in anything other than an analytic sense. Empirically the divides are much fuzzier than these definitions suggest. However, as a way of beginning to find some clarity the distinction is helpful. Equity and inequity are not products of nature they are the products of human actions and, as they are socially, economically and/or politically produced they are, theoretically at least, modifiable. The defining characteristics of equity are fairness and justice; the defining characteristics of inequity are unfairness and injustice⁶¹.

Fairness and unfairness can be conceptualised as absolutes; something or some state of affairs is either fair or unfair – it cannot be both at the same time. But thinking like this in absolute terms misses the point that fairness and unfairness are not properties, things or states of affairs, but are about *relationships* between people. Fairness and unfairness arise as a consequence of the nature of the *relationships* between people and the ebb and flow of human affairs. So too justice is not a simple measure of equitable distribution of resources according to need, but is about the nature of relationships in society.

Justice may be understood in terms of the properties of people, their conduct, the rules that govern their affairs and the characteristics of institutions - an absolute definition The alternative is a *relational* concept of justice which concerns itself with the 'justness' of relations between people - X is unjust to

Y⁶². Such relations involve human agency, purpose and motive. From a relational point of view justice should not be about fair distribution; it should be about seeking to identify the agents responsible for the social arrangements that determine the shape of human relationships⁶³.

Health equity may be conceptualised in distributional or relational terms in the same way that justice can be. The distributional approach is focussed on the goal of equalising good health across society – which is really the underlying value position of most health needs assessment and much of the discourse about health inequity. The relational view is about the balance between the harms inflicted and harms mitigated or prevented. In the relational view social institutions and those responsible for them should have more concern to prevent and mitigate those things they cause themselves and for which they are responsible, rather than those things which are outside of their control⁶⁴. So the real issue in relational terms, with which equity should be concerned, is not the fact that health is differentially distributed, but that social systems contribute to the differential distribution of health and disease. Poverty is the greatest contributor of all to ill health. Organising economic arrangements so that they do not generate the conditions of poverty which generate ill health is thus, it may be argued, a moral duty. Therefore focussing on assessing need without looking at the wider determinants of the causes of inequity in the first place, is misguided. The global economic order is responsible for the generation of ill health and health inequities⁶⁵, and social arrangements that have negative effects on health are unjust⁶⁶.

In a celebrated paper called '*What is the point of equality?*' Anderson outlined a number of the problems associated with the distributional concept of equality. She warns against the notion that we can construct institutions to make them more equal and fair, not least because this tends towards greater and greater state interference in the lives of the citizenry. She notes that one of the dangers associated with egalitarianism and the distributional approach is that it pushes the limits of the state further into the lives of ordinary people. This is a particular danger if states become concerned with equities of health rather than oppressions of the powerful against the powerless. In other words

focusing on rearranging health care resources to make the patterning of health more equitable is rather like moving deck chairs around on the deck of the Titanic after she hit the iceberg - largely irrelevant and pointless when the ship is sinking. "Recent egalitarian writing has become dominated by the view that the fundamental aim of equality is to compensate people for undeserved bad luck – being born with poor native endowments, bad parents and disagreeable personalities, [and] suffering from accidents and illnesses"⁶⁷. This she says is not really the issue. We should instead be preoccupied with ending oppression (which is a relationship) rather than trying to ensure that everyone gets what they morally deserve. It is about creating a community in which people have equality in relationships with one another⁶⁸. She argues for democratic equality which means that all law abiding citizens are allowed effective access to the social conditions of their freedom. Anderson criticizes the view that the purpose of distributive justice is to compensate people for their misfortune. Her argument strikes at the heart of the idea that health inequities are simply unfair; her position is that while life may be unfair, bad luck is not at the heart of it – it is the relations between people and the way that they treat each other that is much more fundamental.

Anderson draws our attention to the fact that concept of equality can mean a number of different things depending on the underlying political value position and the epistemological assumptions of the theory. So a utilitarian seeking to maximise the greatest happiness of the greatest number would see things differently to a Marxist seeking absolute parity in access to wealth for example. She demonstrates that equality is a rationalist rather than an empiricist concept, meaning that the discourse about distributional equality and health equity is premised on the manipulation of ideas and the contest between different ideas and political philosophies, rather than being something that can be demonstrated by empirical methods⁶⁹. True, protagonists will appeal to empirical evidence about poverty and about wealth to justify their arguments, but in the end, much of the discussion about equality is grounded in ideal discussions of future desired states and institutions and the manipulation of ideas to justify that view, rather than the case being made that empirically things could be changed by doing x, y or z.

Where x, y or z are suggested, they are selected on the basis of ideological preference, not empirical science.

Bernard Williams argued that the proper grounds for the distribution of health care are health need⁷⁰. This he saw as a fundamental truth⁷¹. Others have argued that this is not a fundamental truth at all. Nozick has argued that the focus on need, common among egalitarian thinkers, is to define people quintessentially as consumers. The task then becomes one of finding the best way to ensure the fair distribution of available goods to consumers⁷². The problem of course with this approach, is that this casts humanity into a fundamentally passive role and it doesn't consider individuals as active producers⁷³. Williams also argued that there is nothing about need itself intrinsically that should motivate action on equity⁷⁴. What society decides to do for people, particularly in health need, depends upon a moral and ethical stance.

Another argument is that the goal of fair distribution should be treating the worst off as well as possible rather than flat equity⁷⁵. John Rawls argued that difference in the distribution of primary goods such as health is tolerable, so long as the welfare of the most disadvantaged is looked after⁷⁶. Dworkin takes this argument a stage further. He suggests that we need to determine why the worst off are in that position. Dworkin asserts that some may not be able to work because they are unable to find work; but others may decide they do not want to work. Dworkin also notes that some people's needs are greater than others (someone who is severely disabled has greater need than someone who is able bodied for example – although as we noted above this is a highly questionable first premise). But needs, Dworkin notes, are compounded by taste. Some people's needs are determined by expensive tastes say for drugs or wine or jewellery. Dworkin therefore distinguishes between brute bad luck and circumstance from optional bad luck involving some degree of culpability for being in need. For Dworkin, this distinction is all important, as it is his view that the state has a duty to deal with the former, but not the latter⁷⁷.

Some philosophical reflections

Health needs assessment is not value neutral it is premised on a number of philosophical and political concepts. It is helpful to explore the arguments relating to these ideas not least because although they are fundamental to health needs assessment the conventional literature about health needs assessment seldom considers the underlying assumptions and issues in detail. This is particularly so with respect to the central importance of utilitarianism and its contested place in the philosophical canon. The discussion is made all the more confusing because many of the relevant ideas like justice, equality, fairness and so on are in common as well as technical philosophical usage and the meanings attached to common sense understanding of the words and the technical vocabulary usage are seldom commensurate.

Another very intriguing characteristic of the literature – a literature after all which readily uses terms like justice, fairness, equality, is that with the exception of Sen, (more of whom below) the origins of the arguments about justice and need are conducted entirely without reference to their antecedents in Christian or Islamic teachings or the teachings of the other major world religions. The secular attempts to define the equal society, justice and fairness struggle in this regard, to find a moral or ethical point of reference. The other very odd thing is that conventional political philosophy has, down the years, actually paid scant attention to health and health inequalities and issues of distribution of health care resources⁷⁸.

At the heart of the debates about equity and health inequity in contemporary society is, as we saw above, social justice. Health inequities are considered by many commentators to be unjust and unfair and this is advanced as a reason for allocating resources following needs assessment, more fairly. Just as utilitarianism is central to health needs assessment, it has also been central to theories of justice too viz. what produced the greatest happiness in the greatest number was considered to be socially just⁷⁹. This absolute or distributional approach to justice was based on a highly individualistic model

and was premised in turn on the individual as the unit of analysis and not the alternative which is the relational conception of social life. The solution in the utilitarian view of the world is fair distribution and systems which can efficiently distribute resources, a principle at the very heart of health needs assessment. The utilitarian argument overlooks, by virtue of its basis in the maximisation of utility, not only the fact that humans are motivated by a variety of things, not just maximising utility, but also love, social conflict, human venality, and sheer and utter evil, and it doesn't seem have a concept of the social. In other words, individual utility maximising motivated agents are the focus of the argument, not social relations between people. This individualistic approach chimes with medicine.

Medicine has as its principal focus, pathology in the individual human body. This means that, with only a few historical exceptions, the intellectual interests have been oriented to phenomena located in individual human bodies or minds with pathology measurable in ways that reflect the individual and individual variation from some notion of what is normal or healthy⁸⁰. This approach received an enormous boost with the rise of germ theory and with the fantastic successes of the isolation of pathogenic microbes and then antibiotics to combat them. Of course medicine has other foci too; especially body systems, but the variables and phenomena of particular interests are individual. The pathogenic paradigm, in which the fundamental rationale is isolating the specific cause (pathogens) of specific outcomes (pathologies), reinforces the individualistic approach. Psychology has likewise made its main focus the individual so measures of intelligence, personality, quality of life, all reside in the individual or are characteristics or properties of individuals. The approach is about the degree to which things go wrong in individual bodies and minds and the preceding causes of the pathology. Need as an individual property is an obvious next step in this way of thinking.

Economics and especially health economics has bought into this individualistic paradigm in a big way. The QALY and the application of cost utility analysis and health technology assessment are deeply infused with an

individualistic orientation. The greatest happiness of the greatest number is the utilitarian philosophical view which sits very comfortably with the individualistic paradigm because it conceptualises the notion of the good as the aggregate of lots of different individual utilities. The ontological consequence of this – i.e. the assumptions made about what constitutes human life and how and why it is the way that it is – is the idea that the essence and meaning of human existence can be captured by isolating these individual characteristics and seeing how they connect to each other. So individual characteristics as different as height, weight, blood pressure, bone density, hair colour, IQ, biological sex and size of tumour for example can each in turn be linked to the presence of other characteristics in the individual like health of mother *in utero*, poor nutritional status in childhood, genetic coding, parental heredity, age, chromosome structure and exposure to tobacco smoke. The causal link is from one individual characteristic to another.

Now all of this is intuitively meaningful – in the modern Western world the individual and the individuated self are touchstones of the way we live our lives and the way the state regulates our lives - we have for example individual national insurance numbers, passport numbers, birth certificates, tax codes and genomic structures. Individual variables seem natural. Further in medical terms there have been some remarkable successes in isolating disease mechanisms and offering curative technologies using the individual approach – although far less than the popular imagination often supposes - using these principles.

However, there are two fundamental objections which suggest that another way of viewing things might be helpful. First the individualist approaches dehumanise people – people are reduced to some sub-human characteristic – a number, a genetic code, a pathological organism, a utility. But second, and more importantly, and notwithstanding the advances that have followed in the wake of some of the individualistic connections which have been made, above all it ignores or relegates the fact that humans live in groups and that those groups are in relations with each other and that membership of those groups is a defining characteristic of identity and of profound importance to most

people – one's family, class, tribe, caste, gender, ethnicity, nationality are all paramount social markers in life. Moreover, the relationships within which we live our lives, the relations with other people, the relationships within and between different groups, shapes the nature of our human selves, our experiences and our behaviour. The defining characteristic of human life is belonging - to be a member of multiple groups and communities. We live our lives in a network of interlinked and overlapping relations with others. Knowingly or not, the desire to belong has far reaching consequences on the types of behaviours that we adopt and the choices that we make. Not surprisingly therefore, the effects of social exclusion or isolation from social groups are of paramount importance when trying to explain the health of an individual.

What this makes us pause and reflect on is not that the individual understanding of human affairs is unimportant – that would clearly be an absurd position to adopt. Rather it is that a full understanding of the human condition requires additionally another set of concepts – which capture human relationships – relational concepts – in order to develop a rounded account of human life. And moreover inequity and injustice are best understood in relational not individualistic terms.

Social theorists have grasped the idea of a well-rounded approach very neatly in the conception of the dynamic interaction between agency and structure. The idea of agency is that we are all unique biological, psychological and physical individuals. We all engage in individually motivated actions and behaviours which are in part the results of our unique individuality. But the sum of all human behaviours is social structure which is the consequence of the millions and billions of human relationships that are the medium for individual actions. Those structures or webs of human relationships are relational and in turn they constrain, drive, and facilitate individual human behaviour. So we have individual behaviour, the medium for its expression which are human relationships, and social structures which are the sum of all those relationships which in turn impinge on and delimit the possibilities of individual behaviour⁸¹ . .

This rather abstract approach allows us in turn to consider some of the thorny problems at the heart of health needs assessment. Thinking of the dynamic interaction between agency and structure moves us beyond the methodological individualism of traditional epidemiology and therefore of health needs assessment and provides an escape from the individual level of explanation⁸². This in turn allows for a fuller understanding of the dynamics of the development of health inequalities⁸³.

This way of thinking has been linked to what is called capability theory⁸⁴. The core characteristic of capability theory is its focus on what people are effectively able to do within relationships with each other⁸⁵. Individuals being able to engage effectively in what they really want to do, is the core idea. . These engagements include being active, healthy, and being able to work but the list is not limited to these activities. In the capability approach, resources and their fair distribution to individuals (the focus of the traditional utilitarian approach) are not the central interest. Resources are not ends in themselves they are means to ends. And neither are resources reducible to monetary utilities. People's abilities to realize their life goals and plans are the focal point. In the capability approach, the issue of justice, fairness and need does not apply to resources *per se* but to the range of options for agency – the capabilities⁸⁶.

Sen is a seminal thinker in relation to these arguments. He makes the case for a dynamic approach to social justice. He has argued that to think about justice in terms of fairness is a major shift away from the traditional ways that philosophers have thought about justice. This is because they were locked into the utilitarian/ distributional tradition⁸⁷. This is important in the context of needs assessment which is fundamentally utilitarian and implies that through its rationality and market allocative efficiency it will be possible to deliver fairness by market redistribution. This follows a tradition which goes back, according to Sen, to the Enlightenment. The utilitarian position is a rationalist position writ large, i.e. a position which is about the manipulation of ideas, rather than the observation of empirical facts⁸⁸. The ideas about social justice which are being manipulated are that it is possible to design institutional arrangements that will deliver justice and this will be the basis of a perfect

society. For Sen, justice is a relative concept and is about relations between people. Justice is a process, an aspiration; it is about advancing justice or reducing injustice. It is not about finding or describing the perfectly just society. Because social structures and their properties emerge out of human relationships, it means that to try to legislate to change social systems to make them more just or fair can only ever be partially effective. In a sociological sense justice and injustice are properties of social systems not abstract transcendental things that can be made by social actors. Sen's approach is comparative, plural, iterative, dynamic, and acknowledging of alternatives.

Justice in this view is not a given – a rationally derived static universal principle. It is about relations between people and arises as a consequence of social action and social structure. Therefore injustice will also arise socially in social interaction and is decided upon morally or metaphysically. The judgement about whether the relations between people, such as differences in health, are just or unjust is a value judgement. In short, seeking to bring about equality in relation to health by the utilitarian redistribution of resources is never likely to work, or to produce fairness and justice because justice is not a quality of individuals or institutions. Equality is about human relationships and the utilitarian approach at the heart of health needs assessment is based on an alternative individualistic ontology.

Sen's argument is that theories of justice major on something; it could be happiness as in the case of classical utilitarianism, and it could be resources or income. Sen argues that in contrast to these utility-based or resource-based lines of thinking, individual advantage is judged in the capability approach by a person's capability to do things they have a reason to value. A person's advantage in terms of opportunities is judged to be lower than that of another if they have less capability – less real opportunity – to achieve those things that they have reason to value. The focus is on the freedom that a person actually has to do this or be that – things that they value doing or being⁸⁹. Sen's approach is about human life and the opportunities for living - living as against just existing. Justice for Sen cannot be created by social

institutions. Justice should aim to reduce injustice, i.e. change the nature of the relationships between people, rather than aiming to produce a perfectly just society.

Conclusion

Health needs assessment can be seen as a highly rationalist straightforward means of identifying health needs, of linking needs to patterns of health inequities, of marshalling appropriate resources to match those needs and then deploying resources accordingly. And of course that is what it aspires to do. But that aspiration is based on the traditional rationalist approach of utilitarianism and in turn on an individualist ontology. Need, as we have shown, is not a static, objective thing. It is therefore intrinsically difficult to measure and as soon as one starts to try to capture the idea fundamental questions about fairness and justice are raised.

The objective and measurable concept of need is located in an individualist ontology. When we think instead in relational terms about equity, justice and human capabilities a different perspective is possible. Capabilities theory captures the idea of equity in a far more nuanced way than individualistic utilitarian accounts. It also offers a more complete way of understanding how we might rethink health needs assessment.

So rather than seeking to measure individualistic objective variables and then seeking to apply resources accordingly the relational capabilities approach bids us to think about the relations between service providers and users in a much more novel way. It requires us to not to try to match resources to a completely slippery and spuriously objective concept of need, but instead makes us consider the nature of the relationships between people and services.

Maximising health outcomes, a utilitarian fundamental principle, may not be what social justice requires and alleviating injustice may require more than maximising efficiency⁹⁰. The argument then hinges on several fundamental things: the degree to which the structure and organisation of services permits people to meet their own capabilities, the degree to which it allows human

potentials to be realised, the degree to which the relationships with services do not distort or alienate people from themselves or from others. The capability approach privileges human functioning, not maximising utility or achieving an idealised and biologically improbable disease free state⁹¹.

This means that service design should reflect and respect human dignity; this means respect for an individual person, but at the same time acknowledging the limitations which disease and disability genuinely impose on people while recognising that there is not a direct cause and effect linear relationship between disease state and social functioning. It should acknowledge the fact that illness and disease by their very nature tend to exacerbate disconnectedness between the person and their normal role responsibilities, their primary social attachments and their desired capabilities. The experience of disease and disability can also produce a profound separation of the individual from their sense of self or their sense of who and what they want to be. The capability approach therefore requires us to respect the lifeworlds of ordinary people and work with them to build their skills, assets and capabilities (rather than focussing on their deficits and trying to correct them via redistributive activities). These skills, assets and capabilities allow them to manage their lifeworlds with minimal interference. The kinds of skills which enhance capabilities include interpersonal relationships, technical skills to manage the routine aspects of social and economic and domestic life, skills to develop emotional and psychological resistance (often referred to as coping or resilience mechanisms) and an ability to make life seem meaningful. These skills enable people to manage the routine travails of ordinary living as well as the more significant life events which engulf everybody from time to time⁹². It also allows people to manage the material lifeworld they inhabit. This is important because the material and psychological lifeworlds mediate the stressors - physical, psychological and biological - which assault the human body periodically. The greater the ability people have to control their lifeworlds, the greater the resilience they will have. Skills to control the life-world are quintessentially capabilities. The inability to exert that control forms the basis of the patterning of health inequities because the ability to exert control is not spread uniformly through the population. Following Sen's prescription,

we should seek not to measure need in a potentially spuriously scientific way, but rather acknowledge that the *total* population, all of us, are in need of strengthening our capabilities. Further it is relatively easy to predict where the need to develop more capabilities and skills is greatest and that is among the poor, the disadvantaged, sub-groups and minorities, and people with disabilities. Efforts to develop and build the skills and capabilities should be proportionately, but not exclusively, focussed on these groups. The level of self-empowerment to help to realise these capabilities needs to be appropriate for the individual. This is an important consideration when deciding where to deploy resources.

Moreover upstream efforts need embrace a public health preventive approach; an education in basic skills for living, appropriate role modelling as the basis of the most appropriate skills for human interaction, appropriate deportment, manners, respect for others, management of emotions and the development of an appropriate sense of self and identity – are the basics of human socialization. This means that the early years are particularly important and that taking the edge off encounters between people that are destructive and harmful is paramount.

While all of this plays out on life's grand stage, it must also apply to the way health services are provided and delivered. If services are organised around allocative efficiency alone and neglect the sense of self, the identity, the skills required to negotiate the system, and they alienate patients and public from and systematically deskill the recipients of care, they meet no one's needs at all, and serve only to make the patterns of inequities worse. They become, in other words, a contributor to the problem, rather than a solution to the problem. Unfortunately, the utilitarian approach with its individualistic ontology, and its emphasis on ideal rationality, is focused on a question, which on the face of it is not unreasonable, of how to match resource deployment to need. This is in fact the wrong question, so it often ends up doing exactly the opposite of what it is trying to do and making matters worse.

None of this should be taken to be a yet another Utopian recipe for the perfect society. Human venality, greed, jealousy, laziness, prejudice, incompetence and even evil will always be part of the human condition, resources will always be scarce and groups will compete, sometimes viciously, for those resources. But the development of human capabilities allows the harder edge of human existence to be ameliorated. It does mean though that the temptation to try to find purely rationalist solutions which can only ever work in theory, or indeed in Utopia – nowhere - rather like transcendent theories of justice, must be resisted. It must be acknowledged that it is about human relationships and allowing those relationships to be as humanly meaningful and fulfilling and permitting of enhancing human capabilities as possible. The most important task in a good and just society is to prevent the erosion of those things which protect and maintain human capabilities. It is to protect the virtuous and the virtues and to enhance them where possible and to protect them by supporting social arrangements which facilitate that. Relationships cannot be legislated for, nor made to happen by complex processes of resource allocation. Justice and the social arrangements that maintain relationships are in the end the emergent properties of social relations. Those relations must be cultivated in a humane, and as far as possible, just way that protects and enhances people's capabilities. This must be the pre-requisite for any state wanting to deploy its health care resources in a way that is both effective and meaningful. Building capability into service design is a fundamental pre-requisite.

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