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A response

Reconciling the capability approach and the ICF: A response

Réconcilier l'approche par les capabilités et la CIF : commentaire

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About a decade ago, scholars in different disciplines started using the capability approach (CA) to define disability (e.g., Burchardt, 2004; Mitra, 2006; Morris, 2009; Terzi, 2005a, 2005b). Under the CA, disability has been conceptualized as a deprivation in terms of functionings (achievements) or capabilities (practical opportunities). Whether an individual with an impairment or health problem has a disability depends on whether his/her functionings or capabilities are restricted. In this context,

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there have been a number of comparisons of the CA and the International Classification of Functioning, Health and Disability (ICF). Some authors have pointed out shortcomings of the ICF compared to the CA.

In *Reconciling the Capability Approach and the ICF*, Jerome Bickenbach asks for caution in "this head-to-head comparison" and attempts, first, to clarify what the CA and the ICF are and are not and, second, to reconcile the CA and the ICF. This is a difficult task as ICF is both a model and a classification, and as there is not a single treatment of disability from the perspective of the CA. Bickenbach's literature review spans a very broad territory. He starts with a careful and comprehensive account of the CA and its applications to define disability. Although the literature has been mostly focused on applying Sen's version of the CA, Bickenbach also presents Nussbaum's version. In addition, Bickenbach goes over uses of the CA to define health, and he rightfully points out that authors focused on disability have not engaged with the definition of health.

Bickenbach's main argument is that the ICF has been misunderstood. I will thus start with what the ICF is and how is has been used so far, then take up Bickenbach's reactions to the major criticisms of the ICF that he identifies in the CA literature. Finally, I will react to Bickenbach's proposal for a reconciliation.

1. What is the ICF and how has it been used?

Bickenbach notes throughout his paper that the ICF is a classification. At the risk of explaining the obvious, I would like to note that a classification is a way of organizing information. Bickenbach writes: "the ICF is a classification whose primary purpose is to collect saliant data about the lived experience of health conditions." In the book that first introduced the ICF, WHO (2001; p. 25) states that "as a classification, ICF does not model the "process" of functioning and disability. It can be used, however, to describe the process by providing the means to map the different constructs and domains." However, further along, WHO (2001; p. 28) ends up describing how the ICF is based on an integration of the medical and social models. "In order to capture the integration of the various perspectives of functioning, a "biopsychosocial" approach is used. Thus ICF achieves a synthesis, in order to provide a coherent view of different perspectives of health from a biological, individual and social perspective". This is also noted by Ustun, Chatterji, Bickenbach, Kostanjsek and Schneider (2003): "All features of the ICF reflect the underlying model of functioning and disability. The current ICF model represents the resolution of a long-lasting theoretical debate between two competing models." The authors then move on to explain the medical and social models. They then note that: "A better model of disability is one that synthesizes what is true and useful in the medical and social models, without making the mistake each makes in reducing the whole, complex notion of disability to one of its aspects. This might be called the biopsychosocial model. The classifications within ICF are constructed around this model, an integration of the biomedical and the social. ICF provides, by means of this conceptual synthesis, a coherent view of health domains as well as domains that are influenced by or influence health, namely health-related domains such as education, employment, community life and so on."

Bickenbach (2011) alone notes elsewhere: "ICF provides both a model of functioning and disability and a set of classifications for describing these phenomena in detail. ICF understands these phenomena as outcomes of an interaction between an underlying health condition (disease, disorder or injury) and the full range of environmental factors (physical, human-built, social and attitudinal) and personal factors." In the ICF model, disability refers to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors). At the same time, in the ICF classification, disability is the umbrella term for impairments, activity limitations and participation restrictions. ICF is thus a model as well as a classification, with the ICF classification being conceptually based on the ICF model. For clarification purpose, when relevant and applicable, I will now append model or classification to ICF.

Recently, Cerniauskaite, Quintas, Boldt, Raggi, Cieza, Bickenbach and Leonardi (2011) conducted a systematic review of the literature that uses the ICF. They showed that "the majority of publications (30.8%) were conceptual papers". Thus it appears that the ICF model has been widely used. The authors also note that "diffusion of ICF research and use in a great variety of fields and scientific journals is a proof that a cultural change and a new conceptualisation of functioning and disability is happening".

Influential publications such as WHO-World Bank (2011) use the ICF-model as a conceptual framework. Thus the ICF is widely used as a model of disability and appears to have been influential in that capacity. Cerniauskaite et al. (2011) also find that 25.9% of papers were studies focusing on the description of disability of patients in clinical contexts and 9.2% of papers dealt with theoretical descriptions or practical applications of the ICF in contexts other than health (e.g. disability eligibility, employment, education, ICF training). In contexts other than health, for example Resnik and Allen (2007) use the ICF classification to analyze qualitative data on the community reintegration of injured veterans. Okawa and Ueda (2008) find that ICF was influential in national legislation and policy in Japan. Thus, the ICF has been used for a variety of purposes, to describe but also to explain and analyze the lived experience of health conditions and to inform policy.

2. What's wrong with the ICF?

Bickenbach goes over the advantages of the CA as found in the literature and points out those that are common features of the ICF and the CA, in particular the "role of both impairments and environmental factors in the creation of disability", the distinction of deprivation in capabilities and functionings in the CA and an analogous distinction in the ICF classification of capacity qualifier and performance respectively. Bickenbach also notes the tension in the CA serving as a framework for individual subjective assessments of wellbeing and as a framework that can be used to inform policy and thus require standardization. Bickenbach focuses on what he considers to be the three main shortcomings of the ICF that CA authors have put forward.

2.1. "ICF does not embody a theory of justice", nor a normative metric

He responds to this first criticism in that ICF is a classification, not a theory: "ICF is a classification, not a theory of justice applicable to disability." It is worth noting here that only Nussbaum's version of the CA aims to be a theory of justice and that it has not been used in the disability and CA literature[1] so it is less relevant here than Sen's CA. Sen's CA is a normative framework, not a theory, for defining wellbeing, poverty and development, and it is that framework that has been primarily used with respect to disability.

Here my views are somewhat different from those of Bickenbach or found in the CA literature. The ICF classification is a tool that helps structure data on disability and the lived experience of health conditions. First, this descriptive work is very important for policy: it can highlight differences and disadvantages that policy makers may decide to act upon because to them these are injustices. Thus descriptions are not done in a vacuum, they may be used to inform policy.

Secondly and relatedly, it is my understanding that descriptive work is in fact central to the capability approach. Sen (2009) argues that a useful theory of justice should not be focused on finding the requirements of a "perfectly just" society in a transcendental approach to justice, as mainstream political philosophers such as John Rawls (1971) have done. Such an approach provides little help while trying to eliminate "cases of manifest injustice" such as slavery in the eighteenth and nineteenth centuries (2009; p. 21–2). Instead, Sen proposes a comparative approach to justice that focuses on questions related to how justice could be enhanced. To that end, Sen proposes to make comparative assessments of people's lives. People's lives are assessed by looking at what people are able to do and be, i.e. "capabilities". Sen (2009) is the fully-fledged argumentation of an approach of justice that uses this metric of capabilities and focuses on practical human behaviors and situations of injustice. Sen (2009) expresses a powerful pragmatic idea of justice that may influence contemporary political philosophy, and provides a framework for the removal of injustices in the real world. It may also encourage those involved with justice, whether at a theoretical level or in the field, to dedicate more attention to improve the lives of people in groups that have been subject to "manifest injustices". Sen develops several examples of such groups, including women, slaves and persons with disabilities. I see some synergy here between the ICF and the CA, in that both value empirical assessments of people's lives.

[1] For a study that considers Nussbaum's application of the capabilities approach to persons with disabilities and its implications, see Stein and Silvers (2007).

Last, it should be noted that a description, a factual statement, and the presentation of information, for instance structured by the ICF-classification, implies the selection of information. Sen himself has written on the subject. Sen (1980) notes that "description inevitably involves selection. It can be usefully seen as a choice of a subset from a set of possible statements" (p. 368). There could be several motives behind description, including prescription and curiosity. When description is conducted with a view to prescribe, description becomes normative and the ICF may be used in that capacity. Given the variety of motivations in the utilization of the ICF in the past decade, including for policy, as discussed earlier, the ICF to some extent has been used as a normative metric.

Still in relation to description, Sen (1980; p. 354) notes that "it is perhaps not an exaggeration to say that any conscious act of description contains some theory-usually implicit-about the relative importance of the various statements dealing with the subject matter. I shall call this the "choice basis of description" (p. 354). This takes us to the second and third shortcomings of the ICF that Bickenbach finds in the CA literature.

2.2. "ICF does not incorporate choice and personal goals" and "ICF does not distinguish resources and environments"

In his defense of the ICF on these two shortcomings, Bickenbach stresses that ICF is a classification and has a descriptive objective. Perhaps this was the initial intention when the ICF classification was developed with the ICF model included to ground the classification. However, as explained earlier, the ICF has been used both as model and classification, and for a variety of objectives, descriptive, as well as analytical and for policy. Even if the ICF is used to describe, is the lack of information on choices/personal goals and resources really a lacuna of the ICF? I think it is. How much of a lacuna it is probably depends on the health conditions and the settings, which are the subject of the description. If having a particular health condition might be associated with coercion and little consideration for personal goals, it would be a significant lacuna to describe the lived experience of such health conditions without any consideration for choice and personal goals. For instance, this is particularly relevant for severe mental illness. It is also relevant more generally for the study of medical decision making and in particular, shared-decision making. It is no surprise that the capability approach has been used in these areas (Hopper, 2007; Entwistle & Watt, 2013). The CA has the advantage to link an individual's capabilities and functionings with choices/decision-making in between.

The ICF does not explicitly represent how resources may be a determinant of the lived experience of health conditions. Bickenbach argues that to some extent it is in the ICF. Environmental factors include information about the person's socioeconomic context, but not about what the person owns. We would not know if a person with a mobility limitation owns the type of wheelchair that is needed. He notes that this cannot be expected of a classification of the lived experience of health conditions. This would be a significant lacuna in resource poor settings where economic resources may influence how individuals and families cope with the consequences of health problems, and thus on the very lived experience of health conditions, which the ICF is to describe. For instance, in the study of the challenges that veterans with injuries in the US face to reintegrate into the community, Resnik and Allen (2007) use the ICF classification to structure the data collected from veterans in open-ended interviews. Perhaps it is not surprising then that there is no consideration for resources in the results, while poverty is known to be rampant in this population group. Under the CA (Mitra, 2006), resources are a factor that interacts with the individual's characteristics and environment that may lead to disability in terms of capabilities or functionings.

3. Reconciling the ICF and the CA?

Like Bickenbach, I see some commonalities and some synergies between the ICF and the CA but I see them differently. Both the ICF and the CA are not theories that can explain wellbeing and disability, rather they are frameworks to conceptualize these phenomena[2]. In addition, as noted earlier,

[2] A similar point is made by Robeyns (2005) on the CA in general.

description is central to both the ICF and the CA. The ICF has been used and can be used for prescription, and thus can be a normative metric, like the CA.

There are also important differences between the CA and the ICF. The CA is an open-ended conceptual framework and is more holistic than the ICF in that it includes additional relevant components of the lived experience such as resources and choices. The ICF leaves out these components of the lived experience, which implicitly may tell about the lack of importance of these components. The ICF is a model to a close-ended classification, which is problematic in that it is meant to portray the lived experience of health conditions, which is complex and multifaceted. Perhaps the ICF can be extended to become an open-ended framework that recognizes that some aspects of the lived experience are left out, with the caveat that not all dimensions of life may be specified and classified. Thus the classification does not, and cannot be expected to, provide an exhaustive account of the lived experience of health problems.

A decade after the CA started being used to define disability, some data collection and research has been done to operationalize the CA with respect to disability, including disability policy (e.g. Trani, Bakhshi, Noor, & Mashkoor, 2009; Trani, Bakhshi, Bellanca, Biggeri, & Marchetta, 2011) but further work is needed in this area. This is an area where Bickenbach points out there is scope for complementarity and reconciliation between ICF and CA. Indeed, he notes that the CA "will need stable, valid and comparable data about health and functioning, data that is independent of both cultural and linguistic variations as well as individual differences in preferences and aspiration. Making it possible for such important data to be collected, and used, was WHO's aim in developing the ICF." In other words, one could use the ICF-classification to operationalize the CA at an international level. I agree about the importance of collecting internationally comparable data on disability. This call is timely in preparation of the Post-2015 Development Agenda (Mitra, 2013). I also agree that the ICF-classification can be a tool to implement a CA-based disability measure, in particular to structure data collection on impairments or health problems, as well as capabilities and functionings. It would need to be expanded though to capture central aspects of the CA (e.g. resources) that are not in the ICF. Further research is clearly needed in this area.

Bickenbach goes on to argue that "For better or worse, ICF is the international standard for disability and functioning data collection: it is the only game in town". ICF has indeed the monopoly of an internationally accepted classification of functioning and disability, but it is not a data collection instrument. While it can help structure data collection, it is not absolutely necessary for developing a data collection instrument on the CA and disability. WHO has developed a specific survey instrument based on the ICF: the World Health Organization Disability Assessment Schedule II (WHODAS II) (WHO, 2009). It covers all types of functional limitations (physical, mental, sensory), for various countries, languages and contexts, so it is suitable for international use. WHODAS II includes four alternative versions, with 89 items, 36 items, 12 items and six items.

This questionnaire and more generally the data structure provided by the ICF-classification is not the only way to go about collecting data on the lived experience of health conditions. The Washington Group on Disability Statistics, which was set up in 2001, also developed a set of questions to collect internationally comparable information on functional limitations (Madans, Loeb, & Altman, 2011). Its purpose was to provide guidelines, which would facilitate the production of comparable international and cross-cultural disability measures that could be used for designing equal opportunity policies. A set of questions has been agreed upon and tested in different settings. It covers four functional domains (seeing, hearing, walking and cognition) and two additional domains (self care and communication). The recommended questionnaire is consistent with the ICF model of disability but did not use the ICF-classification to structure data collection. Data started being collected in several countries on these six limitations, as well as on a variety of life outcomes (functioning under the CA) (e.g. employment, educational attainment) (Madans et al., 2011).

4. Concluding remarks

Bickenbach makes a call for caution in the "head-to-head comparison" of the CA and the ICF in relation to defining disability and describing the lived experience of health conditions. While I agree on the need for caution, I have a different view on how ICF compares to the CA. Bickenbach reconciles ICF

and CA by arguing that they are different things, with the ICF being a classification aimed at describing the lived experience of health conditions and the CA being a normative open-ended framework. In contrast, I argued that ICF is both a model and a classification that has been used with a variety of objectives, in descriptive as well as analytical studies and for policy. The ICF has been used and can be used for prescription, and thus can be a normative metric, like the CA. Description is central to both the ICF and the CA.

I see the lack of consideration for choices and resources as shortcomings of the ICF model and classification. The latter could benefit from becoming open-ended, with an explicit caveat that not all dimensions of life may be specified and classified, and thus the classification does not, and cannot be expected to, provide an exhaustive account of the lived experience of health problems. Bickenbach points out the potential synergy of the ICF and the CA in that the ICF classification can help operationalize the CA. I agree, but unlike Bickenbach, I do not see the ICF classification as the only tool in town to implement the CA in relation to disability.

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