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## Health Capability: Conceptualization and Operationalization

Jennifer Prah Ruger, PhD

Current theoretical approaches to bioethics and public health ethics propose varied justifications as the basis for health care and public health, yet none captures a fundamental reality: people seek good health *and* the ability to pursue it. Existing models do not effectively address these twin goals.

The approach I espouse captures both of these orientations through a concept here called health capability. Conceptually, health capability illuminates the conditions that affect health and one's ability to make health choices. By respecting the health consequences individuals face and their health

agency, health capability offers promise for finding a balance between paternalism and autonomy.

I offer a conceptual model of health capability and present a health capability profile to identify and address health capability gaps. (*Am J Public Health*. 2010;100:41–49. doi: 10.2105/AJPH.2008.143651)

### VARIOUS ETHICAL

approaches provide different justifications that underlie health care and public health. Some models assert consumer rationality in health behaviors and a willingness to forgo care beyond the individual's means. Other approaches focus on fair processes, equality of opportunity, utilitarianism, or



equal distribution of goods. Libertarians emphasize autonomy. However, none of these approaches captures a fundamental reality in the health ethics realm: people seek both good health *and* the ability to pursue it. Existing models cannot effectively address these twin goals because they typically favor either a consequentialist (outcome-oriented) or a proceduralist (procedure-oriented) perspective.

The approach I develop captures both these intuitions in a concept I call health capability. Health capability integrates health outcomes and health agency. Why is it so difficult for some populations or individuals to translate health resources into health outcomes? Why have health literacy efforts been only moderately successful? Why do some individuals have such difficulty adhering to specific treatment regimens? Why are some individuals harmed or helped by cultural norms about health behaviors? Conceptually, health capability enables us to understand the conditions that facilitate and barriers that impede health and the ability to make health choices. It offers a more accurate evaluation of the aim and success of social policies and change.

Health capability is comprised of both health functioning and what I call health agency. I define health agency as individuals' ability to achieve health goals they value and act as agents of their own health; health agency achievement represents what one's realized actions are compared with potential actions.<sup>1</sup> Health functioning is the outcome of the action to

maintain or improve health. It is comprehensive, inclusive of mental and physical health functioning and more. Health is constitutive of, but different from, well-being or quality of life. These theoretical distinctions and others have been discussed extensively elsewhere.<sup>2</sup> By respecting both the health consequences individuals face and their health agency, health capability offers promise for striking the delicate balance between paternalism (the practice of an individual or state interfering with the choices of another individual with the justification that the individual or population will be better off or protected from harm) and autonomy (to live one's life according to one's own reasons and motivations). Health capability allows the assessment of a wider range of injustices, beyond the distribution of resources or liberties, to include attributes and conditions affecting individuals' freedoms: self-management, decision-making ability, skills, knowledge and competence, and social norms and relations, as well as structures within which resource distribution takes place.

This approach seeks to enable individuals to exercise personal responsibility for their health through health agency. Rather than justifying health, health care, or public health through equality of opportunity, this approach rests on human flourishing as the philosophical justification for enabling all to be healthy. It holds that health functioning and health agency are the ultimate ends of justice, not equality of opportunity. A more comprehensive analysis of the theoretical foundations and framework for

health and social justice based on the "health capability paradigm" is provided elsewhere.<sup>2</sup>

Bioethics and public health ethics aid in the understanding of ethical reasoning as it applies to health, health care, and public health. Bioethics evolved to establish individual autonomy, the right to refuse care, and the right to voluntary and informed consent as preeminent moral principles.<sup>3</sup> Public health ethics places priority on principles of necessity, effectiveness, proportionality, public justification, and least infringement.<sup>4</sup> But for much of the past several decades, these principles have focused too narrowly on issues surrounding the allocation of material and financial resources to solve problems.<sup>5</sup> Moreover, some approaches have overemphasized individual autonomy and procedural processes in judging the rightness of health care delivery. Others have focused on utility or health maximization or even broader forms of well-being.<sup>6</sup>

The health goals of a just society, however, are to ensure all individuals the ability to be healthy.<sup>7,8</sup> Despite considerable progress in bioethics and public health ethics, neither field has successfully developed a theoretical paradigm for achieving this aim. Building on a theoretical framework<sup>2</sup> that advances the health capability paradigm, I aim to illuminate what individuals are actually able to be and do in an optimal environment (health capability) versus their current environment (health achievement). Assessing and understanding the gap between these 2 states of affairs will

improve our ability to foster health capability.

A comparison between other ethical approaches—such as equality of opportunity, equality of resources, or even equality of welfare or dimensions of well-being—and a health capability paradigm raises some important distinctions. One such distinction concerns social obligation. Unlike other approaches, the health capability paradigm purports that the fundamental societal obligation is to ensure conditions for all to be able to be healthy, not to ensure equal welfare, or happiness, or employment opportunities. And unlike libertarianism, it does not support individuals opting out of social guarantees and their responsibilities to help pay for those guarantees. Thus, under universal health insurance, one cannot opt out of paying premiums or taxes for premiums, although one may opt to abstain from using health care or public health measures oneself.

Another contrast is between the health capability paradigm and the narrow focus of disease diagnosis and epidemiology, which does not necessarily take into account individuals' ability to navigate the health system and the broader environment to access needed health care and public health services. Nor does that narrow focus help us to adequately understand the constraints individuals face in their ability to be healthy. Additionally, these approaches are more positivist than normative in their orientation.

The health capability paradigm recognizes that health capability



gaps for individuals and populations can be reduced by both individual-level interventions to improve health functioning and health agency and policies to improve the broader social and physical environment. A health capability profile can analyze the impact of individual interventions and social policies by explicitly measuring categories of individual health functioning, health agency, and the more general social factors enhancing or inhibiting health capability.

I offer a conceptual model of health capability,<sup>7,8</sup> define the concepts and domains basic to health capability, and, for its operationalization, present a prototype health capability profile. I identify key indicators for each health capability domain and begin to illustrate how to use these indicators to develop measures of health capability.

As a first sketch of these ideas, this article opens up an opportunity to discuss, refine, and develop valid and reliable components of such a profile. Although grounded in capability theory, which has roots in Aristotelian notions of human flourishing, the conceptualization of health capability I develop creates an intellectual space at the intersection of a number of different disciplines, including public health, health policy, medicine, health psychology, decision theory, behavioral economics, theories of addiction, social epidemiology,<sup>9</sup> and broader social scientific theory. Despite the location of this work at this interdisciplinary nexus, I argue that the concept of health capability is distinctive and unique in a number of critical aspects from what these other disciplines have brought

forth for our edification and consumption.

The principles guiding the content and measurements of the health capability profile are rooted in capability theory; the theory of health capability and its uniqueness as a concept in bioethics and public health ethics has been developed in further depth elsewhere.<sup>7,10,11</sup>

### HEALTH FUNCTIONING AND HEALTH AGENCY

In capability theory, Amartya Sen defines capability in 4 parts: well-being freedom, well-being achievement, agency freedom, and agency achievement.<sup>12</sup> Well-being achievement is the achievement of individual states of well-being; well-being freedom is a person's freedom to achieve individual states of well-being. Agency achievement refers to achieving one's goals and objectives; agency freedom is the freedom to achieve what one values and wishes to achieve and what one pursues. Together, these concepts imply "what the person is free to do and achieve in pursuit of whatever goals or values he or she regards as important."<sup>13(p203)</sup>

Agency freedom and achievement can also apply to a particular dimension of well-being. In the health domain, this concept is here called "health agency."<sup>1</sup> The value of freedoms lies in the functionings they permit, so freedoms have worth when they yield valuable health functionings. Broader agency will, of course, influence health agency; one's educational agency, for example, will affect one's health agency, because better-educated individuals may negotiate the external

environment more effectively to achieve health.

The health capability paradigm values health functioning and health agency as objects of social policy and change. In operationalizing health capability, both theoretical constructs are important to measure.

### A CONCEPTUAL MODEL OF HEALTH CAPABILITY

Health capability includes, but is broader than, health functioning and health itself; it is the ability to be healthy. A working model of health capability involves a number of different theoretical constructs at the individual and societal level. This is because individual health capability is dependent on how one's external environment enhances or detracts from an individual. Despite the recognition that individual health capabilities are socially dependent, the health capability paradigm rests on the notion that the individual is the unit of analysis for evaluating health policy and institutions. Thus, individual, rather than supraindividual, subjects are most relevant for this analytical framework. As a result, it is necessary to conceptualize, operationalize, and gather information on health capability from individuals rather than institutions.

Moreover, the health capability paradigm addresses the ecological fallacy by attempting to understand and measure the impact of irreducibly social goods—i.e., goods provided for entire groups of people rather than for individuals, such as democracy—on the

individual, in each individual circumstance, rather than assuming their goodness or badness from a social perspective and attributing that value at the individual level. The very existence of irreducibly social goods must therefore be evaluated and justified by their impact on individual health capability. This conceptualization aims to provide a framework to evaluate the extent to which external characteristics such as social goods and structures enhance or impede one's health functioning and health agency.

The constructs of health agency and health functioning provide the guiding principles for further definitions of health capability. The box on page 45 lists broad health capability elements that are internal and external to the individual. Internal factors include health status and health functioning; the ability to acquire accurate health-related knowledge and obtain health-related resources and to use both to prevent the onset and exacerbation of morbidity; the ability to link knowledge of potential health benefits and harms of behaviors and interventions to health outcomes; health-seeking skills, beliefs, and self-efficacy; values of health and health goals; self-governance and self-management to achieve health outcomes; the ability to make balanced decisions; motivation to achieve desirable health outcomes; and positive expectations about achieving outcomes. At the societal level, one's health capability includes external contextual influences: social norms; social networks and



social capital related to health outcomes; decisional power or latitude in familial and social contexts; group influences; material and social circumstances; economic, political, and social security; access to and utilization of health-related goods and services; and the extent to which the public health and health care systems create an environment in which individuals can improve their health.

Internally, the foundation of health capability requires self-management, self-governance, and confidence in one's ability to achieve health goals. Furthermore, it entails the ability to take responsibility for acquiring the information, knowledge, and skills necessary for good health. It is a life-long set of abilities that is always changing and adapting to new situations, and often involves managing multiple contexts and conditions (HIV/AIDS and tuberculosis, for instance) simultaneously. There is frequently a cumulative and dynamic effect, as when technology, monitoring, knowledge, treatments, and their contexts change over the years.

Health capability relates to, but differs from, capacity. Capacity has volume or quantity implications and is typically accompanied by specific conditions—for example, the “ability to receive or contain.”<sup>14</sup> Capability is an ability or power to perform with the potential for achieving desired ends. Capability entails aptitude, a condition “capable of being converted or turned to use.”<sup>14</sup> Capability also differs from human or natural endowments,<sup>15</sup> as it recognizes and incorporates social factors as part of its definition.

To model health capability, we must consider both individual and societal factors to discover interactive influences. Where the circles overlap, Figure 1 represents the way individual and social factors interact to affect health capability. Health capability is incarnate and measured at the individual level.

This model differs from causal, sometimes reductionist, models in health policy and the medical sciences, in that it is one of multiple relationships among factors. Its overlapping circles allow for a more nuanced, sequentially interactive, iterative, and multi-dimensional understanding. This is unlike linear models, which are limited to one-to-one associations between variables even with interactive terms and even when one controls for a number of variables. Similarly, reductionist models examine simple relationships first and then sum the principal subcomponents; the aggregated form of these models, however, can be difficult to interpret. By accounting for both internal and contextual influences at the individual level, the health capability model is a more flexible analytical approach that reveals greater heterogeneity in the influence of irreducibly social goods on the individual.

This type of model is fruitful for longitudinal, intersectoral, and multisectoral policy and institutional analysis and design over time. It allows for heterogeneous relations among individual-level variables (e.g., income and education) and attempts to address the problem of lack of information on the direct impact of external factors by measuring a different construct, health

capability, as opposed to just health. It therefore incorporates external factors into the individual level rather than trying to draw inferences about individual health based on group- or macro-level characteristics (e.g., race or socioeconomic status).

### HEALTH CAPABILITY PROFILE

To measure health capability at the individual level, one must identify how well individuals can act as agents of their own health. This starts to enter the realm of subjective health psychology measures such as self-control,<sup>17,18</sup> self-efficacy,<sup>19</sup> and motivation to achieve desirable health outcomes,<sup>20, 21</sup> but none of those measures quite pinpoints what is relevant in health agency—the ability to acquire and draw on health-related information, knowledge, and skills to preserve health and to develop a set of habits and conditions to prevent, to the extent possible, the onset of morbidity and mortality. Unlike the concepts derived from health psychology, health capability requires the assessment of societal-level factors on which individual health capabilities depend. Thus, health capability is not just a set of individual skills, but it is also a set of situations or conditions that enable optimal health.

It is important to note, however, that this notion of socially dependent capabilities differs from multi-level analytical frameworks typically employed in the social determinants of health, epidemiological, or health economic literatures. These approaches use group-level variables (e.g., neighborhood

income) that can lead to inferential fallacies, such as atomistic fallacy, which draws inferences about groups based on individual-level data, and ecological fallacy, which draws inferences about individuals based on group-level data. Rather, the socially dependent capabilities are intended to directly incorporate at the individual level the extent to which group-level factors influence individual health capabilities. In this paradigm, group-level factors may have individually heterogeneous effects, and require evaluation in terms of their direct contextual effect in impairing or enhancing individuals' ability to be healthy. Figure 1 illustrates how both individual- and group-level factors combine to influence individual health capability.

Although my previous work has developed a theoretical framework known as the health capability paradigm,<sup>2,7,10,11</sup> no work to date has developed a conceptual model or health capability profile leading to methods for addressing health capability deprivations. The box on the next page is an attempt to help investigators select concepts and domains for a health capability classification and map out the components of a working health capability profile. This profile clarifies the distinction between health functioning and health agency and creates a framework for operationalizing health capability. At this point, there is no weighting scheme for combining these domains into a single summary measure, number, or index; the profile merely offers a range of useful indicators.

Different applications will require different measures. At the



## Health Capability Profile

### I. Internal Factors

- A. Health status and health functioning
1. Measures of self-reported health functioning (e.g., SF-36, mental functioning, and physical functioning)
  2. Measures of health conditions (e.g., biomedical markers, biomedical diagnoses, disease [e.g., HIV/AIDS, tuberculosis, diabetes, depression and other mental health disorders], risk factors [e.g., smoking, exercise, diet, drug abuse or dependence, safe sex practices, obesity, interpersonal violence])
- B. Health knowledge
1. Knowledge of one's own health and health conditions (e.g., does the person with HIV, tuberculosis, or diabetes know they have it and know how to manage the disease?)
  2. General knowledge of health and disease, preventive measures to protect health, and risk factors for poor health (e.g., nutrition and diet, transmission of disease, and protection [from STDs], sanitation [handwashing and waste disposal and storage], immunization [to protect against onset of disease], pregnancy and child birth)
  3. Knowledge of costs and benefits of health behaviors, lifestyles, exposures
  4. Knowledge of how to acquire health information and knowledge (e.g., modes of information gathering [health care provider, Internet, journals and books, special interest groups])
- C. Health-seeking skills and beliefs, self-efficacy
1. Beliefs about one's ability to achieve health outcomes, even under adverse circumstances
  2. Ability to acquire skills (e.g., monitoring glucose levels, use of condoms) and apply them under changing circumstances to work toward positive health outcomes
  3. Confidence in ability to perform or abstain from health behaviors and actions
- D. Health values and goals
1. Value of health
  2. Value of health-related goals (e.g., cholesterol levels)
  3. Value of lifestyle choices and behaviors (e.g., moderate versus excessive drinking)
  4. Ability to recognize and counter damaging social norms
- E. Self-governance and self-management and perceived self-governance and management to achieve health outcomes
1. Self-management and self-regulation skills and expectations
  2. Ability to manage personal and professional situations: ability to handle external pressures (e.g., children, work, household and extended family responsibilities, finances, marital and personal relationships)

### II. External Factors

- A. Social norms
1. Extent to which health norms are scientifically valid and evidence-based
  2. Extent to which health behaviors and health-seeking skills are viewed favorably (e.g., cultures of abstinence from alcohol, drugs, sexual activity) or unfavorably (e.g., cultures of alcohol abuse, obesity within family)
  3. Extent to which a health behavior is adopted by a majority or minority of a population in the culture (e.g., whether circumcision is widely accepted and practiced) and by whom
  4. Extent to which discrimination or antidiscrimination is the dominant norm in the provision of health care and public health services, influencing disparities in access
  5. Norms about decisional latitude or power in familial and social contexts
  6. Society's ability to recognize and counter damaging social norms and promote positive ones
- B. Social networks and social capital for achieving positive health outcomes
1. Emotional or instrumental support from friends and family (e.g., loving and caring family and friends who help with specific tasks or needs, such as watching children, picking up children from school)
  2. Existence of available networks of social groups
  3. Extent to which social networks may negatively impact health (e.g., bullies and their complicit accomplices, the "old boys" network, the "in crowd")
- C. Group membership influences: church, union, community membership to supplement or counterbalance social norms and social assistance in other social contexts
- D. Material circumstances
1. Economic: income and employment status
  2. Neighborhood and community (e.g., safety, noise, environmental pollutants, neighborhood facilities and resources)
  3. Safe water and good sanitation
  4. Housing
  5. Food security
  6. Extent to which immediate environment is toxin- or disease-free (e.g., toxic air, soil, water, inundated with malaria-infected mosquitoes)

*Continued*



## Continued

3. Ability to make the connection between cause and effect with regard to personal behavior and health outcomes; personal responsibility
  4. Ability to draw on networks of social groups
  5. Vision, direction, planning, strategy, and ability to make positive health choices
- F. Effective health decision-making
1. Ability to effectively use both knowledge and resources to prevent onset or exacerbation of disease or prevent death
  2. Ability to weigh the short-term and long-term costs and benefits of health behaviors and actions (e.g., smoking)
  3. Ability to identify health problems (e.g., employ guidelines of prevention, recognize signs and symptoms) and pursue effective prevention and treatment
  4. Ability to make healthy choices under various environmental constraints (e.g., abstain from unpotable water, use sunscreen and bed nets)
- G. Intrinsic motivation to achieve desirable health outcomes: extent to which motivation for current or future behavior maintenance or change is internally (e.g., personal responsibility, personal assessment) or externally (e.g., mandates, rewards, requirements, peer pressure) motivated
- H. Positive expectations about achieving health outcomes: optimistic or pessimistic viewpoint on personal life and health prospects
- E. Economic, political, and social security: extent to which individuals and groups feel secure or insecure in their immediate and broader macrosocial environment (e.g., broader changes in the national and subnational economic and political systems generating job, financial, or political insecurity and pessimistic outlook, violence, criminal activity)
- F. Utilization and access to health services: sought and obtained health services when care was thought needed
1. Serious symptoms of poor health conditions (e.g., shortness of breath, frequent or severe headaches, chest pain, lump in breast, fever, back or neck pain, loss of consciousness)
  2. Morbid symptoms of poor health conditions (e.g., sadness, hopelessness, anxiety, pain in knee or hip, fatigue or extreme tiredness, difficulty hearing, fall or other major injury)
  3. Perception of the need to see a health provider when experiencing a serious or morbid health symptom
  4. Ability to obtain health services when there is a perceived need
  5. Presence of barriers (e.g., geographic, financial, linguistic) to access and utilization of services
- G. Enabling public health and health care systems
1. Extent to which health care and public health system environment interacts with individual to build and enable health agency (e.g., a health coach for diabetes management)
  2. Extent to which health care and public health system environment protects health and safety of public (e.g., contaminated blood supply, food safety and contamination, drug regulation)
  3. Health care and public health system effectiveness and accountability

Notes. SF-36=36-item short form health survey<sup>16</sup>; STDs=sexually transmitted diseases.

individual level, each person will integrate multiple domains of health capability. At the population level, it could be enough to examine discrete health capability domains to identify deprivations for policy action. A battery of scores<sup>22</sup> with entire scales and subscales from the survey is more likely to be useful at

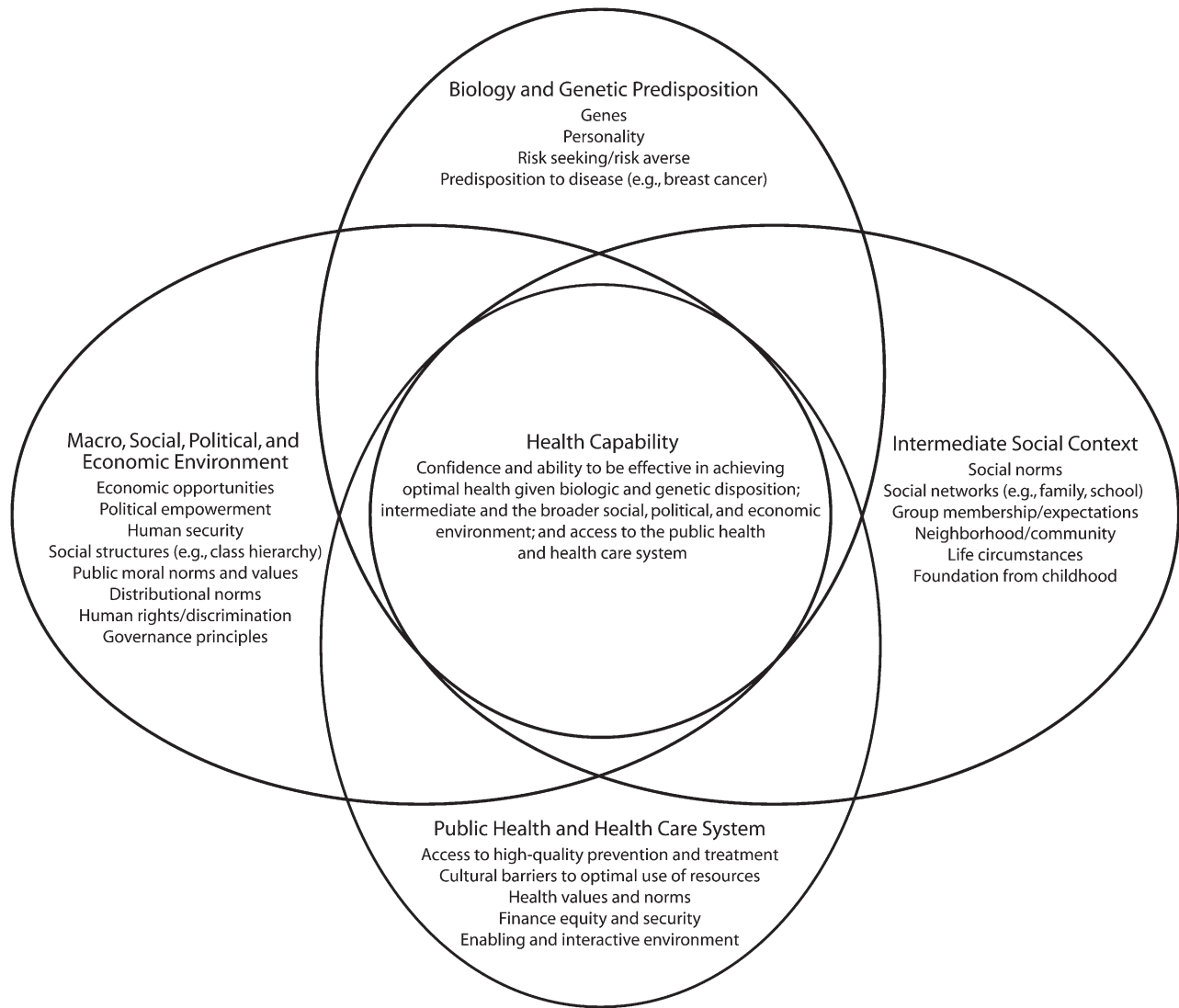
this stage than an overall score, which may take the form of a health capability index. Some policy questions might, however, require combining health capability domains, which, in turn, might require weighting. The profile could later be turned into a health capability index, and it would be necessary to

determine weights and aggregate data across domains.

### OPERATIONALIZATION AND SURVEY DEVELOPMENT

Determination of individuals' various health capabilities under the

profile requires a baseline survey. Batteries of questions measuring several key profile constructs to assess an individual's perspective about her ability to be healthy are currently in the pilot testing stage. The instrument can be used to shape the best possible circumstances for individuals to be healthy. Understanding



**FIGURE 1—Conceptual model of health capability.**

both the major dimensions of health capability and the reliability and validity of specific scales to measure these dimensions will require further study,<sup>23</sup> as will the potential usefulness of these surveys for policy evaluations and population-scale health assessments.

Study among specific populations will be especially important, both in

terms of individuals' conditions and the socioeconomic barriers to health functioning and health agency.

These early efforts will, I hope, create momentum for conceptualizing and measuring health capability for social policy, public health, and health care assessment.

Lessons learned from medical outcomes assessment and other

performance-based measures<sup>24–27</sup> will be useful for informing health capability measurement efforts. These assessment approaches have highlighted the importance of the patient's viewpoint in monitoring the quality of medical outcomes.<sup>28</sup> Methodological advances have improved the ease and usefulness of

self-administered questionnaires.<sup>29</sup> Like other self-reports, this exercise will attempt to assess conditions from the individual's viewpoint. However, the profile also incorporates objective data from individuals (for example, glucose and cholesterol levels), and emerging biotechnologies such as microfluidic diagnostics hold promise for



collecting biomedical data rapidly and at low cost.

## APPLICATIONS, ASSESSMENT AND INTERVENTION DESIGN

The conceptualization of health capability developed here recognizes the centrality of human motivation and the multiple internal and external factors that impact individuals' health capability, as noted in Figure 1. When one is designing interventions at the individual, meso, and macro levels to reduce health capability gaps, the health capability profile can be useful in serving both individuals and broader populations.

My purpose is to conceptualize, in an ethically justifiable way, society's collective obligations in the health realm and then to operationalize a means for fulfilling them. This involves normative and positivist implications above and beyond the primarily positivist orientation of epidemiology or the primarily normative orientation of ethical theory.

The framework offered in the box on pages 45 and 46 and Figure 1 provides a conceptual basis for intervention design and policy formulation under a health capability paradigm. As a comprehensive population health capability measurement framework, it offers a way for countries, subnational governments, and local entities to improve health policies and public health practices and achieve improved health capability for their populations so that health systems are both fair and cost-effective. There are a number of possible applications of this approach.

At the individual level, the profile can be helpful both for assessing an individual's level of health functioning and health agency, and shaping interventions and environments. The profile can also help evaluate an intervention's effectiveness and can help individuals understand their own health capabilities. One individual-level component of the profile, intrinsic motivation, is significant to the health capability paradigm because it influences behaviors that affect health choices. Of particular concern is how much individuals are subject to social influences in governing and managing their decisions. Research has demonstrated that although extrinsic motivation achieves outcomes in the short run, these effects often attenuate over time, absent external reinforcement.<sup>30</sup> Similarly, external constraints on decisional power (e.g., social norms that denigrate women's authority at home and elsewhere) squelch efforts to employ intrinsic motivation to improve health.

I hope that the health capability profile will help medical and public health researchers and practitioners evaluate the costs and effectiveness of medical interventions and behavioral approaches<sup>31,32</sup> that might foster health capability. Experience with 2 behavioral interventions—motivational interviewing<sup>33,34</sup> and motivational enhancement therapy<sup>35</sup>—suggests, for example, that although these interventions typically focus solely on the individual level, they might be useful in combination with broader economic and social changes rooted in public policy. Unlike motivational interviewing and motivational enhancement

therapy, however, health capability focuses on the early onset and long-term development of health agency as empowering motivation.

More specifically, health capability might help researchers and practitioners develop a new behavioral–social intervention archetype, especially the augmentation of individual-level approaches with broader structural interventions. The ability to understand socially constructed or socially dependent health capabilities offers hope for a more nuanced approach to the impact of social structures on an individual's health functioning and health agency.

More broadly, the profile could help providers and policymakers assess individuals' societal needs and current barriers to addressing these needs. The profile might also inform policy development through legislation and regulation by illuminating the ways the social environment facilitates or obstructs health capability and the need to design and implement features for improving individuals' health capability profiles. In research, the profile can provide an overarching framework for interdisciplinary scholarship nationally and internationally—beyond narrow foci on mortality, morbidity, or even health functioning—to health capability and the social factors affecting it.

Health capability is a complex concept. Intervention development, then, must draw on multiple scientific disciplines. Strategies that integrate aspects of the behavioral and social sciences are especially promising. Components of potential programs include, just in one instance, for example, behavioral interventions grounded

in motivation theory and economic policies grounded in the economic theory of addiction. A combination of such approaches would be advantageous.

I have presented a conceptual model of health capability and a health capability profile. I have discussed several potential lines of survey and intervention development and application. This framework offers a model for further discussion, refinement, and development in efforts to address deprivations in individuals' health capabilities. ■

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## Schools of Public Health and the Health of the Public: Enhancing the Capabilities of Faculty to Be Influential in Policymaking

Beaufort B. Longest Jr, PhD, and George A. Huber, JD

Faculty members of schools of public health contribute to better health largely through their teaching, research, and community service roles. We suggest attention to another role: exerting their influence to ensure effective public health policy.

Using recent actions taken at the University of Pittsburgh's

Graduate School of Public Health as a template, we describe some of the key steps that public health schools can take to help their faculties be more influential in public health policy. These steps include (1) building infrastructures to support and facilitate this role, (2) teaching faculty members how to

be more influential in the policy arena, and (3) aligning incentives and rewards for faculty who contribute to improved public health by influencing the formation and implementation of public health policy. (*Am J Public Health*. 2010;100:49–53. doi:10.2105/AJPH.2009.164749)

**AS REFLECTED IN THEIR MISSION** statements, operations, and organizational behaviors, schools of public health seek to contribute to better health. The core pathway to this end is the teaching, research, and community service contributions made by the schools' faculties. The central theme of this article is that public health