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A Critical Evaluation of the Capability Approach as a Theoretical Foundation for Person-Centred Care in UK Health and Social Care

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Introduction

Person-centred care has become a defining principle of contemporary UK health and social care policy, reflecting a shift away from paternalistic models of service delivery towards approaches that recognise individuals as active participants in decisions affecting their lives (Barnard, 2023; Mackreth, 2021). The principles underpinning person-centred care originate from the humanistic work of Carl Rogers (1961), whose person-centred philosophy emphasised empathy, respect for autonomy and collaborative relationships. Although developed within psychotherapy, Rogers' ideas have significantly influenced contemporary health and social care practice, where promoting dignity, choice and participation has become central to person-centred care.

Among the theories that have shaped contemporary person-centred care, the Capability Approach offers one of the most influential philosophical frameworks for understanding how individuals can be supported to live lives they have reason to value. Originally developed by Sen (1985; 1999) and further advanced by Nussbaum (2011), the approach argues that wellbeing should not be evaluated solely by the resources individuals possess or the services they receive, but by their genuine opportunities to achieve lives they have reason to value. By emphasising freedom, agency and the interaction between individual circumstances and wider social environments, the Capability Approach provides a broader understanding of wellbeing than traditional biomedical models (Robeyns, 2016).

This essay critically evaluates the Capability Approach as a theoretical foundation for person-centred care in UK health and social care. It first examines the emergence and development of the theory before critically evaluating its principal strengths and limitations. The discussion then analyses its influence on contemporary UK policy and practice, including the challenges associated with implementation, before proposing recommendations and drawing an overall conclusion.

Section 1 – The Emergence and Development of the Capability Approach

The Capability Approach emerged during the late twentieth century as a response to dissatisfaction with dominant theories of welfare and social justice that measured wellbeing primarily through economic resources, income and preference satisfaction (Sen, 1985; Robeyns, 2016). Such approaches assumed that individuals with similar levels of wealth or access to services would experience comparable wellbeing, yet failed to recognise that people differ significantly in their ability to convert resources into meaningful life outcomes because of variations in health, disability, education, age, gender and wider social circumstances. It was within this context that Sen (1985) introduced the Capability Approach, arguing that attention should shift from what people possess to what they are genuinely able to do and be.

A key feature of the Capability Approach is the distinction between functionings and capabilities (Sen, 1985). Functionings refer to the valuable states of being and activities that individuals achieve, such as maintaining good health or participating in education, while capabilities represent the genuine opportunities available to individuals to achieve these valued functionings. This distinction recognises that two people with identical resources may experience very different levels of wellbeing depending on their personal characteristics and social environment. For example, an older adult living with mobility impairment may receive the same financial support as another individual, yet still experience reduced independence if inaccessible housing or limited community services restrict their opportunities for participation. The Capability Approach therefore shifts attention from equality of resources towards equality of real opportunities (Sen, 1985).

Sen (1999) subsequently expanded the theory by arguing that development should be understood as the expansion of substantive human freedoms rather than simply economic growth or increased service provision. Central to this perspective is the concept of agency, which recognises individuals as active participants capable of making choices and pursuing goals they personally value—representing a significant departure from paternalistic models in which professionals traditionally determined a person's best interests with limited involvement from the individual concerned. In this respect, the theory provides a compelling philosophical justification for person-centred care, as both perspectives emphasise autonomy, participation and respect for individual values (Nussbaum, 2011).

Despite these contributions, Sen (1999) intentionally resisted defining a universal list of capabilities, arguing that decisions about what individuals should value ought to emerge through democratic discussion rather than philosophical prescription. While this flexibility increased the theory's adaptability across diverse contexts, it also created uncertainty for policymakers seeking practical guidance. Without agreed criteria for determining which capabilities should be prioritised, the theory was criticised for offering limited operational direction, a tension that became the catalyst for the next major stage in the approach's development, led by Nussbaum (Robeyns, 2016).

Section 2 – The Development of the Capability Approach: Critiques and Responses

Although Sen's (1985; 1999) Capability Approach fundamentally transformed understandings of wellbeing and social justice, its practical application generated significant debate. Many scholars argued that Sen's deliberate avoidance of a definitive capability list limited the theory's usefulness for policymakers and practitioners, making its translation into health and social care policy and practice increasingly difficult (Robeyns, 2016).

Nussbaum (2011) argued that governments require a clearer normative framework to promote social justice consistently. Rather than leaving capability selection entirely open to public debate, she proposed ten central human capabilities—including life, bodily health, bodily integrity, practical reason, affiliation and control over one's environment—considered essential for achieving a life of human dignity. For health and social care, this development is significant because it extends the concept of care beyond the treatment of illness to encompass social participation, independence, emotional security and meaningful relationships.

Nussbaum's contribution has nonetheless generated substantial debate. Supporters argue that her capability list transforms an abstract philosophical theory into a practical framework capable of informing legislation and professional decision-making, establishing minimum standards of justice while reducing ambiguity (Nussbaum, 2011). Critics, however, question whether any universal list can adequately reflect the diversity of human values, cultures and life experiences, arguing that Nussbaum introduces a degree of philosophical paternalism inconsistent with Sen's (1999) emphasis on democratic participation and individual agency.

These debates have been explored extensively by Robeyns (2016), who argues that many criticisms of the Capability Approach arise not from its underlying principles but from the

challenges of operationalising a broad philosophical framework. Rather than viewing Sen's and Nussbaum's perspectives as mutually exclusive, she suggests they represent complementary responses to different purposes: Sen's framework offers a flexible evaluative space for democratic reasoning, whereas Nussbaum provides greater normative guidance for public institutions seeking to reduce injustice. Nevertheless, Gasper (2007) observes that capabilities represent opportunities rather than directly observable outcomes, making them inherently more difficult to measure than traditional indicators such as income or clinical performance—a tension that helps explain why contemporary health systems increasingly combine capability thinking with broader outcome measures and personalised care frameworks. Similarly, Terzi (2008) argues that individuals possess different conversion factors, including disability and social circumstances, which influence their ability to transform resources into meaningful capabilities. This suggests that equal access to services alone does not guarantee equal opportunities or outcomes, reinforcing the need for genuinely person-centred approaches within health and social care.

Section 3 – Application of the Capability Approach to UK Health and Social Care Policy and Practice

The Capability Approach has strongly influenced UK health and social care policy by shifting attention from service delivery towards individual wellbeing, autonomy and meaningful participation. This philosophical shift closely reflects Sen's (1999) argument that wellbeing should be understood in terms of people's real freedoms to lead lives they have reason to value.

One of the clearest policy examples of this influence is the Care Act 2014 (Care Act 2014), which established the wellbeing principle as the foundation of adult social care in England. Rather than focusing exclusively on meeting eligible needs, the legislation requires local authorities to promote wider aspects of wellbeing, including personal dignity, physical and mental health, protection from abuse, participation in work or education, social relationships and control over day-to-day life. These statutory principles closely mirror capability thinking, encouraging professionals to identify and build on people's existing abilities rather than focusing solely on their limitations (Care Act 2014; Sen, 1999).

Similarly, the Mental Capacity Act 2005 (Mental Capacity Act 2005) reinforces principles that align closely with the Capability Approach through its commitment to respecting individual autonomy and maximising decision-making capacity wherever possible. The Act begins with the

presumption that every adult has capacity unless demonstrated otherwise, reflecting Sen's concept of agency by recognising people as active decision-makers rather than passive recipients of professional intervention. Nevertheless, translating these legal principles into everyday practice remains complex, as professionals often face tensions between promoting autonomy and managing perceived risk, particularly when working with individuals living with dementia, learning disabilities or severe mental illness (Mental Capacity Act 2005). For example, social workers, community nurses and domiciliary care staff routinely balance respecting individual choice with safeguarding responsibilities in everyday practice.

The influence of capability thinking is also evident within NHS England's (2024) personalised care agenda, which seeks to ensure that individuals become equal partners in planning and managing their own health through shared decision-making, personalised care and support planning, personal health budgets and social prescribing. Rather than asking only "What is the matter with you?", personalised care increasingly asks "What matters to you?" As Barnard (2023) argues, contemporary person-centred care requires practitioners to understand the individual within the context of their relationships, environment and wider social determinants of health, while Mackreth (2021) and NHS England (2024) emphasise that effective support depends upon collaborative communication, shared decision-making and personalised care.

Despite these policy developments, the practical implementation of capability-based person-centred care remains inconsistent. Needham (2011) argues that although personalisation has become a dominant policy narrative, the reality experienced by many service users is often constrained by organisational bureaucracy, limited resources and tightly controlled eligibility criteria. This creates a significant gap between the philosophical ideals of the Capability Approach and the realities of frontline practice, demonstrating that adopting capability language within legislation does not automatically transform professional practice; expanding people's capabilities also depends upon sufficient resources, skilled practitioners and organisational cultures that support positive risk-taking. Furthermore, Venkatapuram (2011) argues that health should be understood as a capability in itself, rather than simply the absence of disease. This perspective strengthens person-centred care by emphasising that health services should expand individuals' opportunities to participate fully in society, rather than focusing exclusively on clinical outcomes. Similarly, Glasby (2026) argues that effective health and social care depends upon integrated, person-centred services that recognise the complexity of individuals' needs and promote collaborative working across professional boundaries. Together, these

perspectives reinforce the importance of translating capability theory into coordinated, personalised practice.

Section 4 – Recommendations for Health and Social Care Policy and Practice

Improving person-centred care requires more than adopting capability-based language within legislation; it demands sustained investment in workforce development, organisational culture and outcome measurement (Needham, 2011; NHS England, 2024).

The first recommendation is to strengthen professional education and continuing workforce development around capability-based, person-centred practice. While UK legislation promotes autonomy, shared decision-making and personalised care, professionals may continue to adopt paternalistic approaches when faced with heavy workloads, safeguarding concerns or organisational pressures. Education should therefore move beyond procedural compliance and encourage practitioners to understand how capability thinking can support meaningful conversations about individual goals, strengths and aspirations (Barnard, 2023; Mackreth, 2021). However, the effectiveness of this recommendation depends upon organisations providing protected learning time and sufficient staffing levels, which may be difficult during periods of financial constraint.

The second recommendation is to develop more comprehensive approaches to evaluating person-centred outcomes that extend beyond traditional biomedical indicators. As Gasper (2007) highlights, capabilities are inherently more complex to assess than measurable outputs such as hospital admissions because they concern people's real opportunities rather than simply observable achievements. Mitchell et al. (2017) demonstrate that capability-based measures are increasingly being explored within health research, suggesting promising alternatives to conventional health status indicators. However, implementing these approaches consistently would require investment in training, digital infrastructure and evaluation systems.

Finally, stronger partnership working across health, social care and community services in frontline practice is essential if individuals are to experience genuine capability enhancement rather than fragmented care, since people's opportunities are shaped not only by healthcare interventions but also by housing, employment, education, family relationships and community participation. This principle aligns with NHS England's (2024) personalised care initiatives and

the wellbeing duties established under the Care Act 2014. However, Needham (2011) argues that fragmentation between organisations, resource limitations and bureaucratic systems frequently undermine these ambitions, meaning that progress towards integrated working is likely to remain gradual rather than immediate.

Overall, these recommendations demonstrate that the Capability Approach provides a practical framework for improving health and social care when supported by effective leadership, professional development and coordinated policy.

Conclusion

The Capability Approach enriches person-centred care by defining wellbeing as the genuine freedom to achieve lives people have reason to value. Developed by Sen and further advanced by Nussbaum, this framework prioritises autonomy, agency and dignity, influencing UK legislation, including the Care Act 2014, alongside NHS personalised care initiatives. However, implementation remains challenging. Debates surrounding the measurement of capabilities, together with organisational pressures and financial constraints, mean that policy commitments do not always translate into genuine choice in practice. Despite these challenges, the Capability Approach remains a persuasive framework because it shifts attention from service provision to the opportunities people have to live meaningful lives. Continued investment in workforce development and person-centred practice will be essential if its principles are to be realised consistently across UK health and social care.

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