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INTRODUCTION

In the current medical ethics literature, the concept of agency is receiving growing attention. There are many different definitions, such as the capacity to control voluntary actions, coined by Szasz (Szasz, 2001), or "the capacity for self-directed behaviour", proposed by Blacksher and Lovasi (Blacksher & Lovasi, 2012)(p.173). Nevertheless, many of those definitions are narrow in scope or applicable to a small number of individuals with particular characteristics (Lopez et al., 2016). Agency is also a relevant concept for many normative frameworks, and for some authors is referred to as "the ability to act on behalf of what you value and have a reason to value" (S. Ibrahim & Alkire, 2007, p. 383).

This article intends to provide a deeper understanding of this concept, allowing for its use in clinical practice and public health policies. First, it revises the uses of agency as an alternative to ensure that people's attitudes are taken into account during the design and implementation of the policy. However, the notion of agency has not been further developed, leading to problems when is used in real life scenarios. To overcome these shortcomings, the article presents two philosophical accounts of agency, identifying three relevant features, namely *time-extended organised planfulness*, *endorsement* of their own actions, and *identification* with the activity. Finally, the article depicts how those features may help in the application of agency to the analysis of health policies by means of a number of examples at the individual and collective levels.

INFANT MORTALITY RATE: THE CHILEAN CASE

Using the Capability Approach as theoretical and normative framework, James W. McGuire claims in *Wealth, Health, and Democracy* that human development is not about economic progress but expanding people's "capability to lead a thoughtfully chosen life" (McGuire, 2010, p. 14). As such, it would be a socially valuable goal. Public policies should then foster human development. The practical problem, as McGuire acknowledges, is that this capability to lead a chosen life is difficult to appraise and measure; therefore, other indexes, used as proxies, have to be selected instead (McGuire, 2010). McGuire analyses premature mortality indexes, such as infant and under-5 mortality rates, in eight different middle-income countries (Argentina, Brazil, Chile, Costa Rica, Indonesia, South Korea, Taiwan, and Thailand) (McGuire, 2010). After describing that the best way to explain early mortality is a combination of economic indicators (GDP, Gini coefficient and income-poverty rate), social indicators (urbanisation, ethnic diversity and religion) and social services (education, water and sanitation, health and nutrition services, and family planning), he claims: "it is reasonable to assume that mortality indicators such as infant mortality and life expectancy are good proxies for the degree to which some very basic capabilities –to be adequately nourished, to be cared for when sick– have spread throughout a society" (McGuire, 2010, p. 16). Infant mortality analysis would provide information about the *health potential* of a population.

Chile is one of the countries analysed by McGuire. This South American country is an interesting case because its epidemiological data challenge the previously mentioned conclusion. In the last 50 years, Chile has had a very significant reduction in the infant mortality rate and an increase in life expectancy. Nevertheless, the greatest improvements in the infant mortality rate occurred when it was ruled by a non-democratic government and was performing very poorly in economic development (McGuire, 2010). During the first 11 years of the military government, economic growth was severely affected by two recessions; a number of economic indexes, such as the Gini coefficient, and the poverty rate, also showed this poor economic development. Moreover, public services spending shrank from 26 to 13 percent of the GDP, neglecting policies, such as sanitary inspection of

food handling facilities, leading to a sharp increase in the prevalence of hepatitis and typhoid fever (McGuire, 2010). Despite the discouraging economic and social prospects, between 1973 and 1984 the infant mortality rate "fell from 65.2 to 19.6 per 1000 [live births], one of the sharpest sustained drops on record in any country ever" (McGuire, 2010, p. 95).

Moreover, the Chilean case illustrates a problematic scenario, which is frequently neglected when democracy and political freedoms are taken for granted, such as coercive public policies. Improvements in infant mortality rate can occur in the presence of coercive public policies. It is normally assumed that if an individual has achieved a given feature, he had the freedom to achieve it beforehand, and achieved this feature by exercising this freedom of choice. Nevertheless, under coercive circumstances, the goal is accomplished because the subject *is forced* to do so, and not because this person *freely decided* to pursue it. Therefore, in order to operationalise the *freedom to achieve good health*, we must take into account not only outcomes, but also some aspects of the process that brought about this achievement, including people's abilities and attitudes towards the outcome.

The concept of agency, defined as "the ability to act on behalf of what you value and have a reason to value" (S. Ibrahim & Alkire, 2007, p. 383), gives room for this procedural dimension. In a definition of agency from the Capability Approach literature, Ibrahim & Alkire explicitly refer to *what you value,* and to *have a reason to value*, appealing to two dimensions: while the first refers to the *subjective* motivational aspect of human behaviour, including wishes and desires, the second aspect is closely linked to an *objective* rational deliberation process. It seems that the particular way in which agents value goals and activities cannot be reduced to deliberation, but it also cannot be equated to wishes and preferences (Watson, 1975). Hence, the act of valuing is a central feature in agency, and its two dimensions, i.e. objective and subjective, should not be considered as opposite, but complementary. Being an agent, then, is acting wilfully, which supports the conception of agency as "the degree to which one's activities are one's own, or, so to speak, the 'ownership' of one's activities" (Drydyk, 2013, p. 252).

For the case of health, Ruger defines health-agency as "an individual's or group's ability to pursue valuable health goals and to effectively bring about health" (J. P. Ruger, 2010, p. 82), and some characteristics must be highlighted. First, it considers *groups* and not only *individuals* as possible entities able to exert agency. Second, it focuses on the *ability to pursue*, a *procedural feature*, in contrast with the outcome-oriented perspective, which mainly considers achieved indexes. Third, it requires that the agent *values* health and deems it to be a significant goal. Finally, it also considers the achievement of some *effective outcomes*.

But, is a decision-making process without coercion - or participation and deliberation in collective decisions - enough to claim that one was the agent of an action? Sometimes it is difficult to assess to what extent our actions are the expression of our values, even in the absence of coercion, or whether in a deliberation our participation was really honest. Hence, it is not always evident if one was a true agent. To clarify this point, a deeper understanding agency is required.

AGENCY: TWO PHILOSOPHICAL ACCOUNTS

In *Structures of Agency*, Michael E. Bratman provides an insightful analysis of agency (Bratman, 2007). He defines agency as a quality of "an agent with considered desires and beliefs, stable plans and policies, and higher-order self-governing policies" (Bratman, 2007, p. 63). In Bratman's account, the agent organises her *beliefs* (about the surrounding world) and *desires* (concerning possible states in that world, including one's own actions within this world); without this task it is more appropriate to say: 'it happens to this agent to want something' than 'this agent wants something'. In order to make this organisation (or hierarchy), agents undertake an iterative process of reflection, first about their desires in light of their beliefs (yielding *considered desires*), later about the already considered desires (yielding *high-order desires*), and finally weighing those different high-order desires to set priorities. Throughout this process, agents integrate previous experience and knowledge, which include social

interactions and self-awareness. This deliberation finally brings about *plans* (organised and coordinated courses of action) and *policies* (general plans on potentially recurrent occasions).

In order to consider plans and policies as truly organised and coordinated, there must be some sort of consistence and coherence among them. The agent's ability to perceive herself as "a temporal persisting planning agent, one who begins, continues, and completes temporally extended projects" (Bratman, 2007, p. 59) allows for the required stability. Moreover, an agent considers policies not only in the light of her own beliefs, but also in her whole psychological structure, establishing *high-order policies*. Those high-order policies considered by an agent as *reason providing* and therefore able to justify her behaviour, are called *self-governing policies*. For example, suppose that an agent, after an excruciating experience of disease, forms a strong desire to avoid physical illness. As a consequence of this desire, she wants to have a healthy lifestyle (a higher-order desire) and designs long-lasting plans, such as enrolling herself in the gym, and eating healthy food. She has developed a *healthy lifestyle policy*, which enforces the aforementioned plans. Eventually, a desire to procrastinate may threaten her wish for going to the gym, but if the policy and desire of avoiding physical illnesses are stronger, then the agent will persist in her intention and will go to the gym. If this desire is strong enough, she will develop a policy of treating her desire to avoid disease as reason-providing: if someone asks her why she is so devoutly committed to such a healthy lifestyle, she will answer 'because I was sick and I don't want to be sick again'.

This account does not imply that the agent must have fixed intentions over time; the agent can change her opinion, but if she does so, it must be acknowledged that is the same agent changing her judgement, and not another agent with a new mind. Hence, *temporal self-awareness* is very important for making up agency, as it is an extremely relevant determinant (and facilitator) for establishing stable hierarchies of desires and policies. Other authors echo this perception when they state "if one of the most important elements in the agency phenomenon had to be pointed out, we certainly would highlight autobiographical consciousness" (Quintanilla, 2014, p. 136; translation mine).

There are, however, a couple of issues in this account, which have to be developed further. Agents determine their own self-governing policies, and, therefore, they are self-governing beings, but it is not clear where this ability comes from, and how a policy can turn a desire into a reason-providing desire, speaking for the position of the agent. Higher-order desires can endorse lower-order desires, but a very-high-order desire could always be endorsed by an even-higher-order desire and they are not *per se* reason-providing desires. This is what Bratman calls the *agential authority problem*, and he proposes a solution to it by claiming "[a]n attitude has a claim to agential authority when its role in the psychic economy is to support the cross-temporal organisation and Lockean unity of practical thought and actions" (Bratman, 2007, p. 134). Therefore, if the desire to avoid illnesses is deeply rooted in and is coherent with the agent's autobiographical consciousness, it would have the agential authority to become reason-providing. If the agent observes two policies colliding within her temporal extended psychic stew ('one day I want something, the next day I want the opposite') and cannot resolve her ambivalence, she can modify one of them and thereafter take up new plans. Therefore, there will be consistency among her reason-providing desires. The case would be different if, due to external factors, the agent was not able to merge those desires. In this case, she could claim 'I don't want to do it, but I have to!' It could be said that 'it happens to the agent that she has to eat unhealthy food'.

Christine M. Korsgaard points out a different characteristic of agency (Korsgaard, 2009). She develops her interesting account from an empirical observation: "sometimes to our own pleasant surprise, sometimes merely with bewilderment or bemusement, we find ourselves doing what we think we ought to do, in the teeth of our reluctance, and even though nothing obvious forces us to do it" (Korsgaard, 2009, p. 2). Her first step is to highlight the subtle distinction between *acts* and *actions*. While *acts* refer to an *activity in itself*, *actions* include the *reason to carry out* these activities. As she illustrates, "if you choose to dance for the sheer joy of dancing, the dancing is the act, and dancing for

the sheer joy of dancing is the action" (Korsgaard, 2009, p. 12). The problem, she argues, is that reasons (causal reasons) are often confused with purposes (justificatory reasons). For instance, 'John is going to the gym' is a good example of an *act*, because only the activity is described; if it is also added that he is doing so aiming at exercising, the reason would now seem to be clear and we would have the description of the *action*. This analysis, however, is mistaken since the exercise is the *purpose*, not the *reason* for the act. He might be going because he wants to please his wife ('you must go to the gym because you're too fat'), or because he has a desire of going there and exercising. In both cases, the act (going to the gym) and the purpose (exercise) are the same, but the activities cannot be equalised because the reasons are different: in the first case, it is to adhere to an external pressure and, in the second, it is to do something valuable for its own sake. If John is questioned about his reason for going to the gym, in the first case he may answer 'because *my wife* wants me to go', and in the second case 'because *I* want to go', taking responsibility for the activity. The key is that if I am a self-constituting agent, I deem my activities to be "an expression of myself as a whole, rather than as a product of some force that is at work on me or in me" (Korsgaard, 2009, p. 18). The concept of the wholeness of the agent is extremely important in her account, as it makes a difference between whether the act is originated from within the agent or not. What if John, who has a nurturing and caring relationship with his wife, internalizes her advice and makes it his own wish? Starting from his wife's opinion, he may actually start wanting to go to the gym ('my wife thinks I'm too fat; she loves me and has always been concerned about me and my health; I'm a little bit fat, it's true; being fat compromises my health; I want to be healthy; I want to go to the gym'). This process may yield to what has been called the *adaptive preferences* problem. Even if this may not be the case, a complete discussion of this issue is beyond the scope of this article, but more insights can be found elsewhere (Enoch, 2020). The empirical evidence suggests, however, that healthy and nurturing relationships are important to avoid this eventual issue (Chirkov, Ryan, & Sheldon, 2011).

As has been discussed, a person acts as an agent -or exerting agency- when he values the activity he is participating in, i.e. the agent endorses it based on his high-order self-governing policies, which in turn are rooted in his temporal self-awareness. Moreover, the agent deems this action as a genuine expression of his own self. Hence, according to these accounts, there are three features of agency that must be acknowledged: *time-extended organised planfulness*, *endorsement* of their own actions, and *identification* with the activity.

AGENCY AND HEALTH CARE POLICIES

At the individual level, applying the concept of agency to health care is an uncomplicated task: health care policies should foster individuals' agency by paying special attention to the way health goals are achieved. This account implies that people *value* the outcome and take ownership, at least to some degree, over the activities in which they are taking part. Hence, health care policies entail patient-centred care policies and the support for self-management (Entwistle & Watt, 2013). Some authors suggest that agency is promoted by providing information to patients (Kinghorn, 2015), but this may be insufficient. The identified features of agency provide useful insights into the use of this concept in health care. For instance, a pregnant woman going to her routine check-up because that is the only way to have access to other social benefits would be a non-agentive performed action (it happens to her that she has to go); on the other hand, if she understands the advantages of adhering to this health care program, considers these advantages in the light of the costs, has a voice in planning her visit, and is able to integrate these check-ups into her own maternity policies, then she will be able to *endorse* this behaviour and *identify* with it. Hence, she will be the agent and the owner of her actions. In the assessment of health care outcomes, agency must also be taken into account. In this way, people will be considered agents of their own health, and not mere "passive recipients of interventions designed to meet this goal" (Levine, 2013, p. 55). Health policies seeking to decrease the infant mortality rate may succeed in this aim; however, as the Chilean case suggests, the population may not always claim this achievement as their own.

Agency demands deliberation, planning and *endorsement*, processes that have to be embedded in the *autobiographical* consciousness and *identity* of the agent, as Bratman and Korsgaard's accounts suggest. However, it has to be admitted that people can exert different levels of agency according to their personal circumstances. Public health care policies should foster people's agency as much as possible; if subjects are not able to exercise an adequate level of agency, decision makers may be allowed to implement more directive (and eventually restrictive) health care policies, aiming at the protection of vulnerable people. For example, health care workers rejecting the SARS-CoV-2 vaccine is a complex case, where people do not *endorse* a behaviour (being vaccinated), but this fact does not seem to be coherent with their own (as they have devoted much time and effort in caring for the sick and their decision put vulnerable people at risk).

AGENCY AND PUBLIC HEALTH POLICIES

Nowadays it is widely acknowledged that health is not only the result of individual behaviour and personal predisposition, but also health care provision and economic, social, cultural and environmental factors (Schroeder, 2007). As health is not only the outcome of individual action, public health policies should be designed and implemented beyond the health care domain. The COVID-19 pandemic in Chile has provided evidence that even if people do have access the health care, still social determinants of health play a role on explaining health outcomes and people from lower socioeconomic status have higher mortality rates than better off populations (Bilal, Alfaro, & Vives, 2021).

As was the case for individual health care interventions, people should have the opportunity "to participate in such deliberations and decision-making and know the risks, benefits and cost of health prevention and treatment and various health policy options" (Jennifer Prah Ruger, 2015)(p.107). Nevertheless, is participation in deliberation of public policies enough to claim that one was the agent of an action? A health action planned and brought about by the community (as opposed to centrally driven or top-down), and which brings about a valuable health goal may not be freely pursued by its members. It is highly unlikely that every single individual within a country deliberates, plans and *endorses* all the multiple public health policies that the government executes; moreover, there are cases of collective action leading to manipulation (Cleaver, 2007) and even coercion (Godfrey-Wood & Mamani-Vargas, 2016). Some criteria have been proposed for assessing the success of groups in terms of enhancing individuals' capabilities (S. S. Ibrahim, 2006), but the analysis of these kinds of situations is still problematic. How can one ensure that a given public health policy is really *valued* and *owned* by the population and not only by the policy-makers? How to design a public policy that a society *identifies* with, or deems this policy to be as a genuine expression of themselves?

In collective action scenarios, the philosophical accounts on agency inform some relevant aspects of human behaviour, such as whether the agent considers desires and motivations, makes plans, endorses aims, processes rooted in her autobiographical consciousness (Bratman, 2007), and whether the agent identifies herself with the activity, deeming it a genuine expression of her own self (Korsgaard, 2009). The North Karelia Project illustrates how these features may be used in collective level analysis.

In the late sixties, Finland had a high prevalence of cardiovascular diseases and in the North Karelia region the problem was a major concern for the population. In 1971, Esa Tomonen, North Karelia's governor, social organisations' representatives and regional members of the Finnish parliament presented a request to the central government to address this issue. The diagnosis and the main objective were clear, but the processes that would best bring about this outcome were not so certain. As was known, a community lifestyle change was required to tackle most cardiovascular risk factors, but the way to achieve this goal was still under research. A group of scientists "genuinely immersed themselves in the community and among the people, where they developed and adjusted programme activities according to the available local options and circumstances" (Pekka Puska, 2009, p. 29) and they realised that "permanent changes in the community can ultimately only be achieved

through the existing community structures" (Pekka Puska, 2009, p. 36). Therefore, they worked in close association with organisations, such as housewives' associations, mass media, business leaders, key members of voluntary organisations, local politicians, and health services, among others. The cardiovascular mortality rate plummeted dramatically, and even if it is true that this result cannot be attributed solely to the activities involved in the project, it was extended to the whole country after 6 years.

A reasonable requisite to fulfil agency demands at the collective level is a popular deliberation process, which includes all the parties at stake. "The political community is possible only under certain circumstances: being able to *organise itself*, allowing political discourse, as well as *complying with the needs and interests of their members*" (Heinrichs, 2016, p. 98; translation and emphasis mine). Public health policies that foster health must be democratically designed and implemented. The proposed criteria from Bratman and Korsgaard's accounts, namely *time-extended organised planfulness*, *endorsement* of their own actions, and *identification* with the activity are useful in collective action cases. Rather than being driven centrally, political communities sharing some degree of common *identity* and *history*, and aiming at common goals, should value, design, implement and *endorse* public policies. Any collective action that does not take into account the existing social structure and history, and manipulates or excludes some members, is not an activity respecting individuals' agency. The case of North Karelia illustrates a project including existing social organisations and key representatives' perspectives, and allowing the whole community to participate in the different stages of the project and finally "to feel a genuine sense of *ownership* about the project" (Pekka Puska, 2009, p. 40).

The North Karelia ideal scenario is in sharp contrast to which has occurred during the COVID-19 pandemic. In many countries unpopular policies were implemented top-down, such as confinements, social distancing and the obligatory use of face masks, and people from some localities have demonstrated against these restrictive policies, showing that they do not endorse them. However, even if some communities (with particularly good results) may claim ownership over these policies (Lewis, 2020), the urgency of this situation demands that effective policies be implemented without delay. The proposed features of agency, *time-extended organised planfulness*, *endorsement* of their own actions, and *identification* with the activity are valuable also at the collective level, however as was the case for health care policies, if communities are not able to exercise an adequate level of agency, the government may be allowed to implement more directive (and eventually restrictive) public health policies, aiming at the protection of vulnerable groups.

CONCLUSION

When analysing health policies, the achieved health status is a key component, but the process that brought about the outcome must be examined; agency informs about this procedural dimension. Features of agency coming from philosophical accounts, namely *time-extended organised planfulness*, *endorsement*, and *identification*, are appealing and rend the concept of agency itself easy to understand and apply to real-life scenarios. This article does not intend to give a full account of what collective agency could be, but to identify some features of agency that can be used in the analysis of health policies in the real world at the individual (health care) and collective (public health) levels. Bratman's and Korsgaard's insights support the notion of agency as acting wilfully and wholeheartedly, and therefore agents can claim not only *authorship over decisions*, but *ownership over actions*. The aforementioned features of agency make room for concerns for human freedom and are particularly useful in the appraisal of collective actions, where coercion, exclusion and the protection of vulnerable groups should be taken into account. Martha Nussbaum states "[a] life that is really human is one that is shaped throughout by these human powers of practical reason and sociability" (Nussbaum, 2000, p. 74); I would add that agents have not just *a* human life, but *their own* human life.

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