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Disability, Basic Justice, and Habilitation into Basic Good Health

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Not every philosophical essay on disability needs to be about justice. But at least some of them should be explicit and detailed about the connection between the two – especially when a failure to do this would amount to a missed opportunity of some significance for both theory and practice. Alas, that missed opportunity occurs in too much philosophical work – some of it my own, most recently in a book on habilitation and justice (*HHA*).[1] This essay addresses part of that missed opportunity.

The exposition here starts (section I) with a swift outline of the argument to be made here, beginning with some distinctions used in *HHA*, and conclusions reached there, as the basis for its missing argument about disability and the circumstances of justice. Section II adds some material designed to put the new argument in a practical context, and to make its premises equally plausible there. Section III does the same thing for the argument's conclusion.

I. Putting Abilities First in Theories of Justice

If *HHA*'s main line of argument is basically correct, then the topic of disabilities, in theories of distributive justice, should be merged – submerged, actually – into a discussion of *abilities*. Of course, there is nothing new about emphasizing the abilities of agents in normative

discussions. What is not made fully explicit in *HHA*, however, is the following set of conclusions, whose terms and premises will be defined and explained immediately thereafter:

Focusing on the human necessity of habilitation leads to a more inclusive and adequate account of the circumstances of justice. Such an account involves paying persistent attention to similarities and differences in the physical and psychological abilities of actual human agents. That in turn leads to equally persistent attention to the basic good health (or lack of it) in such agents, and to their inabilities (disabilities) as well as their abilities. Such attention to basic good health then yields a disability-friendly starting point for the construction of normative theories of basic justice generally. It does this by providing a constant undercurrent of attention to the crucial problems of human habilitation and rehabilitation that any plausible normative theory of justice must address. Those problems of justice, moreover, are framed as part of the inescapable project of working around human disabilities, or through them, toward situations in which their salience for basic justice is minimized. Moreover, it does this in a way that is logically prior to any theoretical commitment one might make to a given theory type (e.g., consequentialist, deontological, eudaimonistic), or to any particular distributive principles.

That is the burden of the argument proposed here. The outline of it is fairly compact – in six steps.

A. Definitions.

The first step is just a quick definition of some terms: basic justice, basic good health, and habilitation.

1. *Basic justice*. The subject here is basic justice, and not perfect or ideal justice. It isn't crucial for the argument just how we conceive of the basic part of justice – whether we think of it

in terms of basic human rights, or basic human capabilities, or basic human needs, or the minimum necessary conditions for good lives, or the minimum necessary conditions for peaceable coexistence.

My personal preference is for a schematic, political definition of basic justice in terms of the practical commitments people must share (and historically have apparently always shared) when they have been willing and able to survive, thrive, and coexist cooperatively among or alongside people with whom they compete for living space or resources, or who hold radically different visions of perfect justice, or of an ideal form of human life. We must have practical commitments along these lines, for example, if we want to travel in other lands, do business with other peoples, have diplomatic and legal relationships with them, and make peace with them – before, or after, making war on them.

But the important point is simply that the focus of the argument here will be on the minimum necessary conditions for justice – that is, the fundamental or basic part of it, rather than its perfection.

2. *Basic good health*. Similarly, the notion of basic good health will enter into the argument. Again, it is not perfect or ideal health that is at issue. Rather, it is a limited form of functional good health that people with significant disabilities can often have – namely, the ability to function reliably and competently in a limited range of physical and social environments, ones in which they can carry out the activities of daily living, the demands of a job, and so forth. Basic good health in this sense has both physical and psychological dimensions. Moreover, it is not just about the absence of pathology, but also about the presence of agent-energy, resilience, and resistance to pathology.

So in that sense basic good health is reliably competent physical and psychological functioning in a given range of physical and social environments. Section II will develop this point.

3. *Habilitation*. The final term to be introduced here is habilitation. It is through that term that the argument will connect basic justice and basic good health. Habilitation, like its better-known derivative *re*-habilitation, refers simply to *the process of equipping a person or thing with capacities or functional abilities.* That process obviously raises questions of justice – basic and ideal, distributive and corrective.

Habilitation is a lifelong necessity for human beings. We are born in desperate need of habilitative care from others. If we get that care, and are otherwise fortunate, we develop (to various degrees) into more or less *self*-habilitating persons. Alone, or together with others, we work to habilitate our physical and social environments – to make merely survivable environments into genuinely hospitable ones. And then we decline in various ways toward a reprise of infantile needs.

B. The circumstances of basic justice.

The second step in the argument is to point out an important connection between habilitation and basic justice – namely, that focusing on habilitation gives us an *alternative account* of the circumstances of basic justice. This alternative enlarges and refocuses not only Hume's influential account, but also many previous and subsequent variations of it – all of those, in fact, that accept the general line of ideas behind Hume's analysis. The alternative proposed here reveals basic good health as an utterly central and pervasive concern for basic justice.

1. *The circumstances of conflict.* Roughly, the general line of ideas underlying Humean accounts identifies the circumstances of justice with the circumstances of interpersonal and social conflict.[2] Such conflict typically arises when resources are persistently scarce, and our motives are persistently mixed (especially in the tension between self-interest and benevolence). Moreover, the level of conflict that generates basic *injustice* typically involves either inequalities of power and vulnerability between the people involved, or the failure of some people to adequately sympathize with the desires, difficulties, fears, joys, pains, pleasures, and suffering of others. This failure of sympathy is especially prominent when the relationships between the people involved are either remote or highly schematic (e.g., stereotyped), and when those relationships appear to some to involve radically repulsive conceptions of human needs, goals, virtues, worthwhile lives, and good societies.

Now, of course, if our focus is on ideal or perfect substantive justice, we may jump right past a discussion of the circumstances of conflict. Like Socrates in Plato's *Republic*, we may come back around to it only after we have imagined an ideally harmonious and effective society. But insofar as we focus on basic justice (as opposed to utopian ideals) and respond to a world full of injustices, we must confront the reality of conflict, and its circumstances. Essentially, we must address the general line of ideas that underlies Hume's account. We need not accept every detail of Hume's account, however; or only those details. Many philosophers (including Rawls) have proposed modifications of it.

2. *The circumstances of habilitation.* For example, if we construct an alternative account based on habilitation rather than conflict, we make the Humean account more inclusive – in what I think is an especially satisfying way.

That "habilitation framework," as I call it, comes from paying attention to the obvious human necessity of habilitation. We need to acquire and sustain the abilities to cope with the challenges we face throughout our lives. And we need to create and sustain a multigenerational social environment that successfully addresses habilitative necessities for a sufficient number of people. Unless we do that, we cannot survive productively and reproductively for long, let alone thrive – either as individuals, groups, or as a species.

3. *Three habilitative tasks*. In general terms, we human beings face three lifelong habilitative tasks: (1) we need to elicit and accept habilitation from others, as necessary, so that we acquire and sustain the functional abilities sufficient for our own well-being; (2) some of us, at least, need to help others to acquire such functional abilities; and (3) some of us need to habilitate the physical and social environment, in ways consonant with the first two tasks.

These tasks raise the full range of problems of basic justice – conflict resolution, of course, but also coordination and cooperation problems generally. Such collective action problems are pervasive in human affairs, and the source of action or inaction that produces injustice, or allows it to remain.

4. *The three habilitative tasks all require basic good health*. Focusing on the human necessity of habilitation throughout our lifetimes calls attention to the centrality of basic good health, especially in the form of healthy agency.

We need the initial physical endowments necessary for coping with the initial physical and social environments into which we are born. If we cannot elicit or accept the initial habilitation offered to us, we will not survive. If we cannot make use of this initial habilitation, so as to get the sustained nurture we need in order to develop into self-habilitating beings, we will not thrive. If we cannot participate, either directly or indirectly, in the cooperative ventures

that habilitate us and our physical and social environments, we will also fail to thrive, and perhaps eventually fail to survive.

Basic good health, then, defined as reliably competent physical and psychological functioning in a given range of physical and social environments, is a necessary component of each individual's habilitative tasks. It is a necessary good, and should be central – a pervasive concern – for any normative theory of distributive basic justice.

C. Theory-neutrality.

The third step of the argument is to note that adopting the habilitation framework does not commit us to a particular normative theory of basic justice, nor even to a particular type of normative theory.

1. *Theory* w*ithout prior distributive principles or theory-construction commitments.* The sort of normative neutrality involved here is simply an indication of the fact that the habilitation framework is indeed an alternative account of the circumstances of justice. It has the same sort of theory-neutrality that a standard Humean account has. For example, one can argue for a contractarian, or utilitarian, or capability theory of basic justice based on a Humean account. And one can embed a rationalist, or Aristotelian, or feminist theory of justice in a Humean account, especially with some modest additions. Further, each theory-type is capable of generating a wide range of distributive principles.

The same thing is true of the habilitation framework, which is an enlargement – a more inclusive version – of a Humean account. One can use it to build up any of the standard types of normative theories of basic justice, in many varieties. One can use it, together with principles of theory-construction, to generate a wide range of distributive principles.

2. *Normative neutrality with headwinds.* That does not mean, of course, that the description of the circumstances of justice we choose will be *entirely* neutral, normatively. The description we choose might be a better set up for some normative theories than for others *in a given physical and social environment*. To the extent that a normative theory is difficult to implement in a given environment, it will have a difficult problem of justification.

That is certainly true of the habilitation framework. While it does not dictate a particular normative theory in any given environment, it creates some predictable headwinds.

Examples: If we adopt the habilitation framework, go-it-alone-libertarianism will find its task relatively easy in a sparsely settled frontier or colonial situation, with a minimal level of social organization. It will find its task much harder in our current social conditions throughout most of the world. By contrast, welfare liberalism will have the opposite difficulties: easier than libertarianism in many contemporary social conditions; harder on a remote frontier. The difference comes from differences in the level of social commitment that are effective in sustaining a genuinely hospitable and habilitative social environment in a given physical and social environment.

But variable headwinds like that – ones that vary with the circumstances of physical and social environments – are just what any theory of basic justice must deal with. By itself, that kind of variability is not a mark against the habilitation framework, or any particular account of the circumstances of basic justice. The choice between alternatives can be made on other grounds.

I suggest that inclusiveness – in terms of persistent and pervasive elements of the human condition – is the appropriate criterion for making that choice between alternatives. That is why the habilitation framework is preferable to standard accounts of the circumstances of basic justice.

D. The focus on abilities.

The fourth step in the argument is to show how thoroughly the focus on abilities permeates the circumstances of habilitation – and thus the background conditions for normative theories of basic justice generally. This will submerge, at that background level, the concept of disabilities.

Putting abilities first. Habilitation is directly about abilities, not disabilities. The abilities at issue are those that are habilitative necessities in the three habilitative tasks – that is, in the task of eliciting and receiving habilitation from others; in self-habilitation; and in habilitation of the physical and social environment. All of these tasks, in whatever form they take in specific situations, involve producing and reproducing resources, both in human beings themselves and in their environments. And that, in turn, entails the development of a wide range of abilities in people across the population – particularly those abilities necessary for solving (in a stable way) problems of coordination, cooperation, and conflict reduction that are likely to arise along the way.

So with respect to the habilitative enterprise, disabilities are of only derivative interest, and then only insofar as they are permanent *inabilities* that no practicable form of habilitation can turn into abilities. Even then the focus stays on abilities in the sense that it shifts to the abilities of others: when some of us have massive and permanent inabilities, the question is whether others can habilitate themselves, or the physical and social environments sufficiently to cope with this fact. All of this raises the full range of normative questions about basic justice.

E. Habilitation and basic good health.

The fifth step in the argument comes from examining the relationship between habilitation and basic good health. It begins with the question of what abilities we should aim to develop. The answer seems to be that, for the purposes of basic justice, the tasks of habilitation require the development of fundamental, versatile, and adaptable abilities. These are the sorts of abilities (physical, intellectual, conative) that make us able to cope competently with the physical and social environments accessible to us, and make us adaptable to changes in those environments.

These abilities are adequately summarized in the definition of basic good health as reliably competent physical and psychological functioning in a reasonably wide range of environments. These matters will be elaborated in section II.

It is unusual for people to be completely healthy even in this basic sense. Rather, we typically have some stubborn inabilities (phobias about elevators, or crowded rooms, for example) that limit our functioning, or at any rate limit the range of environments within which we can function reliably, or competently. Typically, we are basically healthy "with an asterisk" that flags one or more limitations. Habilitation can erase some asterisks, and reduce the salience of others by arranging one's physical and social environments in an appropriate way.

Focusing on abilities rather than disabilities, and explicitly the abilities necessary for basic good health, has advantages. Disability is a notoriously vague term. Defining it in the context of awarding disability benefits is now a major industry in US law, politics, and applied philosophy. Not being able to define it in minute detail can be politically alarming. Defining a functional ability, however, is significantly less challenging.

Assembling a list of such abilities that represents basic good health in a given range of environments is not much more challenging – at least if we can find a convincing way of limiting

the range of abilities involved to those that can plausibly be called basic ones. Section II will also address this task.

In any case, the habilitation framework remains focused on the possibilities, not the impossibilities. It remains focused on the development of human abilities; not just on their absence. It is as relentless as good parenting, good education, good medical care, good community building, and the self-habilitation needed for the development of self-reliance and agent-energy, and the moral and intellectual virtues generally. Questions about the distribution of these fundamental abilities are the fundamental questions for all normative theories of basic justice.

F. Putting abilities first.

The sixth and final step in the argument is to develop this point about how putting abilities first is significant. It is especially significant if we do it before we get started on the normative enterprise; if we do it when we are laying out the background conditions for normative theory; the circumstances of habilitation for basic justice.

When these matters are introduced de novo at the normative and practical levels they tend to undercut habilitative and rehabilitative tasks. They do this by labeling people in a way that distracts from a series of truths important for all normative theories: that all human beings are limited in one way or another; that they can work around those limitations if they have basic good health; that such limitations do not put one at the margins of humanity, marking one as a "patient" who has no active role in his or her own lifelong habilitation; that the habilitation of the physical and social environment necessary for working around a limitation is not typically a matter of "making accommodations" for a special class of humans along the margins of society;

that it is instead part of the entirely mainstream process of dealing with limited abilities. It is a matter of habilitation, and rehabilitation.

What I am suggesting is that, right from the beginning, normative theories should adopt an appropriate attitude toward human limitations: namely, that we all have them, and that the questions of basic justice are all about distributing habilitation. Who shall live and who shall die? Who shall have plenty, and who shall have little? What shall we fight for? What shall we cooperate for? Those are the fundamental questions of basic justice, and in dealing with them, it is the distribution of abilities that is relentlessly primary. A good normative theory of basic justice should say, in words and gestures and deliberate practice, that it is not interested in what people *cannot* do, but rather in what they might be able to do.

We cannot predict exactly what range of abilities human infants will develop, because we do not know exactly what their potentials are, nor do we know exactly what effective habilitation they will receive. We cannot predict exactly what range of their eventual abilities will eventually be successful, with respect to habilitative tasks, because we cannot predict exactly what their physical and social environments will be like, and what reversals or limitations on their abilities will result from chance – accidents or diseases or crimes or losses; sudden good fortune, or bad fortune. Utopian projects are not helpful in making such predictions, at least in so far as they envision the perpetual harmonization of reason, desire, and will within each individual, and the perpetual harmonization of social activity on a large scale. Historically we have simply not ever been able to create a large, multigenerational, self-sustaining population of human beings that has anything approaching completely uniform abilities across the population, or various subpopulations within it. Dystopian fantasies often trade on this fact.

So basic good health, for almost everyone, will be health with an asterisk. Erasing those asterisks, or making them non-salient in a given range of physical and social environments, will be a lifelong habilitative task for almost all human beings. Any normative theory of basic justice will face a serious justification problem if it recommends limiting the distribution of basic good health to a subset of the population. It will face a similar problem if it recommends giving up on habilitation before the habilitative possibilities have been exhausted.

II. Disability in Habilitative Practice

A. More about basic good health.

The common usage of the term good health has several elements, all of which have important roles to play in basic justice.[3]

1. *Good health is defined positively as well as negatively.* In both common and professional parlance, good health is only partly characterized by the absence of significant pathology. (That is the "negative" part of the definition.) It is also partly characterized by the *presence* of certain forms of physical and psychological stability, strength, and energy. Both healthcare practice and healthcare research, as well as common usage, recognize that people without any specific physical or psychological pathology can nonetheless be in a very unhealthy state to the extent that they are fragile, weak, or unstable. This much is clear enough in the common usage recorded or implicit in dictionaries – not only under the headings health and healthcare, but under physical health, mental health, emotional health, and so forth.[4]

We can presumably say that the general justifying aim of healthcare is to sustain or restore good health in this ordinary sense.[5] There are no doubt many ancillary reasons for having the health care system that we do. (It may be entertaining, or challenging, or a big economic

engine and job creation machine --like professional sports.) But, presumably, at bottom, we want health*care* in order to avoid or recover from ill health, and to restore or sustain its opposite – good health.

So then, to draw an obvious inference: if the general justifying aim of healthcare is good health, we cannot coherently limit healthcare to dealing with disease, deficit, disability, and injury. We must also acknowledge that it aims to achieve something on the positive side of the health scale. To the extent that we expend energy and other resources on healthcare in ways that treat *only* the pathology (with, say, an appendectomy) but leave the patient so weakened and vulnerable to new infection that she cannot habilitate herself more fully, the task is not finished. It is not finished until the patient is restored to a level of physical and psychological stability, strength, and energy necessary to *reliably sustain* itself, absent further disease or injury or serious declines due to aging. (Or until it becomes clear that further efforts toward that end are futile.)

It is this sense of the term good health that the habilitation framework asks all theories of basic distributive justice to address. This is so because good health in sufficient amounts, throughout the population, is needed for individuals and social organizations to accomplish the three habilitative tasks. In terms of the habilitation framework it is therefore a crucial task for normative theories of basic justice to be explicit about, and give an explicit justification for, distributive principles of good health. Who should have it? At what levels?

2. Good health is defined in functional terms. Good health – both on its negative side and its positive side – is defined in functional terms. The good or bad functioning involved is simply about how fully physical and psychological systems and processes achieve self-sustaining results, in given environments. It is important to note that good health is not just a matter of

having the capacity, or the capability, for such functioning. It is rather a matter of how well such capabilities are actualized.

(A normative theory of justice, such as a capability theory, might go on to cast its distributive principles in terms of capabilities alone, actualized or unactualized. But it will then have to give a justification that defeats the headwinds – from the account of the circumstances of habilitation – blowing toward actual abilities, rather than merely the potential for them.)

In sum, good health is reliably competent functioning, subject always to some obvious age adjustments, and subject always to the challenges of specific physical and social environments. The sort of functioning we have in mind when we attribute good health to an infant will differ from the sort we have in mind for healthy adolescents, young adults, middle-aged adults, aging and elderly adults. The sort of functioning we have in mind for Neolithic hunters will be different from what we have in mind for twenty first century astronauts.

3. Good health is a range, not a point. Good health has an upper boundary as well as a lower one. Just as pathology and its mere absence is "below" the level of good health, so too it is common to think that there are levels of health above merely good health. Conceptually, good health is not perfect health. What we are looking for, then, is an identifiable region of good health that encompasses all of the plausible targets for basic justice beyond merely the absence of pathology and short of the impossible dream of perfect health.

For practical purposes, we can define the boundaries of good health, in an age-adjusted way, in terms of three sets of considerations.

One of these is the extent of the causal linkages between good and bad health. It makes sense to set the lower boundary of good health at a point that includes the full range of strength, stability, and energy causally important for preventing or recovering from pathological

conditions. Think of the levels of immune system resistance, or psychological resilience, needed to prevent the deterioration of good health into bad health. Or think of the decision tree faced by hospital staff in overwhelming emergencies: diagnose for treatment or discharge; treat for discharge or for admission to the hospital; discharge with or without follow-up treatment.

Another set of considerations is the extent of our abilities to cope with the specific habilitative and rehabilitative tasks we face, as well as the goals we pursue. We want good health to include adequate and reliable coping mechanisms for these tasks and for our purposive behavior generally. That often includes a fairly robust form of healthy human agency.

A third set of considerations involves the range of physical and social environments in which we live – or might be called upon to live. We want good health to include adequate functional abilities for the environments that we cannot avoid, as well as for a reasonable range of other accessible ones.

Good health typically comes with an asterisk – an implicit qualifier. It is important to notice how often we attribute good health to people only under an implicit or explicit qualification. "Given the person's age" is an obvious one. But so is a distinction we draw between health traits and transient health conditions. A physician may say "Fundamentally, your health is very good. This is just a transient upper respiratory infection that will take care of itself if you drink plenty of fluids and get plenty of rest."

Similarly, we may introduce the qualifier by isolating a genuinely threatening trait or condition of bad health by saying that recovery is possible with the right kind of treatment. A physician may say "You're very sick. Your gallbladder has to come out immediately. But there shouldn't be any problem with that. Everything else about your health is very good."

And yet another way we introduce the qualifier is by ascribing good health to people with the ability to function competently only in a limited range of environments. People with potentially lethal allergies to shellfish can still be in good* health as long as they can avoid shellfish, or failing that, can get prompt and effective treatment for anaphylactic shock.

For convenience, let us stipulate for practical purposes that when good health has no qualifiers – no asterisks – it is robustly good health. And beyond the boundary of robust health is the range (or point?) of ideal or perfect health.

A summary definition of good health. The elements of good health outlined above can be put together into a more compact definition along the following lines.[6]

> The health of an individual human being is a set of functionally significant traits and/or states defined on a range running from non-survivable forms of disease, deficit, disorder, impairment, injury, or distress (ill health) to states or traits of physical or psychological strength, resistance, resilience, momentum, energy and activity (good health) that have reciprocal causal connections to ill health. (81)

It is possible to develop that definition into a health scale, running from worst to best, which defines an interesting range of health states from barely good to robustly good. (82-87) The region of robustly good health seems especially promising for questions of basic justice related to health care. And since the health scale can be represented in quantitative as well as qualitative terms, it is also a versatile tool for public policy analysis. (85-86)

B. Why the habilitation framework is not a capabilities theory.

As noted in the outline of the argument above, the habilitation framework is an alternative account of the circumstances of justice. As such, it is not itself a normative theory of

basic justice, but rather a precursor to any such normative theory. It proposes a metric for such theories (basic good health), but is silent about distributive principles. By contrast, a capabilities approach, whether of the Sen variety or the Nussbaum variety, is a full-fledged normative theory. It either assumes or proposes distributive principles – as well as a metric for judging how well they are satisfied. And as noted above, while the habilitation framework is concerned with functional abilities rather than mere capabilities, some capability theorists want to frame their normative principles explicitly in terms of capabilities rather than functional abilities.

Moreover, in a further contrast with the habilitation framework, various versions of the capability approach always exemplify a specific type of normative theory. Sen rejects the search for transcendental principles and proposes instead a search for practicable principles and results that are comparatively better than those we have.[7] Nussbaum proposes an objective list of basic capabilities derived from historical conceptions of a good (human) life, which she accepts as compatible also with a version of the human rights approach to normative theory.[8]

Nonetheless, it may seem that focusing on habilitation, and thus on abilities, is at least a covert set up for a capabilities approach to basic justice. It is not. The habilitation framework is deeply indebted, causally, to both the capabilities approach and to work in feminist political philosophy that emphasizes dependency and the centrality of the concept of care. But this causal story about the origins of the habilitation framework has very little bearing on the nature of the result. Yet for some readers what has been said on the matter in *HHA*, and summarized here so far, is not fully convincing. They remain convinced that there is enough proto-normative content in the habilitation framework to make the claim of normative neutrality suspect.[9]

Perhaps the quickest way to add to the case for normative neutrality in a more decisive way is to consider the fact that the circumstances of habilitation do not include any normative

guidance on the matter that is, arguably, a cornerstone of *every* normative theory of basic justice, historical and contemporary: that is, the position any normative theory takes on the moral equality or inequality of the various people who are subject to its distributive principles. Equality is now the default position for most contemporary theories of justice; it is inequality that needs a special defense. But it was not always so – perhaps not even *ever* so prior to the Enlightenment. It apparently seemed obvious for most of the history of political philosophy that the "natural order" of the human condition was hierarchical, and that the principles of distributive justice (as opposed to the practices of charity, or love, or mercy, or kindness, or common courtesy) would have to reflect such inequalities.

The habilitation framework does not take a normative position on matters of moral equality. It is again like standard accounts of the circumstances of justice in this respect. It complicates the task for some normative theories in some physical and social environments; it simplifies the task for the same theories in other environments. But that is not a covert set up for anything.

And as for capability theories in particular, as already noted, the habilitation framework does not take a normative position for or against contractarian, contractualist, utilitarian, Aristotelian, or eudaimonistic accounts of distributive justice. That means that it takes no position for or against various versions of a capabilities approach to distributive justice, or one developed from an ethic of care.

C. Why the habilitation framework is nonetheless sometimes disability-friendly.

In a social environment in which a norm of moral equality operates, the habilitation framework and its initial focus on abilities does point the way toward normative theories that

explicitly address disabilities, however. This may seem unlikely, given the way in which disabilities are submerged in the habilitation framework. Because the focus is relentlessly on abilities, disabilities do not apparently get much attention except as a remainder of cases in which (further) habilitation is not possible. That doesn't sound very disability-friendly. But actually it is, even though the history of political philosophy is initially discouraging on this point. Here is why:

Historically, a focus on abilities has been at the center of slave societies, caste societies, and the full range of hierarchical societies that ruthlessly subordinate people into "lower" and "higher" orders, and women within each order into subservient breeding and caregiving roles. Those in positions of power and the theories of justice that prop them up have always been very aware of the importance of the range of human abilities and the distribution of them. Social stability is damaged, historical theories have often said, by widespread literacy and higher education among slaves or the lower classes. Disabled people are of interest only insofar as they lack the abilities necessary to carry out the duties of their class. If they lack some of those abilities, those disabled people get attention (as a matter of justice) mainly to the extent that they are a drain on social resources for the classes superior to them.

At first glance, it can seem as though we get a similar result even in a society with a relaxed attitude toward class boundaries and a commitment to the moral equality of all members. People with serious disabilities often still wind up on the short end of a series of economic trade-offs in which their habilitation often appears to be too expensive. Consider the vexing Medicare rule that restricts reimbursement for power wheelchairs to people who *require* them for use within their residences – rather than, say, only for use in getting around outside their residences. Such people may actually be unable to use a power wheelchair at home (or be unable to

truthfully certify that they actually need it there), but yet be unable to get to and from work, or move around at work, or go out to public places without such a chair.[10] This is a good example of letting narrowly conceived costs (purchase price), and narrowly conceived enforcement decisions (preventing fraudulent sales) to defeat habilitative tasks.

In fact, *when we think of disabilities apart from the project of dealing with habilitative necessities generally, it is all too easy to exaggerate the social and economic burden of identifying and marginalizing the people who have them*. But keeping the initial focus on the circumstances of habilitation, and thus people's abilities rather than their disabilities, turns out to be a nontrivial thing – for the reason that it gives a central place to basic good health.

The notion of basic good health, physical and psychological, both negatively and positively defined nicely captures the range of abilities at stake in habilitative necessities. Whether we have the abilities to survive and thrive will be determined by the nature of our initial physical and psychological endowments, the extent of our developmental capacities, and the nature of the physical and social environments available to us. The notion of basic good health covers this same terrain. For health as it is defined negatively, ill health (pathology) is what damages or weakens the necessary abilities in the range of physical and social environments that we face or might face. For health as it is defined positively, basic good health beyond the absence of pathology is what sustains and strengthens the necessary abilities. Basic good health stabilizes us against developing or relapsing into pathology; and it strengthens the necessary abilities by providing us with resistance to them, resilience from them, and restorative powers. Basic good health also provides and sustains the physical and psychological energy needed for developing the new abilities that become necessary as we age within a multigenerational, changing social environment, and changing physical environment.

When basic good health fails, or threatens to fail, either for individuals or subpopulations in a group, then habilitative or rehabilitative tasks emerge. Those tasks, as they emerge from the habilitation framework of ideas (the circumstances of basic justice for habilitation) point normative concerns initially toward creating abilities – not as a matter of kindness, or charity, or human rights, but as a matter of human necessity. The burden will be on any normative theory that excludes one person or group or another from habilitation or rehabilitation.

The range of abilities that will get this initial normative concern will be limited to the habilitative necessities for a thriving, multigenerational society in a given range of physical and social environments. Modern postindustrial democracies are so complex and so demanding in terms of human resources that they require a huge amount of coordinated, specialized productive and reproductive cooperation, from people with a bewildering array of distinct abilities. And in fact, any reasonably stable, large-scale, multigenerational social environment will depend on a very wide distribution – throughout the entire human population – of active, effective, individual agency. From the standpoint of habilitation, the concept of active, effective basically healthy agency summarizes the abilities necessary for habilitative tasks.

In societies like our own the basic good health necessary for the reproduction of such agency also requires wide distribution. (Child neglect is not a recipe for reliable success in the reproduction of healthy agency – that is, agency without crippling physical or psychological disability. And industrialized approaches to the reproduction of human agents don’t seem to be reliable either. They seem to amount to child neglect.) As a consequence, whether a social system distributes this reproductive labor narrowly, to nuclear families and a limited number of surrogates, or widely, to extended families or villages and later to schools, the social investment in the reproduction of agency is enormous.

There is a further distributive issue: it is a tricky business to stop the development of agency at various levels tolerable for a large-scale, stratified but upwardly mobile liberal democracy. Language acquisition, reflection, practical reasoning, sociability at any needed level will have considerable momentum – and without constant social intervention will upset patterns, to borrow Nozick's phrase. (It is not liberty alone that upsets patterns; it is healthy agency at liberty that does it.) And then what would have we done? We would have made an enormous social investment in the reproduction of a social pattern that runs counter to the very forms of habilitation that produce and sustain it. It does this because it amounts to damaging basic good health for the individual agents whose development is (at great cost and effort) limited in this way.

For example, adaptability to changes in physical and social environments is one of the characteristics of healthy human agency. Limiting the development of agency powers limits adaptability, and thus the ability to cope with changed circumstances. We see that in some sectors of our multigenerational labor force (e.g., coal miners; textile mill workers) some people have been encouraged to drop out of school as soon as they are able to work at highly specialized, physically demanding and dangerous jobs, and not encouraged to develop other skills, or to further their educations. More to the point, what we see are the disabilities that are suddenly revealed by the closure of the mines and mills. And often we see as well a sense of helplessness and despair in the suddenly unemployed people. That helplessness and despair can then defeat modest social investments in retraining (rehabilitation), and make adequate rehabilitation seem too expensive to pursue. This is parallel to the cases of disabilities created by disease or injury. Rehabilitation all of those cases goes better if one's initial habilitation has produced the ability to cope with changed circumstances.

That is the way the habilitation framework creates headwinds for a normative theory of justice. It isn't that a theory of rigidly patterned distribution – with respect to the development of healthy agency – is impossible to imagine. It is just that it is difficult to imagine how we could successfully implement such a theory in a fast changing, large-scale, multigenerational, industrial or postindustrial society. Plato's thought experiment was acknowledged in his own day as an un-implementable ideal. In ours, it is satirized as a Brave New World.

D. Basic good health as the general justifying aim of health care legislation and regulation.

The habilitation framework also has some consequences for normative theories of basic justice in healthcare. And again, those consequences come from attention to the importance of basic good health. Here is an example of how things can go wrong in practice, especially about disabilities, but can be set right by returning to the precursors of normative theory in the circumstances of habilitation.

Consider: people who are immersed in the legislative and regulatory processes of implementing Medicare, Medicaid, the Affordable Care Act (ACA), and other healthcare insurance programs quite naturally focus on *access* to health care. How much access? At what cost? For whom? And in the midst of those complex and demanding activities, it is natural to think that the goal of *access* to health care must be getting health care itself. The legislation and regulation is about getting access, and access is for getting health care. This is an inappropriately truncated chain of goals.

The ACA is also, on its face, an example of such truncation.[11] The provisions of the statute are distributed as amendments in several places of the United States code, and gathered in Title 42, The Public Health and Welfare. But the act itself – the text of the law passed by

Congress and signed by the President in 2010 – has no overall statement of purpose at the beginning. It goes directly to a description of its various provisions for improving access to health care and healthcare insurance, to protecting the recipients of healthcare by enacting various quality assurance measures for the delivery of healthcare, and for making healthcare affordable for us all, individually and collectively.

In general, there is nothing extraordinary about truncating the discussion of a series of instrumental goals for practical purposes. Only philosophers and four-year-olds always want to run the “Why?" question all the way to the ground. But notice how peculiar it is to think of health care in that truncated way. As noted above in section II. A., health *care* is obviously not an end in itself. It is obviously for other things, one of which is presumably (good) health itself. That is true for practitioners and recipients alike, even if at times they both have to settle for something less, such as palliative care, custodial care, or even triage options. If healthcare were only a jobs program for providers, or only entertainment or comfort food for recipients, we would think of it very differently than we do. Rather, we appear to think that *good health is the general justifying aim of healthcare.*

This may seem too obvious to belabor. But obvious things have a tendency to drop out of complex, high-stakes political and public policy practices. This is dangerous. It may leave the legislative and regulatory processes significantly untethered to a coherent set of ultimate or penultimate goals. In that situation, opportunistic rhetoric flourishes; careful reasoning withers. Moreover, we may lose sight of a significant analytical tool – namely, the principle that insofar as healthcare legislation or regulation is (or would be) damaging to good health, then it is self-defeating in terms of the purpose of healthcare.

Arguments that invoke the purpose of a statute or regulation are often found in judicial reasoning. And in United States constitutional jurisprudence some of these arguments are intricately tied to the Fourteenth Amendment – not only to its equal protection clause but to what the court takes to be the general justifying aim of that Amendment itself.

This is vividly illustrated in cases ruling against anti-miscegenation laws. The California Supreme Court was the first state court to make such a ruling.[12] It issued a lengthy consideration of spurious rationales that had been offered for such statutes. Among those was the claim that the anti-miscegenation laws in California treated people of different races equally because it forbade whites to marry people of color as well as people of color to marry whites. The Court ultimately rejected the equality argument by turning it into a more general one about the meaning of the Fourteenth Amendment, linked with arguments about the lack of a reasonable connection between the statute and legitimate state purposes. And by the time Virginia's anti-miscegenation statute reached the United States Supreme Court in 1967,[13] the case seemed simpler. A unanimous Supreme Court, in an opinion that was quite short, argued that there was no coherent way to read Virginia's anti-miscegenation statute as compatible with the meaning of, or purposes behind, the Fourteenth Amendment.[14] This happened because the Court came to reject decisively the idea that maintaining "racial integrity" was part of the general justifying aim of marriage statutes. Once that happened, arguments about the meaning of Fourteenth Amendment guarantees of equality could proceed with fewer distractions.[15]

The point here is that the habilitation framework points us toward a more direct argument against decisions about disability such as the disgraceful one in Alexander v. Choate cited above in note 14 – this time by focusing on the general justifying aim of healthcare. This is so, in part, because healthy agency has such a special place in practical deliberation generally. Such agency

is an indispensable good for everyone (even for immediate self-destructive purposes). Moreover, good health is a modest form of well-being in itself, and is in almost every case a necessary component of a good life – a flourishing life; happiness. So an argument that shows that a given piece of public policy, legislation, or regulation with regard to healthcare is actually self-defeating – and self-defeating with respect to the general justifying aim of health care itself – is going to be very powerful.

By contrast, in many other matters of public policy, citizens are often deeply divided about the general justifying aim of some significant institution – e.g., the purpose of marriage; the purpose of the right to keep and bear arms. But once there is agreement about the general justifying aim, and agreement about whether a given proposal is coherent with that aim, subsequent appeals to fairness and equality of opportunity have a clearer field in which to work. This doesn't by itself solve the distributive and allocative problems, of course. Individual health is not the only good we pursue through major investments in social institutions. So health care for individuals may have to compete with public health goals, and with national security, national defense, education, and so forth. And we will also have to settle questions about distributive priorities within a given allocation.

Nonetheless, it is important to have at hand the ability to rule out, as incoherent or self-defeating, some legislative or regulatory proposals about healthcare. This will have consequences for incoherent limitations on habilitation and rehabilitation for everyone, the disabled included. As follows.

E. Good* health, disabilities, and disadvantages generally.

A pertinent consequence of the conception of good health sketched above is the way in which it reaches across the whole range of health-related difficulties, disadvantages, and disabilities. It puts into sharp relief some important public policy questions that should be prominent in the legislative and regulatory processes involved in healthcare. It does this by calling our attention to the environmental dimension of good health – the way in which the range of physical and social environments adds or subtracts asterisks from good health.

Consider a young adult who sustains a serious spinal cord injury. Suppose there is permanent and complete paralysis of the lower limbs and a considerable portion of the trunk. There is significant muscular weakness in the upper limbs. Loss of sensation is complete or partial, following the line of complete or partial paralysis. Bowel and bladder control is problematic. Many of the activities of daily life are now impossible (e.g., walking unassisted), or extraordinarily strenuous (using a manual wheelchair on steep inclines), or unusually hazardous (burns, pressure sores). And suppose that during the initial three to six months of medical treatment and rehabilitation, the person is otherwise restored to the sort of physical and psychological strength and stability that would count as a version of good health. But it is good health with a lot of asterisks, indicating restrictions in the range of physical and social environments – even within a given society – in which the person's health will remain in the good range rather than quickly degrading.

Now something like that is true for every human being, officially labeled as disabled or not, whose health is short of robust. There are many sorts of physical and psychological deficits and functional disadvantages scattered throughout the population. Some of them are merely latent in the sense that they do not have any serious functional consequences for the people who have them in the environment in which those people live. It may never occur to those people

themselves (or to public officials) to think of their health as anything less than robust. Nonetheless, it may be clear to everyone that *if* the environment were to change in specific ways, those people would suddenly emerge as significantly disabled – perhaps lethally so. Some of us don't function well in crowded, high velocity urban environments with a highly articulated division of labor. Others don't function well in remote, isolated environments. And in some cases, prolonged exposure to such difficulties degrades our health.

The general public policy question is what we should do about possible changes in the physical and social environments that will cause these largely invisible asterisks on good health to become serious disadvantages or disabilities for the individuals involved. There is nothing novel in this question. But it is one that we often seem to ignore in the public discussion of possible health-related changes in other sectors of society – in education, employment, immigration, public security, national defense, and public housing, among others.

To reconsider an example introduced earlier, consider areas of the country where whole extended families have built their lives for many generations around jobs requiring minimal formal education, and where now the steel mills, or textile mills, or factories, or coal mines have shut down, leaving few employment opportunities. The consequences ripple through people's lives and begin to degrade their health. Remedies directed to new employment opportunities can then be nearly beside the point. People may be caught in a downward spiral in which unemployment degrades their health, their degraded health blocks them from pursuing even the opportunities remaining to them, which then results in further degradation of their health. Breaking the cycle may require directly addressing the health problems.

The general point here is that health care legislation and regulation need to be explicitly embedded in a more general set of public policy concerns about the range of physical and social

environments in which various individuals can sustain the version of good* health they happen to have. When the range of health-sustaining environments for a given individual is quite narrow, and when the stability of those environments is at risk, those individuals face what amounts to a healthcare emergency. This is clearest for people with patent, permanent, visible disabilities or dependencies – e.g., a heart transplant recipient dependent on a daily supply of sophisticated drugs, and thus on the system that produces them, distributes them, and keeps them properly stored for use. But it is also true for people with latent and mostly invisible disabilities.

III. Conclusion

A normative theory of basic justice built in terms of the habilitative enterprise will begin with something like the focus one finds in the care of infants, early childhood education, and some areas of medicine – sports medicine, for example, or better yet rehabilitation medicine of the sort pioneered for polio survivors such as himself by Franklin Delano Roosevelt at Georgia Warm Springs. The interest there is not on what people cannot do, but rather on what each one might be able to do, with the appropriate habilitation – habilitation not only of their physical and psychological powers, but of the physical and social environments they inhabit; and habilitation in which they are always active participants insofar as they are able to be.

There is a ferocious kind of momentum built into this kind of habilitative, and rehabilitative focus on abilities. Anyone who has been subjected to it for an extended period of time can testify to this. Physical therapists are, well, relentlessly physical. So are athletic trainers. Parents are relentless in other ways, as are the best teachers, flight instructors, drill sergeants, graduate school or professional school environments. This momentum comes from their focus on what people might be able to do, and their ability to enlist those people in the project, and get

them to internalize it. It is a philosophically interesting kind of momentum; it is the sort of thing that initially fuels a normative theory, and not the sort that starves from the lack of one. Habilitation is a project built into the human condition, and it comes with built-in momentum. Normative theory has to clarify, direct and control that sort of momentum, not get it going.

NOTES

[1] Lawrence C. Becker, *Habilitation, Health, and Agency: a Framework for Basic Justice* (New York: Oxford University Press, 2012). That book has only three indexed references to the topic of disability, and only one short passage that amounts to a discussion of it. That is clearly a missed opportunity. And a mistake, in fact. In retrospect, I suppose this was predictable. My connection to disability has been long and sharply compartmentalized. I've had an avocation of 60+ years in the world of polio survivors – as an advocate, writer, interviewee, and public specimen. Until quite recently, and then only in a few footnotes like this, none of that has made its way into my philosophical work – partly, I suppose, because one of the things I love about philosophy is its remoteness from the daily demands of living with a disability. Happily, that sense of remoteness remains, even in the process of correcting the mistakes it promotes.

[2] Humean accounts capture something that seems to be presupposed in many discussions of justice from Plato to the present day. See David Hume, *A Treatise of Human Nature*, Book 3.2.2; *Enquiry Concerning the Principles of Morals*, Part 1.3. Then compare it to Plato's *Republic*, Books, I-II and, say, John Rawls, *A Theory of Justice* (Cambridge MA: The Belknap Press of Harvard University Press, 1971), pages 126-131. Most intermediate stops in the history of political philosophy also emphasize circumstances of conflict as central to the circumstances of justice, though some diagnose its sources and resolution somewhat differently than Hume does.

[3] For a more developed view of what follows in this section, congruent with the commonsense definition articulated here, see *HHA*, Chs 3-5.

[4] The definition used by the World Health Organization is more expansive and controversial. It has led to some efforts, mainly in bioethics, to define the concept of health

negatively – as the absence of pathology. For an overview of this controversy, see Sissela Bok, "Rethinking the WHO Definition of Health," *International Encyclopedia of Public Health,* Vol. 6, edited by Kris Heggenhougen and Stella Quah (San Diego: Academic Press, 2008), pp, 590–97.

[5] The felicitous term "general justifying aim" comes from an essay by HLA Hart, "Prolegomenon to the Principles of Punishment," in his *Punishment and Responsibility* (New York: Oxford University Press, 1968), pp. 8-11.

[6] This section refers directly to material in *HHA*, Ch. 5. Page numbers are to that text.

[7] Amartya Sen, *The Idea of Justice* (Cambridge, MA: The Belknap Press of Harvard University Press, 2009). See especially the Introduction and Chapter 4. It seems clear from Sen's remarks on pages 231-238 that he would resist interpreting capabilities as the actual abilities represented by good health and healthy agency as the terms are used here.

[8] Martha Nussbaum, *Frontiers of Justice* (Cambridge, MA: The Belknap Press of Harvard University Press, 2007). See her objective list on pages 76-78, and her remark about human rights on page 78. Jonathan Wolff and Avner de-Shalit, *Disadvantage* (Oxford: Oxford University Press, 2007) develop welfare-state utilitarian theory about functional abilities in terms of a modified version of Nussbaum's objective list. See also Nussbaum's*: Creating Capabilities: the Human Development Approach* (Cambridge, MA: The Belknap Press of Harvard University Press, 2011) for remarks on the *Disadvantage* book, on pages 42-45 and 144-46, as well as her resistance there and on pages 25-26 to emphasizing actual functioning rather than capabilities.

[9] Leslie Francis, "Habilitation into Healthy Agency and Theorizing about Imperfect Justice," *APA Newsletter on Philosophy and Medicine*, 10:2 (Spring, 2011), pages 18-20; This is

a response to a 2010 draft of *HHA*. But a similar, if more muted worry is raised in a review of the book itself by David A. Crocker. See *Notre Dame Philosophical Reviews*, 2013.02 28.

[10] Medicare pays for durable medical equipment, including power wheelchairs, "prescribed by your physician for use in your home." The implementation of this rule has occasionally been so strict that it has prohibited people from using such equipment outside their homes. But regulators have apparently not been willing to consider cases in which people can manage without a power wheelchair inside their residences (e.g., where they have strategically placed furniture or railings, and no place to store or use a power wheelchair), but must use one outdoors or in public places.

[11] Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010), 124 Stat. 119. USC Title 42, Chapter 157.

[12] Perez v. Sharp, 32 Cal. 2d 711 (1948), 198 P. 2d 17 (1948).

[13] Loving v. Virginia, 388 U.S. 1 (1967).

[14] But bad equality arguments die hard. Eighteen years later, an again unanimous Supreme Court considered a similar argument favorably in a disabilities case: Alexander v. Choate, 469 U.S. 287 (1985). The argument there was that limiting both disabled and nondisabled Medicaid recipients to the same number of annual inpatient hospital days treated both groups equally. See the thorough critique in Leslie P. Francis and Anita Silvers, "Disabling *Alexander v. Choate*: 'Meaningful Access' to Healthcare for People with Disabilities," 35 *Fordham Urban Law Journal*, 447 (2008), at 456-457.

[15] Virginia's statute prohibited whites from marrying any "colored person" (with the exception of the descendants of Pocahontas), but did not prohibit people of color from marrying each other, regardless of common racial classifications. A declared purpose of the statute was to

preserve "racial integrity." Loving's brief argued that the fact that nonwhites could intermarry without statutory interference showed that the statute was "arbitrary and unreasonable even assuming the validity of an official purpose to preserve ‘racial integrity’". The court notes this argument in footnote 11 of Loving v. Virginia [388 US 1, 13] but declines to reach a decision on that argument because it finds "the racial classifications in these statutes repugnant to the Fourteenth Amendment, even assuming an evenhanded state purpose to protect the "integrity" of all races."