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Habilitative Health and Disability

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Abstract: This article introduces and defines the concept of habilitative health as the ability to succeed at three types of tasks necessary for human survival and thriving: self-habilitation, habilitation of others, and habilitation of the physical and social environment in which one lives. Habilitative health is an aspect of the complete health scale, ranging from worst to best health in terms of physiological, intellectual, psychological, and behavioral functioning. The argument here is that the nature and gravity of disabilities generally can best be understood in terms of a lack of habilitative health in specified ranges of habitable physical and social environments. This eliminates many differences between the medical and social models of disability, and unifies discussions of individual health with discussions of public or social health. It also recasts the discussion of human rights to healthcare as the discussion of human duties of care to self, others, and the habitable world.

Keywords: complete health, duties of care, disabilities, habilitative health, habilitatve tasks, health scale, hospitable environment(s), inabilities, self-habilitation, survival, thriving

The argument in this chapter is structured as follows. ***SECTION ONE*** outlines some commonsense connections between disability and related terms having to do with individual health and functioning – terms such as inability, disease, disorder, dysfunction, deficit, difference, and difficulty. ***SECTION TWO*** connects this to a conception of "complete" good health, and argues that all disabilities can be traced to an important form of ill health under that conception – namely a lack of habilitative health – but not to ill health per se, and not solely to ill health in the disabled person. ***SECTIONS THREE AND FOUR*** lay out some practical connections between disabilities of various sorts and three aspects of habilitative health: self-habilitation, habilitation of others, and habilitation of the physical and social environments. It then sketches an argument for making the concept of habilitative health central to discussions of disability. ***SECTION FIVE*** recasts that centrality argument into an elementary valid argument form, and draws some conclusions. ***SECTION SIX*** adds some speculation about what all of this might mean for philosophical theories of disability.

1. Commonsense about the Concept of Disability

All inabilities can become disabilities when combined with other factors. Confusion arises when we begin the discussion of disability before the discussion of inability, moving too quickly to an account of the sources of human disabilities and what to do about them. When we do that we immediately notice that many people who are officially labeled as physically disabled are in basically good physical health in most respects, and that many people with permanent physical, psychological, intellectual, and behavioral forms of ill health are not functionally disabled in the physical and social environments they arrange to inhabit. Once we notice those things, the discussion of disability can sometimes begin in an unproductive place. What follows is meant to avoid that unproductive place. It prepares the way for the argument (in sections 2-5) that all

disabilities are instances of a lack of a fundamental kind of health: habilitative health – meaning the level of physiological, psychological, and behavioral health needed to perform various habilitative and rehabilitative tasks. Those tasks, as the term habilitation indicates, are all aimed at equipping people and things with functional abilities or capacities that they might lack.

1.1 Species-characteristics and associated inabilities

Consider some commonsense remarks about human inabilities. We are all mortal, for instance. That is merely a characteristic of our species. So are various lethal physical limits traceable to being human: within minutes, we all die without air; within hours, we all die without shelter from extreme radiation. Injuries or diseases or choices or environments that push us near lethal limits are legion. But since human beings as a species are vulnerable to death, there is nothing in such vulnerabilities in themselves that leads us to think of them as disabilities. They are inabilities, to be sure. Limitations, to be sure. But not disabilities, unless we add something further. So it will be useful to begin with an overview of some primary types of human inabilities.

MORTALITY AND THE MEANING OF LIFE. Some of us have very short lives and others very long ones. We are thus vulnerable, it seems, to having lives that are either *too* short or *too* long. These aspects of the human condition raise questions about the nature of a good life, and a meaningful life. Most of us find effective ways of answering or avoiding such questions. But fear of death, our vulnerability to it, and pessimism about these aspects of the human condition can make us miserable at times, and at the extremes, can be disabling. Such fear or pessimism can become pathological, in an adjectival sense, if we can no longer act effectively to preserve our own health (or life), or act decently toward others, or contribute effectively toward our rehabilitation.

That is a dangerous condition. But we probably need something more than that to justify the claim that it amounts to a disability. For one thing, if it is transient, we would probably want to call it a dark mood or depression, even a temporarily disabling one, rather than a disability (in a nominative sense) or even an inability. For another thing, if the fearful person is by all other measures in basically good physical and psychological health, and not in any special danger of death in terms of age or environmental risk factors, it seems excessive to declare him or her disabled. At least it seems so unless the disabling fear or pessimism is persistent, all-consuming, and resistant to rehabilitation – in which case it seems sensible to say that the person's functional psychological health is *not* good, overall. And for that kind of persistent and possibly permanent ill health, it also seems sensible to say that the person has a disability.

TYPICAL, FUNCTIONAL, BUT PROBLEMATIC INDIVIDUAL ENDOWMENTS. There are also developmental but species-typical characteristics of human anatomy and physiology. They emerge slowly in the process of gestation, and continue to develop through growth, changes in function and strength, and in other respects during infancy (e.g., bone structure of the skull), early childhood (e.g., teeth), puberty (fertility), adolescence (e.g., frontal lobe brain structure), and early maturity. Some people may be unhappy with the species-typical characteristics they have been endowed with, or have developed from their endowments. They may think they are too tall, too short, too thin, too fat, with eyes too close together, too far apart, and so forth – even though the characteristics they have are well within the range of normal or typical anatomy and physiology.

As is the case with human mortality, and the dissatisfaction some people have with it, it does not seem commonsensical to apply the term disability to the dissatisfaction we may have with our typical anatomical and physiological endowments and developments – unless that

dissatisfaction is the source of persistent and possibly permanent physical or psychological ill health. Then, as in the mortality case, it is the ill health that is the disability, and not the species-typical characteristics themselves.

This has notorious consequences when that sort of disability is caused largely by social conventions about normality, and subsequent discrimination. People of color are disabled in an adjectival sense by racism, but surely we would not want to say that *they* are by that fact alone the ones who have the disability in a nominative sense. Similarly for women and sexism. In both cases it is sometimes more commonsensical to think that it is primarily the oppressors who have the ill health and disability (in the form of irrationality or sociopathy) that needs to change. This may, or may not, secondarily produce ill health and consequent disabilities in the people who are oppressed. (The obvious solution is to lift the oppression in a way that restores health, as necessary, to both oppressors and the oppressed.)

ATYPICAL ANATOMY AND PHYSIOLOGY. Many people wind up with atypical anatomy during the developmental process. Even when this is dramatic, however, it does not always lead to inability, let alone disability. For example, in the congenital condition called *situs inversus totalis* all the thoracic and abdominal organs are reversed right to left. This is something that happens in an estimated 1 in 10,000 human beings. And barring concurrent cardiac defects, the reversal of the typical arrangement of organs does not usually complicate health at all, though it may complicate emergency medical treatment if the medical personnel do not discover it. Similarly, congenitally missing parts, or supernumerary ones, may or may not be reflected in inabilities or disabilities. A missing kidney is a bit of a risk factor, but an additional kidney is sometimes not a risk at all. Congenitally missing limbs are another matter, as is a missing long bone, like a tibia. Such missing parts may require special surgery, prosthetic devices, and special

habilitation in using them. Nonetheless, the result of such habilitation may reduce the individual's physical inabilities to the point that it is problematic to consider them disabilities.

Thus we have what will become a common refrain in this discussion: The question to ask in each case about any atypicality (deficit, surplus, or irregular placement in body part or function) is whether it amounts to a permanent form of physical or psychological ill health, or the vulnerability to either – in a given range of environments of special importance to the individual involved. If not, the question of whether to treat it as a disability remains an open one.

DEVELOPMENTAL ABILITIES. It is a species characteristic that our postnatal physical, intellectual, emotional, and agentic powers develop slowly from birth into maturity and then wane slowly as we age. Elderly people have declining powers of many sorts, and ultimately of every sort. Age-appropriate inabilities are not *dis*abilities by that fact alone. Inabilities that everyone has – either throughout their lives or at various age-appropriate stages of their lives – do not need to be singled out with the additional (potent) label of disabilities. At most, they are the occasion for disabling pathologies in the individual, or disabling treatment by other people.

It is important to notice, here, that strengths of agency and character are developmental abilities and inabilities. The extent to which an individual's development in those respects is functional or dysfunctional in a given physical or social environment is directly relevant to the assessment of whether that individual thereby has (or does not have) a disability. It turns out that the concept of habilitatve health (defined below in section 3) probably identifies all those disabilities successfully.

1.2 Individual, non-developmental diversity

Human beings also have inabilities that are the product of injury or disease. These inabilities are not necessarily disabilities either. Here again, the crucial factors are the connection

to health, or to damaging treatment from the physical or social environment, or to neglectful or damaging treatment from others.

We are also variably vulnerable to life-threatening injury, disease, trauma, and illness throughout our lives. Some of us take this in stride. Others ignore it altogether. And still others become obsessively concerned with it. Deliberate ignorance of our vulnerability can become pathological. (Recklessness and foolhardiness are vices, and to the extent that they resist correction toward some semblance of practical wisdom, they can be psychological and/or behavioral disorders.) Obsessive concern with human vulnerability – and perhaps especially with our own – can also generate phobias of various sorts, and phobias can become psychological and/or behavioral disorders. Once any of this reaches the level of a persisting, dysfunctional pathology in a given environment important to the individual, and resistant to rehabilitation, it can generate disabilities.

2. Commonsense about the Concept of Health

So far, this is much too vague. But some better focus can be gained in three steps. First, by a brief comment on the concept of "complete" health." Second, by outlining a conception of functional good health in a given range of environments. Third, by defining a conception of habilitative health. The first two steps will be taken in (2.1) and (2.2) below. They condense, rewrite, and repurpose material from Becker (2012, in chs 3.2, 4.3, 5.1). The third step will be taken in section (3).

2.1 Complete health

In medicine, public policy, and bioethics, there has long been a tendency in some quarters to define health in negative terms – as the absence of pathology – and then to deal first and

foremost with pathological conditions that can be traced to a dysfunctional physiological source. That tends to leave out, or at least discount, the nature of positively good health – defined as the presence of functional strengths rather than the absence of dysfunctional strength levels. In medical practice, of course, the presence of functional strengths and the sort of good health they represent is certainly a prominent concern. But again the focus is predominantly on eliminating pathology: restoring physiological functioning; physical therapy; speech therapy; occupational therapy as devoted to the physical activities of daily life. Psychotherapy and behavioral therapy are available, but are also typically devoted to the elimination of pathology.

This defies commonsense about both disability and health. In both ordinary conversation and professional settings, people generally recognize that the absence of pathology is not equivalent to the presence of robust or even stable good health. And we certainly recognize that the presence of stable, good, psychological and behavioral health is as important (in human affairs) as the presence of stable, good, physiological health. Moreover, we recognize the importance of hospitable physical and social environments in sustaining good health of both sorts, as well as the importance of inhospitable environments in generating ill health. For debates in bioethics about these points, see Boorse and others in Humber & Almeder (1997), and Nordenfelt (1995; 2001) as well, who explicitly connects health to the pursuit of vital goals.

So the first step to take is to notice that the discussion of health and disability must concern itself with what is been called complete health: both good and bad health; both physical and psychological/intellectual/behavioral health; all of it relative to some specified range of physical and social environments. One can be in robustly good physical and psychological health in a peaceful, well organized country village, but vulnerable to anxiety disorders in a well organized but hectic city of millions, and not competent physically or psychologically to be an

astronaut. So it is always wise to specify a range of physical and social environments in giving an assessment of an individual's good health: "The patient is in robustly good physical and psychological health in this rural environment and thriving in the challenges posed to one's health. But it is not clear how she will function in the large-scale urban environment she so much dreads, and will soon reluctantly move into."[1]

Furthermore, the discussion of complete health must concern itself with transient conditions (e.g., appendicitis) as well as stable traits (e.g., a missing kidney and a stable, well-functioning urological system with the remaining kidney). A commonsense health assessment should always be able to make the following sort of distinction: "The patient is a 35-year-old female with acute appendicitis requiring immediate surgery, but is otherwise physically fit, and in good psychological health as well."

What we need next, then, it is a more detailed conception of good health – one that is appropriate for our concerns about complete health in the sense described here. This conception of good health must be able to account for the variety of inabilities (short of disabilities) to which human beings are vulnerable. And ideally, it will also point us toward an aspect of health that identifies the difference between inabilities and disabilities.

2.2 Good health

Suppose we begin at the point where people have achieved health defined in negative terms – as the absence of ill health – and ask what additional factors have to be in place for them to achieve health defined in positive terms – as the presence of good health.

A HEALTH SCALE. We can think of levels of health (both good and bad health) as arranged on a continuum from worst to best, with a dimensionless neutral point in the middle. Suppose we want each point on the continuum to refer to the same set of objectively measurable functional

factors – factors that yield a functional assessment of underlying trait-health, overlaid by transient health conditions, and adjusted by reference to the physical and social environments of special concern. (Example: Your health is fine. Not astronaut material, maybe, but that doesn't matter. Don't worry about the ligament damage. It will heal.)

We want those factors to be broadly enough defined to cover physiological, psychological, and behavioral varieties of good and bad health of all sorts. And we also want those factors to be causally connected to each other so that health is improved or diminished in reciprocal ways: the lessening or absence of factors of bad health contributes to either stabilizing bad health or building it upward toward the good side of the continuum, while the presence or strengthening of factors of good health contributes to either preventing a decline toward bad health, or building good health further upward toward better health; and the reverse. For the moment, let us leave out purely subjective reports of illness, wellness, happiness, or life satisfaction that either are not, or cannot be correlated with, objectively measurable functioning.

FUNCTIONAL GOOD HEALTH. Moreover, let us just stipulate for the moment that typical, age-appropriate human anatomy and physiology, as it functions in the absence of disease, deficit, or any other pathology is at the dimensionless zero point between ill health and good health. Such non-pathological functioning obviously includes some strengths, of course, just in the nominal functioning of the neurological system, immune system, digestive system and so forth. It may be that typical human functioning at the zero point will itself provide some strength and momentum for moving beyond that point into the region of good health. But as the emergency room's revolving door phenomenon shows, we cannot count on this alone even to keep us stable at the zero point, or at any point in good health above zero, rather than declining into ill health.

We apparently need some additional strengths and momentum to keep us in, and improving in, good health.

Suppose we summarize these strengths as follows, noting that they all have both physiological and psychological components. **i**) Resistance to declines toward ill health, in traits or conditions. **ii**) Resilience, via homeostatic mechanisms, in returning to a previous level of health from a lesser level. **iii**) Restorative capacities that can, under some conditions, reverse the declines toward ill health that occur despite an individual's resistance or resilience, or can repair damage to the mechanisms of resistance and resilience themselves. **iv**) Generation of agentic energy, so as to avoid lethargy, helpless passivity, and paralyzing anxiety or fear. **v**) Generation of momentum for development toward good health, and along the typical developmental track for human beings. **vi**) Generation of the self-initiated agentic activity characteristic of good health along its typical developmental track over a complete life.[2]

Functional good health might then be understood as some stable combination of those six strengths, above the zero point between ill health and good health.

GETTING THE STRENGTHS OF GOOD HEALTH. The question now is about what is needed to increase those six strengths so that they are sufficient to bring people out of ill health, prevent declines back into it, raise people above its mere absence, and improve their level of good health.

For all these cases the answer is the same. In order to survive and thrive, human beings need at least a minimally hospitable physical and social environment. And as section three will argue, that turns out to require a special kind of good health (to be called habilitative health). Its complete absence in everyone is an apocalyptic disaster. Its complete absence in anyone is a lethal disability. And the partial lack of it in anyone is a disability under some (and sometimes all) environmental conditions. Habilitative health of the right kinds, in the right amounts, at the

right times is an existential necessity for human beings. That is a very good reason for thinking that habilitative ill health and disability are matters of fundamental philosophical importance.

3. Habilitative Health

All human beings face three fundamental habilitative and/or rehabilitative tasks throughout their lifetimes: receiving habilitation from others as necessary; habilitating themselves as necessary; and habilitating, as necessary, the physical and social environments they inhabit.[3] Effectively addressing those fundamental tasks is a survival necessity for humans, so we need to have the requisite abilities, and that requires having a certain level of what can appropriately be called habilitative health. To the extent that we lack that form of good health we have some particularly unhealthy inabilities, and by that fact potential disabilities.

We thus need to develop, as far as possible, the physiological and psychological abilities necessary for successfully addressing these essential tasks. We need habilitative abilities that are reliable and effective across the whole range of physical and social environments we inhabit, or might inhabit. What we need, in short, is *habilitative health* -- not only in ourselves, but in others, and in our environments. What we want to avoid is fundamental habilitative inability – and more than that, habilitative disability.

To reach those conclusions, a modest amount of restatement and reorganization of material from earlier in the chapter is necessary. As follows.

3.1 Habilitatve health and its necessity

If we cannot effectively *receive* the habilitation we need from other people we may die, or languish, or isolate ourselves to the point that our lives are solitary, poor, nasty, brutish, and short – even outside a Hobbesian state of nature. Think of infants who cannot take or digest food.

Think of adults who cannot accept the help or company of others without being grudging, or contemptuous, or belligerent.

We face a similar fate if we never *give* habilitative help (when we are able to do so) to others in need of it from us. That also has the effect of isolating us – either because we have to avoid all the opportunities to give such help, or because people around us eventually exclude us from the compassionate community of people who will gladly (or at least not grudgingly) offer habilitative help to others when it is needed. Such exclusion can be damaging to our health, both physically and psychologically. Think of the difficulty of finding a subculture of sociopaths in which we could live happily without giving habilitative help to others. A subculture of grifters, for example, as in (Frears, 1990). Then think of living in it.

And finally, things do not go well for us if we are unable, or unwilling, to make any effective effort at all to habilitate ourselves (by, say, learning how to make ourselves agreeable to others) or if we are similarly unable or unwilling even to try to habilitate a hostile social or physical environment. Think of the homesteaders in the challenging physical conditions on the plains of the Dakota territories in the 19th century. They did not survive unless they were willing and able to cope inventively with harsh winters in sod houses, crop failures, and long periods of social isolation. Not all of them could do this. (Rolvaag, 1927.)

Human abilities to perform habilitative tasks are always limited, of course. And this will be true no matter how strong and wise and talented we become, and how fortunate we are in our circumstances. Some things are not within our control, as the Stoics dryly remind us. We are mortal. And that large fact aside, we are limited by the extent of our physical and psychological endowments, whether they are typically described as disabilities or not. We are limited by age and the details of our development. We are limited by the extent and duration of our overall good

or ill health. We are limited by the extent to which our physical environment can be made genuinely hospitable – that is, conducive to human survival and flourishing. (Say, on Mars.) And we are limited by the extent to which our social environment is stable, multigenerational, and hospitable – that is, characterized by enough cooperation and coordination to sustain a productive and reproductive social system at every degree of magnification from personal to global.

Such limitations raise urgent questions of justice about the tolerable extent of possible human abilities and inabilities throughout a given population, as well as their actual distribution in various environments. Everyone has some specific range of abilities and inabilities, including the disabled. Thus it is not true that disabilities are just a special case of inabilities, because some persons with disabilities may have special abilities as well. (Adults who are 3'5" tall may or may not require special medical treatment. They may or may not have some functional advantages in a given physical and social environment. They may or may not be subject to disabling discrimination and inequality of opportunity. And so forth.) So it is best to think of various kinds of disabilities mapped (as overlays) over both categories; over both abilities and inabilities. This is a revealing entry point for discussing habilitative health and disability. We will return to its consequences for justice later.

3.2 Habilitative health and its agentic development

In the typical course of healthy human development in a reasonably hospitable social and physical environment, an individual's ability to cope successfully with the three habilitative tasks develops along with every other aspect of good health – physiological and psychological. But unlike good health generally, habilitative health is essentially a version of agentic health aimed at

accomplishing habilitative tasks. Just as we assess health generally in age-appropriate ways, we assess agentic health in age-appropriate ways.

The newborn's agency is characterized by limited situational awareness and mostly instinctual goal seeking, where the goals are mostly the immediate satisfaction of security needs (warmth, comfort, no sudden changes…). The newborn may or may not instinctively seek nourishment, or be able to nurse effectively. But newborns typically are able to effectively *receive* habilitative help from others, and with such help their overall good health, as well as the beginnings of their self-habilitative health, can be sustained. Similarly for the ability to be comforted, to develop a predictable sleep cycle, and so forth.

At that point, the infant's agency typically begins to become more complex – in increased situational awareness, associative expectations (being held in a certain way is associated with being secure or being fed), and in the infant's developing abilities to signal needs and desires to others, and to make efforts to elicit (rather than merely receive) care from others. Further, the infant typically develops various exploratory interests (watching human faces; making exploratory movements), and the beginnings of reciprocal responses, including mirroring responses.

And so it goes throughout the typical course of human development generally, through the various landmarks of the development of various age-appropriate characteristics of species-typical human agency: increased physical mobility and coordination, walking unassisted, the acquisition of language and other forms of communication, the ability to understand and mirror other people's intentions and affective states (comparing them to their own), along with the development of an effective use of rudimentary practical intelligence in the achievement of some goals, eventually up to the acquisition of various effective traits of self-command (courage,

prudence, moderation, delayed gratification, strategic reasoning), and the transformation of practical intelligence into something resembling practical wisdom (e.g., about what goals are worth pursuing). At that point, the individual has something we can unproblematically call rational agency.

PROSOCIAL AND EUDAIMONISTIC TRAITS. Moreover, in the typical course of human development, the rational agency developed by individuals includes various effective pro-social as well as self-interested traits (including benevolent concern for the health and well-being of others as well as oneself), together with an appreciation of the agent's own causal responsibility (or lack of it) for events. When it does include these things, we can unproblematically say that the individual has developed moral agency as well. This is a lengthy process, sometimes abruptly terminated or reversed by ill health, overwhelming physical or social environments, or old age.

Furthermore, there is good reason to believe that the typical course of individual human development proceeds along the lines put forward in eudaimonistic accounts of the virtues – an account in which practical wisdom is engaged in subordinating our vices to our virtues, resolving conflicts between various virtues (e.g., justice and mercy), prioritizing the virtues, and expressing them coherently in our attitudes, decisions, and behavior. (For detailed accounts of such matters see Becker, 2017 [1998] and Becker, 2012, chs 7-8.)

The important point to notice for present purposes is that, a fortiori from the preceding, it is species-typical for human beings to develop some level of habilitative health – the version of good health that equips us to effectively address (within the limits of our agentic abilities) all three habilitative tasks mentioned at the beginning of this section. At least this is so for human beings with typical anatomy and physiology, functioning without ill health in a reasonably hospitable physical and social environment. (The term is "reasonably hospitable" rather than

maximally or perfectly hospitable just because the development of the six factors of basic good health described in 2.2 above – strengths of various sorts – often seems to require physiological or psychological challenges that stimulate the development of those strengths. Think about the way vaccines stimulate the immune system, or. the way in which difficult environments stimulate problem-solving. What we need for agentic growth is not a utopian environment, or an overwhelmingly inhospitable one, but rather one that is optimal for developing habilitative health.)

4. Habilitative Necessities, Duties, and Disabilities

The concept of habilitative health suggests a way of identifying the disabilities that are of special significance for theories of justice, and for ethics generally. This is so because the three essential habilitative tasks outlined earlier are necessities – they *must* be accomplished successfully if human beings are to survive and thrive in hospitable physical and social environments. So a permanent inability to perform one or more of the three essential habilitative tasks surely counts as a disability coming from habilitative ill health. And perhaps perversely, we should note that human beings bent on destroying such health in themselves and others also need to start on their project with a good deal of habilitative health. Nihilistic, apocalyptic, or psychopathic annihilators – on any scale from themselves alone, to their families, neighbors, fellow citizens, governments, and human beings generally – need some aspects of habilitative health to work with, and against. So even for them, a permanent inability to accomplish a significant range of habilitative tasks qualifies as a disability.

4.1 Disabilities are presumptively connected to habilitative health

Is there anything we would want to classify as a disability that we would miss if we simply focused on those connected to habilitative (ill) health? It seems not. But it is hopeless to try to prove the point a priori. Or by enumeration. Rather, we make the following observations.

It is hard to think of people as disabled if they are fully functional – in age-appropriate ways – in contributing to the accomplishment of all three of the necessary habilitative tasks for themselves and others, even when they have seriously compromised health in other respects. After all, they will be age-appropriately self-habilitating. Think of an electrician, or a law professor, or an actor – each with an artificial leg. Presumably, they can accomplish all the activities of daily living and are thus self-habilitating in that way. Presumably they can contribute to the habilitation of others – and their families, through their work, through their duties as citizens. And presumably they can contribute in some way to the habilitation of a given physical or social environment, as necessary. Similarly for people with more serious physical or intellectual inabilities that limit their mobility, and the range of physical and social environments in which they can accomplish one or more of the habilitative tasks.

But that just means (so far) that they will have habilitative *inabilities*. Under what conditions would we want to say they are thereby disabled? Surely we can make a good case for saying that they do not have disabilities in a nominative sense (on those grounds alone) if in fact they can manage to accomplish all three essential habilitative tasks in some set of hospitable environments that are accessible and important to them. And when we think about when we would reverse that judgment and classify them as having disabilities it seems always to come down to cases in which their habilitative health is actually compromised – for example, by an inhospitable, discriminatory society that prevents them from having satisfying and rewarding lives and work, thus damaging both their physical and psychological abilities to be self-

habilitating, among other things. Everyone, disabled or not, has limitations, difficulties, and unavailable options. That is just to say that they have inabilities. They do not, by that fact alone, have disabilities.

So it seems safe, as a first approximation, to identify disabilities with significant habilitative ill health that is permanent or something that the individual cannot simply work around without significant help from others. This amounts to a rebuttable presumption. It is open to revision if we can find cases of inabilities that amount to disabilities even though they are unconnected to habilitative ill health. (Chronic pain is an instructive test case, and I thank the editors for mentioning this. It can be either disabling or non-disabling, in terms of habilitative functioning. That does not mean that non-disabling chronic pain should not be taken seriously, however, and treated therapeutically. But it does, apparently, mean that some mild forms of chronic pain are not disabilities in terms of the analysis given here.)

4.2 Necessities, practical requirements, and disabilities

Further discussion of the same matter can proceed by beginning with a sketch of how to rate the extent of an individual's habilitative health status. This is followed by some obvious conclusions about what counts as a disability in habilitative terms. Finally, a compact recital of the human importance of habilitation makes plain the basis for constructing an account of human duties to provide such habilitation for oneself, others, and the environment. Each of these elements contributes to the conclusion that disabilities are best understood as a lack of habilitative health. As follows.

HABILITATIVE HEALTH STATUS. The measurement of habilitative health plausibly requires an assessment of at least the following six multipart elements:

First. An assessment of the six strengths of good health generally. Note that such typical development into adulthood – at least in reasonably hospitable social environments – includes the development of prosocial psychological dispositions to provide habilitation for at least some others (and some environments) as well as oneself.

Second. Assessment of the extent to which the physical and social environments inhabited by the individual create and sustain momentum away from ill health and toward improved good health generally, as well as momentum toward or along the typical developmental track for human beings.

Third. Assessment of the extent to which the individual is blocked or inhibited – by either some aspect of limited good health, some aspect of ill health, or some aspects of accessible physical or social environments – from deploying his or her strengths of good health for habilitative purposes.

Fourth. Assessment of the variety of open paths into better habilitative health (either in the existing physical and social environments or other possible ones) if others supply habilitation for the individual, or some environments.

Fifth. Assessment of the extent to which the habilitation from others necessary for achieving and/or sustaining habilitative health for the individual would be extraordinary (compared to what is typical for human beings generally).

Sixth. Assessment of the extent to which the individual has developed strength in developmentally typical psychological and behavioral dispositions to engage in self-habilitation as necessary, providing habilitation for others as necessary, and working to habilitate physical and social environments as necessary.

HABILITATIVE DISABILITIES. The rebuttable presumption is that people are not disabled if they have enough good health to accomplish all three habilitative tasks in ways that are age-appropriate over a complete life. People *are* disabled, however, if they lack enough good health to accomplish all three in the environments they *must* inhabit. (A trivial inability in a temperate climate on earth may be a lethal disability in Antarctica, or on Mars. So if people with that trivial inability in Virginia must go permanently to Mars, their consequent disability is no longer trivial.) This is certainly consistent with refusing the label of disability to a wide range of inabilities that various people can work around in a given environment. Moreover, it is consistent with identifying people as disabled if they are unable (more or less permanently) to accomplish *some* of those habilitative tasks, but are sometimes able to accomplish others.

There is, however, a fairly dramatic difference in the list of disabilities often now in use (for health insurance purposes) and the list that would be generated by a focus on habilitative health. This difference has to do with the healthy individual's level of psychological resilience in the form of adaptability, agentic energy, and species-typical psychological and behavioral development (as it occurs in hospitable social environments). Many things that we tend to identify as malingering, for example, might instead be identified as a lack of habilitative health and treated as such. This is also the case for people who have been pushed off the typical developmental track that generates prosocial dispositions and cooperative behavior – ending up with deeply rooted antagonistic or disruptive dispositions unconnected to any specific or general justification (in an understandable sense of injustice, for example). These are also likely to be regarded as disabilities in terms of habilitative ill health.

This difference in the list of disabilities need not "medicalize" social responses to them, of course. But it should increase our interest in making sure (through educational interventions,

for example, or rehabilitative ones) that the underdeveloped elements of good health that create the inability to be resilient and adaptable, or to be inclined (as a sort of default position) to engage in cooperative prosocial behavior are appropriately addressed. Something like this conclusion, drawn from things other than habilitative health, can be found in Fisk (2016), which argues that ethics itself is fundamentally motivated by concern for social survival; in Pickett & Wilkinson (2009) which argues that "more equal societies always do better;" and in Nordenfelt (2001) which connects the goals of health enhancement to social welfare.

To sum up, then, fully functional habilitative health includes all three of its aspects: abilities related to self-habilitation, the habilitation of others, and the habilitation of the physical and social environment. Anyone who lacks one or more of the three elements of habilitative health completely – in an age-inappropriate or permanent way – obviously has a serious disability. And as the following will make clear, if everyone lacks all three even for short periods, the results would be catastrophic for human beings generally. But most societies and the individuals in them can probably survive (and possibly even thrive) even if most people have even a modest amount of age-appropriate ability in each of the three aspects of habilitative health – especially in well-organized societies with a complex division of labor.

5. Habilitative disabilities and social duties

To see this more clearly, and to see the places where a lack of habilitative health always clearly generates serious disabilities that arguably generate social duties to rehabilitate, care for, or compensate for people with those disabilities, it is helpful to lay out a sequence of practical necessities for habilitation in human life generally. The following outline reorganizes and retraces earlier material about the practical necessities for habilitative health during an individual life from infancy to old age. It begins with a series of descriptive propositions in an elementary

valid argument form, then restates the argument in terms of prudential oughts, and finally suggests how to reach a corresponding normative judgment all things considered.[4]

RECIPIENT HEALTH. The argument begins by affirming the practical necessity of recipient health: (A) All human beings must be able, as a matter of practical necessity, to elicit and receive effective habilitation from others as necessary for survival (and for thriving) throughout their lives, and to be able to provide habilitation for others as necessary for receiving it themselves.

(A) *requires but is not guaranteed by* (B) recipients' having, even as infants and at every stage of life beyond that, at least a minimal level of (egoistically oriented) self-habilitative health themselves which includes enough reciprocal response and activity from them to elicit habilitation from others as necessary, even if those others are themselves egoistically oriented. *That is, A only if B.*

CAREGIVER AND DONOR HEALTH. (B) *requires but is not guaranteed by* (C) each human being's receiving enough habilitation from caregivers and donors – through the species-typical developmental track from gestation, infancy, childhood, and adolescence –to achieve a mutually sustainable level of habilitative health in themselves (as recipients, caregivers, and donors) and in a sufficient number of others (as recipients, caregivers, and donors). *That is, B only if C.*

Note: Even a system of mutual advantage among egoists requires reciprocity. So it requires not only self-habilitative health, but other-directed habilitative activity as well.

MULTIGENERATIONAL HEALTH. (C) *requires but is not guaranteed by* (D) a stable, self-sustaining, multigenerational social environment of a sufficient number of people who have at least minimal habilitative health in all three of its aspects, and who are appropriately placed, able, and motivated to habilitate and/or rehabilitate others into a sustainable level of habilitative health when that is possible – either directly to given individuals (such as their children) or to

habilitatve social institutions engaged in cooperative activities aimed at creating and sustaining hospitable social environments. *That is, C only if D.*

Note: It is plausible to think that sustaining other-directed habilitatve activity requires at least the minimal level of prosocial habilitative health, characteristic of species-typical psychological development beginning in childhood, in which caregivers and donors have genuine concern for the well-being of others, for the sake of those others.

HOSPITABLE ENVIRONMENTS. (D) *requires but is not guaranteed by* (E) a sufficiently stable and hospitable physical and social environment in which human beings generally can survive and thrive in habilitative health so as to accomplish, as necessary, age-appropriate habilitative tasks of self-habilitation, habilitation of others, and of the physical and social environment. *That is, D only if E.*

CONCLUSIONS. Thus it follows that because we have affirmed that (A) is a practical requirement insofar as it is possible to achieve, and because (A) can be achieved only if B, C, D, and E are achieved, they too are practical requirements to the extent that they can be achieved. *That is, (A) only if (B & C & D & E). / And A. / Therefore (B & C & D & E).*

It also follows that *if* we can affirm the corresponding prudential ought judgment – that we *ought* to achieve (A) to the extent that it is possible – then (A) is at least a *prudential normative* requirement. (**Note:** By the time we develop rational and moral agency as defined earlier, we have implicitly been affirming that (A) is both a practical and prudential normative requirement.)

The remaining question is whether (A), and thus B, C, D, and E ought to be achieved *all things considered*, and are thus moral requirements in that sense. Given the practical and prudential necessity for human beings of accomplishing their habilitative tasks, it is plausible to

answer that question in the affirmative. These are paradigm cases of tasks that ought to be achieved all things considered, and the burden of proof would surely be on skeptics and nihilists to show why these practical and prudential necessities are not requirements all things considered.

6. Disabilities, Good Lives, and a Hospitable World

Habilitative health is only one aspect of good health, and as defined here, it deals only with habilitative necessities – those abilities with respect to one's self, others, and the environment that are essential to survival and thriving. Such good health – indeed, good health of any sort – is not enough to guarantee much of anything about one's success in surviving or thriving, let alone having even a minimally good life in a minimally hospitable environment. Habilitative inabilities and disabilities further limit the prospects. But there are some reasons for optimism.

GOOD HEALTH HAS TO BE MORE THAN JUST ENOUGH FOR THE IMMEDIATE NECESSITIES.

Think of a quadriplegic lawyer, working as a highly specialized researcher in a large government agency, depending for his daily needs on a succession of groups of two or three live-in graduate students from a university near his spacious apartment. The graduate students are paid a small stipend, and get free living accommodations, including the food they all eat. They have the run of the place. He confines himself mainly to his bedroom, bathroom, and a small den near his office. He is good at what he does at work, but not exceptionally good. And everything he does is dependent on every aspect of his life continuing to work in exactly the same way. The power wheelchair has to work. The graduate students have to be there, on time, when they have promised. Every reorganization of the government agency threatens the whole arrangement, either by threatening his job itself (his only source of income), or the special accommodations and assistance he needs on the job. In habilitative terms, under exactly the right conditions, he can succeed to some extent at all three habilitative tasks. He is self-habilitating in the sense that

he lives a meticulously planned and scheduled existence, even though it requires a lot of equipment and assistance from others to carry out his plans. He contributes to the habilitation of others (by employing the graduate students). And he devotes some attention to sustaining and improving the larger physical and social environment (by his work in the government agency itself). But he continually skates right along the edge of his abilities to succeed at any of this. And he is pretty thoroughly miserable. But the misery doesn't come from his disability itself so much as from the relentless, daily difficulties of his life. Many people without disabilities have such relentless difficulties.

The moral is this. We do not have good habilitative health if we lack the strength to cope with the misery of relentless difficulties. If our pursuit of essential habilitative tasks consumes one hundred percent of our energy and strength, we will not have an adequate level of habilitative health. Even for necessities, we need a reservoir of strength to draw upon from time to time. That reservoir also supplies energy and strength for both habilitative and non-habilitative activities beyond essential or necessary ones. Such energy and strength can be put to use in pursuit of other aspects of a good life. This means we should be wary of disabilities that confine a person to exactly one way of thriving in exactly one environment. That, in turn, means we should not be willing to accept rehabilitation strategies that provide *only* this sort of confined life. The same thing applies to parenting, and education, and social policy (including the criminal justice system). Preparing children, students, workers, apprentices, job re-trainees, and convicted felons for exactly one confined and insecure path to habilitative health can generate crushing disabilities.

IT HELPS THAT HABILITATIVE HEALTH IS SO FOCUSED ON AGENTIC HEALTH. The quadriplegic lawyer's misery is not necessarily a product of his disability. As described, he is a

relentlessly self-habilitating agent, living in a hospitable environment. It is a confining environment, but it is hard to believe that it needs to be crushing. Instead, he needs to cut himself some slack, and presumably can do so because he has such good agentic health. If he needs to be less miserable (or wants to be), then he ought to spend some energy arranging a less demanding, less all-or-nothing way of life.

The same cannot be said for people who have serious agentic disabilities, with or without physical ones. Otherwise robustly healthy adults with localized brain injuries can have aphasia and related memory and behavioral problems that profoundly affect their agency. They may not be able to live on their own, and be reliably self-habilitating, but in a care center they may be able to help others in kind and compassionate ways, and help the staff with their work. Attention to habilitative health identifies the source of the problem accurately. And it also suggests where the rehabilitative focus should be. And that, in turn, identifies an important task for medical rehabilitation research.

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Endnotes

[1] It is probably no accident that there seems to be a distinction between rural and urban conceptions of health itself. See Gessert, Charles, et al. (2015). And for a gripping narrative account, see (Arnow [1954]).

[2] The elaboration of all of this into a genuine health scale that might be usable in practice may be found in Becker (2012 at 82-94).

[3] Many habilitative endeavors are not fundamental, of course, because they are not actually necessities. Some, like making an especially good meal, may just be optional improvements. Some may even be superfluous.

[4] A more elaborate argument on the topic of agentic patients and healthcare, using some of the same materials, may be found in Becker (2016, at 16-17).