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DRAFT

Habilitation, Health, and Agency: A Response to Wolff and de-Shalit's *Disadvantage*[1]

Between Theory and Practice

The authors of *Disadvantage* are pursuing a remarkable project, situated mainly in that unnamed place between ethical theory and concrete public policy. It is the place where theory and policy meet, and it is all too often treated as a featureless conduit. The authors demonstrate vividly, however, that this interstice is philosophically challenging in its own right, and that good work there makes a direct contribution to both theory and policy. They have given us a fascinating and admirable book.

My comments will naturally enough focus on the topics of most interest to me, but these also turn out to be the ones for which I am most grateful for the authors' splendid work. Specifically, I will address their work on five issues: solving the indexing problem—that is, scaling disadvantages from most to least; folding disabilities into a more general discussion of disadvantage; focusing that general discussion on low functioning with respect to certain capabilities; insisting that *secure* levels of adequate functioning should be a crucial public policy target; reminding us of the importance of identifying especially corrosive clusters of low functionings; and arguing that the de-clustering of such functionings (and the clustering of especially fertile ones) is the best direction for public policy with regard to disadvantage generally.

My comments grow out of certain disquieting features of the authors' treatment of those topics. For one thing I am uneasy about the way in which their alliance with the capabilities approach to distributive justice seems to get detached from its grounding in ethical theory – any ethical theory, not just Aristotelian ones. That has the consequence of deflecting attention from the ways in which a list of capabilities might be unified, theoretically, and thus might provide a basis for a monistic solution to the indexing problem. For another thing, I am uneasy about the way in which focusing on functionings deflects our attention from the importance of stable traits of one sort or another (physical or psychological). Such traits reenter the picture in a broad consideration of making various functionings secure, of course. But I am not convinced they have a prominent enough role there, or elsewhere in the authors' discussion. And finally, I am uneasy about the limited role that health and disability play in the authors' account of disadvantage.

It will be important to keep in mind, as I make my remarks, that the book's agenda is about problems that arise within the theory and practice of developed liberal democracies with fundamental commitments to the well-being of all their citizens. It is thus within the egalitarian tradition as well as the liberal democratic one. I will keep my remarks within those assumptions, even though what I say may have broader implications. And I will try to keep them in the space between theory and practice. I will wind up, at best, on the very edge of that space – the edge that adjoins ethical theory. But I promise not to proselytize; not to try to persuade all of you dreadful Aristotelians, Epicureans, Kantians, and utilitarians of the joys to be found in stoicism.

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[1] Wolff, Jonathan and Avner de-Shalit. *Disadvantage*. New York: Oxford University Press, 2007. This response was prepared for an "Author Meets Critics" session at the Central Division Meetings of the American Philosophical Association, April 18, 2008.

Instead, I will sketch out a conception[2] of disadvantage understood in terms of health-related capabilities and functioning. I think this conception represents a point of intersection among those ethical theories that are relevant to the authors' project. Specifically, I will explore the notion of habilitation – habilitation into a robust form of health needed for lives of active, effective agency. Such agency involves a set of abilities describable in terms of a limited number of factors (health-related traits and functionings). Moreover, movement away from robust health all the way to the worst imaginable form of health can be described in terms of the same factors. Such lesser forms of health are disabilities.

This habilitation continuum, so described, is useful for the authors' project, I think, even with respect to the indexing problem. But to make the case for its usefulness, I will first have to situate habilitation with respect to ethical theory generally, and then develop an account of robust health in some detail—making sure along the way that it is all closely tethered to the authors' project, even though it may cast doubt on some of their conclusions.

Habilitation

Habilitation, in its central historical sense, is the effort to equip someone (or something) with a range of abilities or capabilities.[3] Since entry-level human beings, left entirely to their own devices, will not even survive, the practice of providing *some* habilitation is a normatively necessary one, conditional only on the prior commitment to preserve the life, and the ability to provide what is needed to preserve it.

But habilitation of what forms, and to what extent? Well, human beings come into the world with diverse sets of physiological and neuropsychological endowments, situated in diverse social and physical environments. No matter what their endowments or situations, however, they are all largely unequipped, initially, to *cope* with most of the world in which they are situated -- that is, to survive and thrive in it. Habilitation is thus, at least in part, and for a substantial time, directed toward developing coping abilities. Some of this habilitation must be provided by others, and in the case of people with profound disabilities, perhaps almost all of it will have to be provided. But most of us, beyond infancy, begin to provide more and more of it for ourselves.

In some cases such habilitation will involve developing existing endowments—facilitating physical growth, coordinated movement, cognitive abilities, the acquisition of language, and so forth. In others, it will involve changing existing environments – improving the food supply, clothing, shelter, the stability of social life, among other things. And in still others, it will involve working around existing environments or endowments that cannot be developed or improved. Moreover,

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[2] John Rawls, *A Theory of Justice* (Cambridge, MA: Belknap Press of Harvard University Press, 1971), p. 5, follows H. L. A. Hart, *The Concept of Law* (Oxford: Clarendon Press, 1961), pp. 155-159, in distinguishing between competing "conceptions" of a thing and the overarching "concept" of the thing that all the competing conceptions of it share, in the sense that they all aim to explicate it.

[3] From the Oxford English Dictionary (Online Edition, Accessed 01/14/2007): "Habilitate, verb. [f. L. *habilit$^{\bar{a}}$t-* ppl. stem of *habilit$^{\bar{a}}$re* to make fit, enable…] †**1.** *trans.* To endow with ability or capability; to capacitate, qualify. *Obs.* …. **2.** *intr.* for *refl.* To qualify oneself for office; *spec.* to qualify as teacher in a German University. **3.** *trans.* To clothe, dress, habit. *rare*." The historical sense of the term in †**1** is alive and well in our concept of rehabilitation.

no matter what the extent of their initial habilitation for coping abilities, human beings regularly suffer reversals that require *re*-habilitation. The need for coping habilitation thus occurs throughout the lifespan.

Now it is characteristic of human beings that the ones successfully providing such coping habilitation for others have themselves been equipped as active, effective, socially embedded, self-aware, goal directed agents, living both interdependently in some respects and independently in others. And since the habilitation (or rehabilitation) they provide to others typically takes place in the context of reproduction, either biological, psychological, or social, it is not surprising to find strong, persistent, widely shared reproductive social norms for habilitation – a fundamental one being aimed at producing agents who are at least as well-equipped as their predecessors for coping with the environment(s) they will face.[4] I mean this as a claim about a widely shared reproductive social norm that is independent of other elements of ethical theory or human behavior. If people hold certain background beliefs about race, caste, or gender this norm about habilitation will be consistent with the reproduction of great injustice, as judged by the standards of contemporary ethical theory. But not, I assume, within the framework of the authors' project.[5]

Let us think of this as habilitation in its schematic default mode, more or less pre-theoretical and even pre-reflective. But it is entirely too schematic, as it stands, either for ethical theory or for public policy. We need more detail about the specific traits we should try to produce, how much we should try to control the outcome of habilitation, and how consuming the effort should be.

In order to get this level of detail, it is tempting to jump to a comprehensive ethical theory here, so that we can enrich this schematic concept of habilitation by including a list of more specific capabilities. This is something Wolff and De-Shalit have done by employing Martha Nussbaum's version of the "capabilities approach" to questions of distributive justice. But they could have extracted similar lists (perhaps interestingly overlapping lists) from other eudaimonistic theories, and from deontological or consequentialist ones as well. The idea here, I suppose, is to enrich the notion of habilitation enough so we can think that, given a modicum of good fortune, fully habilitated people would necessarily have the resources to construct at least good-enough lives for themselves, and be strongly and stably motivated to do so.

Another option is to moralize the schematic concept of habilitation by orienting it toward producing at least a short list of moral dispositions or virtues. For example, we might want to include a disposition to be fair (treating similar cases similarly), to be benevolent to others in the moral community (desiring happiness for them for their own sakes, and not just our own), and to be reciprocal (making fitting and proportional returns for the good, and bad, we receive). The idea here would be to moralize the notion of habilitation enough so that, at least when the circumstances of justice prevail for ourselves and neighboring societies, we can think that a society of fully habilitated people would necessarily be a reasonably just society.

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[4] Philip Larkin both acknowledges this reproductive effort and mocks it for its unintended outcome in an infamously pessimistic poem "This Be the Verse," *Collected Poems* (New York: Farrar, Straus, Giroux, 1989), p180, which opens this way: "They fuck you up, your mum and dad,/ They may not mean to, but they do." It concludes: "Man hands on misery to man./ It deepens like a coastal shelf./ Get out as early as you can,/ And don't have any kids yourself."

[5] I leave aside the atypical people, or families, or perhaps even isolated subcultures, operating outside the law, who deliberately disable their children, or who radically neglect their habilitation.

I plan to take an alternative that in effect combines these two alternatives. I will sketch a conception of health as a necessary component of habilitation directed at coping abilities. I think this enrichment of the conception of habilitation will turn out to capture, comprehensively, the normative concerns of habilitative public policy in a pluralistic society. If this is right, then it may give us a fundamentally unified, rather than fundamentally pluralistic, way of understanding the sort of disadvantage which is (to use the authors' language) the lack of genuine opportunity for secure functionings.[6] Such unity thus might have interesting consequences for the indexing problem; it suggests that disadvantages can be arranged on a single scale that defines the difficulty of habilitation, and whose zero point is impossibility.

Health

In ancient Greek ethics of a eudaimonistic sort, habilitation into health was understood as a part of habilitation into ethical life generally.[7] In those theories the final end (ethically) is understood to be one or another form of human flourishing, and development of the sorts of excellence that make eudaimonia possible tracks healthy human development -- especially psychological development -- for a substantial stretch. Each requires the same initial development of emotional, intellectual, and conative traits, which are assumed to rest on some basic physical traits. At some point, once a robust form of health has developed, further development of some of those traits is ethically necessary, because more than robust health is required for the best form of life. But to be a healthy adult is by itself to be adequately equipped to live a minimally decent life, and perhaps a moderately good one, in a fairly wide range of health-sustaining environments. This is so in large part because eudaimonistic theories have a wider conception of health than we are used to using, at least in health policy contexts.

For example: The development of sociality is a part of health, in those theories. Meaning that human health requires early forms of attachment to others, gradually developed concern for, and delight in the well-being of others for their own sakes, and the simple norms of fairness, reciprocity, and reliability internalized from sustained social relationships with others. The lack of such capabilities, and their development into stable patterns of behavior were understood as health-related deficiencies.

Similarly for the development of agency, when that is understood simply as purposive behavior, with the practical abilities necessary for at least occasional success in achieving important goals, and with the specific form of energy needed for initiating and sustaining effective purposive activity (call it agent-energy). Such agency, when it is healthy, has egoistic agendas, but they are quickly complicated by the demands of sociality. Egoistic survival needs, pain avoidance, curiosity, mimicry, pleasure seeking and so on all the way up Maslow's hierarchy are, in a healthy individual, coordinated with if not fully integrated into sociality. The lack of such agency-capabilities and those socio-behavioral agendas for them is seen as a health-related deficiency. Failure to develop them in a timely way is a failure to remain healthy.

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[6] Woolf and de-Shalit, page 14

[7] Martha Nussbaum emphasizes this point in *The Therapy of Desire* (Princeton, New Jersey: Princeton University Press, 1994) throughout, but especially chapters 1 and 2.

Simultaneously, healthy human development involves the differentiation and modulation of primal affective responses, through various developing cognitive processes such as self-awareness, awareness of causal connections between external events and internal affective states, and striving for congruence between the norms of sociality and the aims of agency generally. Thus, in healthy individuals, primal affect becomes emotion proper, and is more or less successfully yoked to sociality and agency.

Moreover, the abilities to communicate, coordinate and cooperate with others – which are so important both to agency and to sociality – develop with considerable momentum in healthy human beings, in the course of ordinary childhood social interactions. (Think of the lengths to which anyone would have to go to prevent a child from acquiring language, or other forms of communication, coordination, and cooperation.) Deficiencies in these capabilities, or in their development, are health issues as well for eudaimonistic ethical theory.

These theorists were well aware of the importance of making health-related capabilities secure forms of functioning. And they were aware of the connection between such security or stability in function and social circumstances. Habilitation into health and agency proceeds incrementally, and recursively, building upon itself. For that one needs to achieve forms of health that are resistant to reversals, and resilient to the ones that overcome their resistance. One needs homeostatic mechanisms – physical, psychological, and social. Without such self-corrective arrangements, one's health is fragile, and subject to reversals that make habilitation difficult or perhaps impossible. When one's social environment is constantly and dangerously in flux -- in ways that cause reversals – habilitation is similarly difficult or impossible.

The conception of health embedded in these eudaimonistic theories is decidedly not the impoverished one so often found in contemporary medicine, the health sciences, and health policy. There the tendency is to define health negatively, simply as the absence of disease, disorder, damage to vital functions, interrupted development, and physical or psychological distress. Eudaimonists would insist that we supplement that with a robust account of the positive side of health, since the mere absence of ill health is not yet a form of flourishing so much as a form of languishing.[8]

The need for an account of the positive side of things has long been recognized in scientific medicine generally, and especially in the mental health arena,[9] including childhood development. But this recognition has frequently been followed by neglect or outright postponement of work on "positive health."[10] Recent work in scientific psychology is at last turning this recognition into a

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[8] See this use of the term languishing in Corey L.M. Keyes, "Complete Mental Health: an Agenda for the 21st Century," in Corey L.M. Keyes and Jonathan Haidt (eds.), *Flourishing: Positive Psychology and Life Well-Lived* (Washington, D.C.: American Psychological Association, 2003), Chapter 13.

[9] Jahoda, Marie. *Current Concepts of Positive Mental Health*. Joint Commission on Mental Illness and Health Monograph Series No. 1 (New York: Basic Books, 1958). A recent review of the various candidates for a picture of positive health may be found in George Valliant, M.D. "Mental Health." *American Journal of Psychiatry* 2003: 160: 1373-1384. I am indebted to Christopher Peterson for pointing me to these texts.

[10] Here, for example, is the mission of the National Institute of Mental Health at the NIH: "The NIMH mission is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior." http://www.nimh.nih.gov/about/index.shtml. (Accessed February 12, 2008.)

research program in that field,[11] and some scattered areas of clinical medicine and medical research are doing something similar. (Think of areas devoted to performance-enhancing therapies: sports medicine, occupational medicine, rehabilitation medicine.[12]) But the fact remains that in Western medicine and public policy, much of what eudaimonistic theorists think of as health is eagerly, and even disdainfully, left in the hands of people interested in "soft" things like flourishing, a good life, wellness, holistic health, happiness, joy, and quality-of-life issues rather than strictly medical health issues.[13]

Something helpful that philosophers can do in this area is to work out the conceptual linkages between negative and positive health in terms that could be of genuine interest to both medical science and public policy. To do this we would have to focus on the physical, psychological, social, and environmental variables that need to be measured – and that can be measured -- on scales that range across *both* negative and positive dimensions of health. Further, we would have to describe these variables in ways that make clear their connection to physical as well as psychological health from top to bottom on those scales.

Ethical theorists have typically not done this. Rather, we have typically separated descriptions of bodily health from descriptions of psychological health, and then focused mostly on the latter after making passing reference to the necessary substrate of physical health required for a healthy psychology.[14] This seems plausible, since we want to focus so much of our attention on a good life, or on conduct, character, motivation, emotion, deliberation, and choice. But it leaves ethical theory in closer proximity to the psychological side of things than to the physiological and "medical" side, thus reinforcing the existing divisions in scientific research and practice. Moreover, it puts us in an awkward position with respect to public policy. Though health policy must concern itself with both

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[11] Petersen, Christopher and Martin Seligman. *Character Strengths and Virtues: a Handbook and Classification*. (New York: Oxford University Press, 2004). Pp. xiv + 800. This massive work is intended as a start toward a positive psychology companion to the American psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

[12] It is notable that positive psychotherapy, these days, is typically called coaching or counseling rather than therapy, and is mostly not reimbursable through health insurance. Insurance coverage for extensive functional habilitation of a medical sort is also problematic. Some things on the positive side fit into the project of stabilizing a physical condition, and that may include extensive assistive devices for mobility and the activities of daily living. But programs designed to develop sociality and agency, for example, in the absence of a recognized disease or disorder, are usually assigned to some form of special needs education, or vocational rehabilitation.

[13] Peterson and Seligman, *op. cit*., tacitly concede this. There is no indexed reference to the word health in the entire 800+ page work.

[14] This seems a fair description of Wolff and de-Shalit's book. This feature of the book appears to follow directly from their use of Nussbaum's list of capabilities, in which bodily health is one item, and various components of psychological health figure heavily in some of the other items. But Nussbaum's list is grounded in an Aristotelian approach to describing a good life. It is not clear to me that Wolff and de-Shalit want to sign on to that approach all the way to its theoretical ground. For a recent book that also goes quickly to psychological matters, see Mike W. Martin, *From Morality to Mental Health: Virtue and Vice in a Therapeutic Culture* (New York: Oxford University Press, 2006). And for a recent article that uses a capabilities approach to ground a human right to health, giving along the way a review of much of the relevant literature, see Jennifer Prah Ruger, "Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements," 18 *Yale Journal of Law & the Humanities* 273-326 (2006).

physical and mental health, the largest share of political attention and public money, by far, goes to the physical side.

It therefore seems appropriate, for present purposes especially, to put aside attempts to show how psychological health might ineluctably unfold into good character and right conduct, given favorable conditions.[15] Instead, I want to sketch the outlines of an inclusive concept of health, both physiological and psychological, in terms of a set of variables applicable to both. Here is what I have in mind.

Habilitation into Healthy Agency

In the literature on both negative and positive health it is common to distinguish health as a trait from health as a condition. It is thus not a contradiction for a physician to write something like this: "Healthy adult female, sleep deprived due to overwork, presenting with an upper respiratory infection and fever." Or "Healthy adult male facing a tenure decision, presenting with generalized anxiety and specific worries about erratic behavior at department meetings." The term healthy in those phrases refers to health as a trait – in particular to a finding that the patients have a range of important capabilities for rehabilitation which can be expected to move them away from their unhealthy conditions, given relatively modest interventions, and back into a stable condition in which the infection and fever, or the anxiety, are absent. People who are healthy in this trait sense can suddenly develop conditions that are quite serious – even lethal if left untreated. But the capability for habilitation or rehabilitation is crucial to the trait/condition distinction. Only if people develop unhealthy conditions that are, or are at risk of being, seriously resistant to rehabilitation do we revise our trait assessment from healthy to unhealthy.[16]

We can think of the trait of health, then, as various degrees of vitality beginning at a state just discernibly above death and rising in increments through various age-adjusted[17] levels of bad health, good health, and excellent health to terminate in optimal health of indefinite duration.[18] What we need for present purposes is a rough identification of the physiological, psychological, and environmental factors of vitality that, taken together, constitute the capability for habilitation and rehabilitation – both away from unhealthy conditions, and toward restored or improved health traits.

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[15] See, for my attempt to do this along stoic lines, the chapter "Virtue" in *A New Stoicism* (Princeton, New Jersey: Princeton University Press, 1998), and the Commentary to that chapter.

[16] Disabilities vary along this dimension also. Some of them are not permanent traits, but merely temporary conditions. Others are permanent, but allow for rehabilitation that is sufficient to bring the person back up over the conventional borderline between good and bad health. Thus the claim "He's disabled, not sick" is often correct, in the trait-sense of health. But it is not correct when the disability itself eliminates the person's capability for rehabilitation back into good health.

[17] A neonate, robustly healthy on the Apgar scale, has risk factors which, in a young or middle-aged adult, would be described as ill-health. We make similar age-adjustments for the elderly.

[18] For public policy purposes we probably aren't going to be interested in degrees of vitality beyond what is necessary for a life expectancy of, say, 100 years. At least that is where the US National Center for Health Statistics, in its annual Life Tables, now loses interest. (Average life expectancy in the United States is now around 80 years.)

Health professionals make such assessments routinely, though more or less piecemeal -- in triage, in emergency or intensive care settings, in hospital admissions or discharge processes, in medical or psychological rehabilitation settings, and so forth. [19] I say these routine decisions are typically piecemeal because they often focus only on part of the health equation: physical as opposed to psychological, or the reverse, or either of those without careful consideration of the family environment or larger environment.

The task here is to try to put all of those well-recognized factors together in the context of habilitation. I will not be able to do this at a level of detail that would be required for either health practitioners or public policy analysts. But the overview may be of some use nonetheless if the factors are described in terms that are conventional among health professionals, and which identify capabilities that are routinely assessed with some precision in functional terms. That means expressing them in terms that are as independent of ethical theory and cultural norms as, say, World Health Organization statements about minimum daily standards for nutrition.

Consider whether the following factors meet those conditions. I suggest that they do.[20]

a) ***homeostatic resistance*** to disease, disorder, distress, developmental interruption, and damage to vital functions generally;
b) ***homeostatic resilience*** in returning to a previous level of health from a lesser level;
c) ***regenerative powers*** for homeostatic mechanisms when they have been damaged;
d) ***generation of agent-energy***;
e) ***momentum toward habilitation or rehabilitation*** along physical, cognitive, emotional, and conative dimensions;
f) ***self-initiated activity*** **as an effective, self- aware, socially embedded agent**, living interdependently in some respects and independently in others.

The first three factors (a,b,c) address the problem of stabilizing a given level of physiological and psychological health with respect to reversals, leaving it labile with respect to improvements. The remaining three (d,e,f) address the energy, momentum, scope, and direction of the capability for habilitation and rehabilitation into physical and psychological health. But all six of these factors are elements of that capability.

Each of the six factors varies along the same three dimensions: *the range of environments* in which they are operative; *the range of health conditions* with respect to which they are operative; and their

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[19] Citations to the Apgar scale, the Glasgow coma scale, the Beck Depression scale, the one for multiple organ failure, etc. For an overview of some scoring systems use in critical care medicine, see D.W. Yates, "Scoring Systems for Trauma," *British Medical Journal* 1990 301:1091-1094. For a research report that compares the merits of some competing scoring systems for multiple organ failure see David Zygun, et al, "SOFA is superior to MOD score for the determination of non-neurologic dysfunction in patients with severe traumatic brain injury," *Critical Care* 2006, 10:R 115. In psychology, some of the instruments themselves, such as the Beck Depression Scale are copyrighted, or otherwise not directly accessible. Martin Seligman's positive psychology website…

[20] I confess I have had little success in persuading medical researchers and clinicians of the value of this list, or of this approach to unifying the medical and psychological, negative and positive dimensions of health. Earlier, considerably different versions of these ideas have been presented to audiences at NIH/NCMRR, to a conference on positive psychology at the University of Pennsylvania, to a graduate colloquium in bioethics at Georgetown University, and to the graduate department of rehabilitation engineering at the University of Pittsburgh. The response has been polite, attentive, not especially critical, and essentially of the form "Thank you. Would you like a glass of wine?"

operative *strength*. (We can think of strength as the degree of resistance/momentum toward change above and below a given point on the vitality continuum. What is built into the notion of health is the notion of an *optimal* level of resistance/momentum in each direction. Optimal resistance to declines gives us optimal security against reversals at each point. Optimal momentum toward improvements gives us optimal possibilities for habilitation or rehabilitation.[21] To say that a factor is at zero strength is to say that it has no resistance to declines, and no momentum toward improvements.)

Incapability is the zero point for each element along each dimension. Absent arguments to the contrary, more of each along each dimension is preferable – healthier – than less. So, as long as we work only with these factors or others like them, it should be possible to define an intelligible scale, for the purposes of public policy, ranging from the worst form of health to the best (or at least the best that is of practical importance), and ultimately to distinguish the worst-off members of society from those in various strata above them.

Worst health. Suppose that this list of factors is exhaustive. Then the worst form of trait-health will be the one in which all these factors are at zero along each dimension. The person lacks (a….f) completely, with respect to every unhealthy condition to which he or she might be subject, in every accessible environment. It is the point of least resistance to unhealthy conditions, and the point of least resilience from them. It is the point of least energy for, and least momentum toward habilitation. The next worst off form of trait-health will be the one in which only one of these factors is above zero, but is just discernibly above zero, with respect to only one unhealthy condition, and is effective in only one accessible environment. And so on, incrementally up the scale of vitality, giving whatever weights to individual factors that are necessary to represent clinical realities.

Worst-off members of society. For the purposes of habilitation and rehabilitation, however, we cannot simply identify the worst off members of society as all and only those with the worst form of trait-health. Vitality is not only a product of traits; it is also a product of conditions. So just in terms of habilitation into healthy agency itself, the worst-off category will include those who have the worst form of trait-health only if they also have a lethal condition (the nadir of physiological conditions), and profoundly disabling distress (the nadir of psychological conditions). Moreover, this category of worst-off members of society will also include anyone with a similar condition and lack of capability for rehabilitation from it, even if that person has one or more strong health factors

[21] Note that optimal levels are often not maximal or minimal ones. For many physiological values, for example, such as body temperature, blood gases and so forth, complete or maximal resistance to change is not characteristic of robust health. This is so in part because each of these elements forms part of a homeostatic cluster in which changes in one value trigger responses in another that are crucial for stability. Decreases in oxygen saturation in the arterial blood normally increase the proportion of CO_2 in the blood, which in turn trigger an increase in the depth or frequency of breathing. That is usually a good thing, and normally brings O_2 saturation back up. Supplying oxygen directly, before the rise in CO_2, can have a paradoxically bad effect on respiration if for some reason this homeostatic cluster is not operating properly. What is true of the stability of particular physiological values can also be true of clusters of them. Too much resistance to change is possible there as well, and by itself amounts to a form of ill health. Similarly, too little resistance to change toward better health can paradoxically inhibit the change -- for example, if there is a causal connection between working successfully against resistance and achieving not only an improvement, but a secure or stable improvement. So it is optimal levels of resistance that are implicated in the concept of health, and not simply maximal or minimal ones.

that would be effective for rehabilitation from other lethal conditions or sources of distress. So there are possibly many combinations of health conditions and health-traits that for purposes of public policy can be grouped together in the category of the worst off. [22]

Bad health. To work our way up the various levels of bad health, we can describe a series of levels that increase the strength of various factors, or widen the range of environments, or lower the level of treatment required for recovery from disease or injury. And at some point we get to a level we are willing to describe as a form of good health.

Minimally Good Health. Suppose we say that we have minimally good health (MGH) when we have measurable levels of all the factors (abcdef), with just enough strength in one accessible environment to provide some across-the-board stability at that level, and some across-the-board momentum toward improvements, and enough strength with respect to one health condition so that it can be reversed with especially competent and attentive efforts at habilitation of the sorts available in the accessible environment. Note the limitation to one environment, one health condition, and especially competent and attentive habilitation.[23]

If that is minimally good health, we can then imagine augmented levels of it (MGH+; MGH++; etc.) that increase various factors, or widen the range of environments or health conditions, or lower the level of treatment required for recovery from disease or injury. And at some point we get to a level we are willing to call good health simpliciter.

Good Health. Suppose we say that we have good health simpliciter (GH) when all the factors (a….f) have enough strength beyond augmented minimally good health to provide across-the-board stability at that level, and substantial momentum toward improvements, in a substantial range of relatively unchallenging environments, with respect to a substantial range of ordinary health conditions, given merely competent habilitation of the sorts available in those environments. Note that habilitation requires only competence this time, and that the environments are limited to

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[22] Notice that subjectively, people might greatly prefer some of these combinations to others. That is relevant to hopes and choices for a good death. And it is relevant to the way public support for palliative treatment is administered case-by-case. But it is hard to see how this would complicate the indexing problem for public policy, since everyone in this fix would presumably be provided with the necessary palliation. It is instructive, however, to notice how diverse this category of the worst off members of the society will be in terms of the appropriate response. The social resources necessary for palliation will be very different from person to person. Think of distress. It may well come from a cluster of conditions – some physical, some psychological, some social. It may be possible to palliate this distress effectively by de-clustering, but how that is to be done will vary from case to case. In some cases, distress may come from being in a hospital rather than from having hospice treatment at home. In other cases it may be the home environment itself that is the source of the distress, the solution for which is to arrange for hospice treatment in an institution. Any attempt to address this by allocating equal amounts of money, either with a money-follows-the-person arrangement or with the provision of institutional care, will fail to address these differences. Such differences will pervade each category above the worst off, as well.

[23] It is helpful to think about this in terms of certain major disabilities. A person with a severely compromised but not entirely absent immune system, for example, may have minimally good health in the protective bubble of an isolation unit. But perhaps only in that environment. Yet with even minimal stability and momentum in that situation, such a person may make progress toward improved health in important respects.

relatively unchallenging ones – e.g., such as stable, safe social situations with adequate economic resources and life-opportunities, perhaps in an economically developed part of the world, with access to health care and extensive public education.[24]

***Robust Health*:** Suppose we next imagine augmented levels (GH+; GH++; etc.), in which good health simpliciter is improved in various factors, in yet more environments, or more challenging ones, with even lesser levels of available education and health care. At some point up this slope we will want to define one of these levels, for public policy purposes, as excellent or robust health.

This level of good health would be a particularly important target for large, complex, highly developed liberal societies with extensive international connections, which have an interest in habilitating all their citizens into active, effective, socially embedded agency in as wide an array of environments as possible, with high levels of resistance, resilience, energy, and momentum for improvement in all of those environments. The desirability of that level of physical and psychological health is obvious, and the robust forms of the developing moral virtues embedded in that level of psychological health would likely be impressive. Presumably, robust psychological health would include robust sociality (including norms of fairness, reciprocity, benevolence, and reliability), active and effective agency (including courage and persistence), and cooperative activity. Lesser levels of health will clearly be disadvantages of the sort that concern the authors: the lack of genuine opportunities for secure functionings.

But notice two things about this target for public policy. First, it will be a moving target within any given society, dependent on social resources and circumstances. Even aspirational public policy should stay within the realm of best-case-scenario practical possibility. Second, it will be a moving target across societies, dependent not only on social resources and circumstances but on culture-specific social norms. What counts as robust health in a society that is deliberately closed to the world at large, and thoroughly committed to a single comprehensive theory of the good, will be strikingly different from what counts as robust health in liberal societies open to the world.

Optimal health. We can perhaps assume for the moment that defining the highest level of health (optimal health) will always involve reference to a comprehensive theory of the good – one that gives an account of what levels of these factors we would need in order to live the best sort of life available to a human being in the full range of environments in which humans can survive. We want the account here to remain neutral with respect to such theories.

The habilitation- into-health continuum. Even without a comprehensive theory of the good, however, it looks as though we can define an intelligible continuum from worst to robust health, at least in terms of the health-traits necessary for habilitation. Although the continuum is complex, all of the same factors are involved in defining each point along the continuum, and the movement

[24] Again, the disability example is instructive. Technology and infrastructure available in developed countries now make it possible for people who require ventilators for life-support 24/7 to survive for many years, in an environment with nonprofessional medical care, as long as they have failsafe arrangements for electrical power, working ventilators, and certain other equipment. Some of these people have fairly robust versions of other health factors, and live active, effective lives as socially embedded agents. When such people are transported to environments without reliable electrical power, however, their reduced social circumstances make their health exceedingly unstable, to say the least.

from one point to another is described in terms increases or decreases in one or more of these common elements along the same three dimensions. Further, we should be able to use levels of trait-health together with the presence of negative or positive conditions to define a corresponding sequence from worst-off to better-than-merely-well-off members of society. This will be a complex endeavor, but it looks as though a unitary metric for the purposes of habilitation into healthy agency is at least a theoretical possibility.[25]

Given substantial progress toward consensus on those matters (some of which, I should reiterate, we already have) framing public policy about disadvantages in terms of habilitation into healthy agency has some practical advantages. For one thing, the general aims of habilitation are not in serious dispute in the way that some other goals of the liberal welfare state often are. For another, health is a more congenial terrain than many others on which to argue for egalitarian public policies.

Concluding Remarks

Let me now bring this discussion directly back to the authors' book. It is about disadvantage generally, which they define as lack of genuine opportunities for secure functionings. That may seem a larger topic than habilitation, health, and agency. So several questions arise about my lengthy digression into those concepts. Is habilitation into healthy agency actually plausible as a monistic solution to the indexing problem? Is it a big enough goal to deal with disadvantage generally? If so, is it too big to be realistic? How does it connect to the authors' important thesis about de-clustering?

On the indexing problem: Policy analysts regularly impose a unitary metric for public policy purposes by monetizing relevant factors, and making assumptions about costs, benefits, substitutability, and reasonable compensation. The authors rightly emphasize how arbitrary those assumptions often are, and outline the pluralism which emerges from the welter of preferences people actually have about these things – what sorts of substitutions they are unwilling to make; what sorts of compensation they are unwilling to take. But liberal democracies constrain this sort of pluralism (the sort that arises from individual preference structures) in many contexts – public health and public education being two big ones, not to mention criminal, civil, and contract law as

[25] Ideally, bench scientists, clinicians, social scientists, and public policy analysts would be able to operationalize these concepts of habilitation, health, and resistance to habilitation. Indeed, they have already gotten quite far along in such work in some contexts, which is why I think we can profitably pay attention to measures of capabilities, functioning, and performance in clinical and educational contexts. Many of these existing instruments, however, are designed to measure bad health or problematic functioning. Getting reliable measuring instruments for good health is crucial as well. Once we have both, we can perhaps persuade the scientific and policy communities generally to construct substantial research agendas in support of making policy about habilitation. There would, for example, be opportunities to test empirical hypotheses about what physical and psychological "equipment" is necessary for each level of health; about what mechanisms move us from one level to another; about whether normal development can drive such movement under favorable conditions; about which capabilities best drive such movement under various conditions, and which ones best support each stage in which environments; about whether movement from one stage to another is likely to be preferred by subjects, and thus motivated; and about how subjective well-being is implicated and expressed in each stage, and implicated in movement from one stage to another.

well. So the question that remains is whether the scale proposed here is a plausible one for a liberal democracy to use in dealing with disadvantage.

I suggest that it *is* plausible, at least in this sense: Norms of habilitation into health and healthy agency are constitutive, and not merely regulatory, aims of public policy in any liberal democracy in which the well-being of citizens is a constitutive aim. So it is not arbitrary to employ a metric that is implicit in such habilitation; it is not an arbitrary imposition of the metric. Moreover, liberal democracy entails allowing people to flourish under a variety of comprehensive conceptions of the good; not just every imaginable conception, but quite a variety of them. Egalitarian commitments impose a further constraint on public policy: when we make certain goods available to some citizens, we must make sure we do not thereby disadvantage others. It is therefore at least initially plausible to think that habilitation into robustly healthy agency might be as far as we can reasonably go (in the health line) in efforts to work out egalitarian public policies about disadvantages. Think of the matching limits we have in the closely related area of education: how much of it we are willing to make compulsory; how much of it beyond that compulsory level we are willing to make available to everyone at public expense; how much of it we are willing to encourage everyone to pursue, through the use of publicly funded incentives.

But is robustly healthy agency an ambitious enough, comprehensive enough, target? Does it capture enough kinds of disadvantages, or do others remain – others that would reintroduce the sort of pluralism that defeats a monistic metric? Or, to the contrary, is robustly healthy agency too ambitious a target?

On both sides of the size question, we should remember that to some extent the answers will depend on where we draw the line between augmented good health on the one side, and optimal health on the other (where optimal is defined by some comprehensive conception of the good). Robust health is somewhere between the two. We should recognize just how difficult it would be for an egalitarian society to reach any target in that range. Getting everyone even close to it would implicate every aspect of a modern welfare state's health, education, and social support activities, and we would still fall short. For one thing, depending on where we put the line, many people with substantial disabilities would reach the point of zero capability for further habilitation well short of robust agency (at least in terms of the range of environments in which their health could be stable). And for another, many people without any otherwise diagnosable form of disability just seem to be stubbornly resistant to habilitation well short of robust agency. (Present company excepted, of course, this certainly applies to philosophers.) So perhaps the real question is not whether to increase the distance to the target but rather whether to bring it within realistic range for an egalitarian public policy.

Still, one wonders whether there aren't obvious counterexamples – examples of disadvantages that an egalitarian would want to remove, but which are not causally connected to deficient health. I confess that my imagination fails at this point (perhaps from a lack of robustness in my agency). The candidates I can imagine either turn out to be deficiencies in healthy agency after all, or turn out to be deficiencies only in terms of some comprehensive conception of a good life that a liberal democratic society could not endorse to the exclusion of others.

[THIS BRACKETED SECTION MAY BE EXCISED FOR THE PRESENTATION. Here is why. First, we must not lose sight of the fact that many disadvantages are not part of the public policy discussions we are interested in here. The authors exclude disadvantages that are the product of informed choice. Presumably they would exclude the

disadvantages produced by ethically defensible criminal penalties as well, since those are inflicted as part of the remedy for problems of rectificatory justice. They also allow disadvantages that are harmless – for example, those that are consistent with a notion of complex equality.[26] And of course we are all harmlessly disadvantaged with respect to superior achievers in one field or another, since specialization in one field produces a level of excellence not otherwise available, and no one can be a specialist in everything.

Second, we need to remind ourselves in detail of the way habilitation into robust health properly understood employs all of the existing organizational structures devoted to health, education, and social welfare generally.

Perhaps the easiest way to see the scale of this undertaking and how it might cover all the territory we need to cover, and only that territory, is to fix our attention at first on adults, in developed societies roughly like our own, who satisfy the conditions of robust health along the lines outlined here, without the need for making adjustments for their ages.[27] Such people are by definition active, effective, self-aware, socially embedded agents, capable of coping interdependently in many respects, and independently in many others, in a wide range of challenging and unchallenging environments. They have a robust form of sociality in terms of attachments to others, concern for, and delight in the well-being of those others for their own sakes, and they have stable, internalized norms of fairness, reciprocity, and reliability. Their primal affective responses are differentiated and modulated into emotions proper, and robustly yoked to their agency and sociality. They have robust abilities to communicate, coordinate and cooperate with others, and considerable momentum to do so. They have substantial resistance, resilience, energy, and momentum – both physiologically and psychologically. They are relatively stable – both physiologically and psychologically -- with respect to reversals, and their lives have, as a poet says, "great forwardness" in the direction of improvement in their abilities and success in their endeavors. They have the genuine opportunities for rest, recuperation, and diverting activities necessary for health. They would also have genuine opportunities for health-giving forms of pleasure, joy, and elevated or transcendental experience of several sorts – in love, aesthetic experience, contemplative life, religious experience, "flow."[28]

Now consider what it takes to get to that kind of health, and to sustain it, from the age-adjusted forms of it we might have beginning in infancy, and throughout our development to the point at which we can achieve and sustain its adult form. And think especially of the environmental dimension of health in this regard.

Infants require what amount to intensive care arrangements: protection against injury, provision of all the necessities of daily living, responsiveness to distress, the availability of good preventive and corrective health care, and the beginnings of health-developing education and social relationships. Liberal democracies typically allocate most of this to families, supported by networks of friends, neighbors, voluntary organizations, and government-funded social and economic services, all of it constrained and enforced by a substantial array of laws designed to protect children against abuse and neglect. As children develop over their first few years, and gradually become able to manage some of the basic activities of daily living themselves, at least with prompting, in sheltered environments, the amount of intensive care gradually decreases, the amount of health-developing education and social relationships increases, and the role played by the child's own agency in habilitation itself increases.

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[26] Walzer, Michael. *Spheres of Justice*. New York: Basic Books, 1984. Chapter 1.

[27] E.g., robustly healthy for an infant, or a twenty-something, or a 65-year-old… etc.

[28] There is wide agreement – historically, popularly, and among people working scientifically in the field of positive psychology -- that these are important elements of psychological health. Peterson and Seligman, *op. cit*., devote a section of five chapters to "Strengths of Transcendence," the first of which (chapter 23) is "Appreciation of Beauty and Excellence (Awe, Wonder, Elevation)," pages 537-552. Succeeding chapters in this section are devoted to Gratitude, Hope, Humor, and Spirituality. Jonathan Haidt, *The Happiness Hypothesis: Finding Modern Truth in Ancient Wisdom* (New York: Basic Books, 2006) singles out "elevation" for special attention.

Notice however, the extent to which the habilitative success of all of this depends on social stability and an appropriate allocation of resources, not only to and within the family but also throughout any society as organized as a large, liberal democracy. Pockets of poverty, or lack of access to health care, or lack of opportunity for economic resources, education, or supportive social networks will mean pockets of poor health for the children -- poor health that is likely to be sustained, and even replicated in the next generation, since it is central to the sort of clustering of corrosive social conditions Wolff and de-Shalit are so rightly concerned about. And it may well be that the best way to handle this is to de-cluster these social conditions by going after something other than health, strictly construed. In the approach I am exploring, however, the test of success would always be found, ultimately, in the consequences for habilitation into healthy agency. And the allocation of public resources would be scaled to such consequences. Consider:

Throughout childhood, adolescence, and young adulthood, human development into fully adult forms of robust health requires appropriate, society-wide allocations of resources. Stability in health at each stage will require stability in social arrangements at each stage. And the introduction of permanent physical or psychological disabilities at any stage in the person's development -- or even the risk of such disabilities – will require a social commitment to genuine rehabilitation toward robust health if possible, rather than mere stabilization at a lower level. It will also require society-wide accommodations for people for whom rehabilitation by itself cannot fully restore development toward robust health. Furthermore, the development of robust health will require opportunities, for each person, for experiencing the pleasures, joys, and elevated or transcendental forms of life that complete and reinforce health. Given the requirements for habilitation into age-adjusted robust health over an entire lifespan, for overlapping generations, and given our vulnerability to permanent physical or psychological disabilities any society with egalitarian commitments to health will need to sustain social structures that prevent the clustering of corrosive factors that damage health.[29]

So an egalitarian project of habilitating everyone into robust health is a very big project. Is it big enough? Are there harmful disadvantages left untouched by this approach – disadvantages that we think should be addressed by large liberal democracies with egalitarian social welfare commitments? My response is again, then, a tentative no.]

So suppose, for the moment, that my proposals here are plausible. What would this mean for the authors' arguments about the importance of achieving secure functionings, identifying both corrosive and fertile clusters of functionings, and orienting public policy toward de-clustering those that are especially corrosive? Nothing at all. Or rather, nothing but emphasis. I think my proposals underline the importance of the authors' arguments on those crucial topics.

[29] Immigration sometimes poses another problem, especially when immigrants come from closed, traditional or even tribal environments in which the socially necessary forms of physical and psychological health are much more limited than those necessary for robustly healthy agency in developed liberal democracies operating with egalitarian commitments. One can argue that "The Story of Leah" with which the authors open their book (pages 1-3), and to which they come back repeatedly as the book proceeds, illustrates the way in which immigration can put a person who is healthy in her former environment into one for which she is ill-equipped, and operating with a much lower form of trait-health. In the new environment Leah begins to accumulate physical and psychological impairments, and her health becomes increasingly unstable because the necessary habilitation is not accessible to her – either because it is not socially provided, or not initially acceptable to her family, or not acceptable to her. This directs the public policy response toward providing habilitation, or perhaps even requiring it as a precondition for immigration, much as we might require proof of employment, literacy, or some standard of physical health.