health problems

elizabeth barnes
Health Problems
For Ross Cameron

In Sickness and in Health
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This is not the book I wanted to write. It has turned out an altogether stranger, fuzzier, and more ambivalent beast than I had hoped it would be. A friend once told me that philosophy, when it goes well, is like jazz—you begin to see how the pieces fit, and then you let them flow smoothly together into the work they want to be. Writing this book was not like jazz. It was like tapdancing with a porcupine.

I began to think carefully about health while finishing my first book, *The Minority Body*. I felt there was so much about health that was relevant to what I was saying in that book, but relevant only in ways that made everything more complicated and difficult. So I locked health away in the corner of my mind where I hide the philosophy monsters, to be let out another day.

The late, great Anita Silvers, the last time I saw her, talked with me about her own frustrations with the way health is discussed in philosophy. “Your next book is on health, of course,” she told me, in that special way she had—where it was unclear whether she was making a descriptive statement or a command. Yes, Anita—as you foretold or possibly decreed. This book is on health.

But the book I wanted to write solves problems. It gives clear, crisp arguments that resolve apparent tensions into an elegant precision. Where there is confusion, it brings illumination.

This little porcupine doesn’t do that. The deeper I dove into the philosophical complexities of health, the more I realized that it would take a better philosopher than me to analyze them into clarity. I was stuck marveling at the complexities—the sense that so much of what we care about when we care about health is real, interdependent, and yet often pulls us in different directions in ways we can’t reconcile.

What I slowly became convinced of, in this process, was that as philosophers we’re perhaps too quick with our attempts to resolve inconsistencies. We want to replace unclarity with precision; we want to provide resolution where ideas conflict. And there’s value to all of that. But what I was struck with, the more I thought about health, was my own sense of wonder.

I often come to ideas with a sense of wonder. And in forcing weird ideas into neat solutions or elegant theories, it can be easy for the wonder to slowly ebb away. What I found myself wanting, in writing this, was to find my way to a book that would preserve that sense of wonder. I don’t know what health is. I don’t think that anyone does, or that anyone can. But I’m fascinated by that difficulty.

So I let my little porcupine dance. I hope she has her own rhythm.
And then, the closest thing a philosophy book can have to a plot twist. In the final stages of completing this manuscript, I was diagnosed with young-onset Parkinson’s disease. I have lived with a medically complex disability all my life, so to some degree the subject of health was always personal. But I write this with the knowledge that by the time it is in print, my Parkinson’s will no longer be something I’m keeping secret. And it has been hard not to edit the book in this light. But I’ve resisted this urge—I have added an Afterword, but everything else remains the same. There are bits that now seem personal, even semi-autobiographical, in a way that I never intended them to, and in a way they weren’t when I wrote them. I feel odd about that. But in a way, this very experience speaks to so much of what interests me about health, and what is unique about health.

Health is something we care about. Health is something that matters to our lives in distinctive ways. But for each and every one of us, our health will fail us. We don’t know when, but we know it will happen, sooner or later. And the present might be later than we think.
Acknowledgments

Philosophy takes a village—in this case, a mostly Zoom-based village, as I worked on the most substantial portions of this book during the height of the COVID-19 pandemic. (There is little that better sums up the life of a philosopher than sitting around wondering “but what is health really?” in the midst of international lockdown measures due to a global pandemic.) I’m grateful to audiences, Q&As, random conversations—if you spoke with me about any of the ideas in this book, I am grateful to you. But I would be remiss not to give a few people some extra-special, extra-mile mentions.

My heartfelt thanks and gratitude to Sean Aas, Liam Kofi Bright, Tom Dougherty, Maegan Fairchild, Michael Fara, Shane Glackin, Sukaina Hirji, Sophie Horowitz, Katharine Jenkins, Matt Lindauer, Michaela McSweeney, Trenton Merricks, Sarah Moss, Daniel Nolan, Assyia Passinsky, Jason Raibley, Jenny Saul, Ted Sider, Eric Swanson, and Daniel Wodak. Each of them contributed to this manuscript in substantial ways and deserve a lot of credit for any bits of it that are good. (The bits that are bad are all on me.)

Immense thanks and gratitude to editor-extraordinaire Peter Momtchiloff, for his endless supply of good sense and support. You make this whole process so much better, Peter. Additional immense thanks to RA-extraordinaire, Elyse Oakley. Master of the index, queen of the bibliography, empress of being incredibly helpful—Elyse, you’re the best.

I owe a very special thank you to Mike Rea. He read every part of this book and provided me with detailed, incredibly helpful feedback on everything he read. And he also encouraged and supported me when I really needed it. I don’t have the right words to express my gratitude, but a great thing about Mike is his fondness for plain explanations that cut to the chase. And so, Mike: thanks for everything, friend.

This book also wouldn’t exist in the form it does—and my career wouldn’t exist in the form it does—without the influence of three remarkable women who I can’t thank personally. Katharine Hawley was my dissertation supervisor, my hero, the kind of philosopher I want to be. Anita Silvers told me to write this, and without her work on disability I wouldn’t have the space in the profession that I occupy, and that allows me to write like this. Delia Graff Fara provided the philosophical tools I needed to draw my own view together, and she also provided an extraordinary kind of role modeling that I’m only beginning to fully appreciate. I would not have been able to write this book without these women. And the end result is poorer for not having been able to discuss it with them.
But the book also owes much of its current form to a woman I can thank personally—Sally Haslanger. Sally provided extraordinarily helpful feedback to me as I tried to formulate some of the central ideas in this book. But her thinking—as will be evident to anyone who knows her work—also pervades and impacts almost every aspect of how I do philosophy. Thank you, Sally, for what you are and what you do.

And then there are my forever besties—Jason Turner and Robbie Williams. They read the whole damn thing, even though it’s far outside their areas of interest. And even though it’s far outside their areas of interest, they still had the most incisive, smart things to say. They’re really annoying like that. They’re also the kind of people I’m grateful every day to have in my life.

And finally—Ross Cameron. Without his constant conversation and commentary, this book wouldn’t have made it past a blinking cursor. Without his love, I wouldn’t have made it—simpliciter. I don’t know if he’s been enough to make the book good. But he’s been enough to make my life wonderful.
Introduction

In early January, friends and strangers alike wish each other a “happy and healthy” New Year. Your friends raise a glass to you on your birthday and say, warmly, “here’s to your health!”. Excited new parents proclaim their baby “healthy, and that’s all that matters.” At an especially low point in someone’s life, a friend attempts to reassure them that “at least you still have your health.”

Health is something we care about. Indeed, it’s one of the few things that we assume almost everyone cares about, at least to some extent. Whatever else divides us, we’ve all experienced the unpleasantness of a cold, and we’re all going to die. Health is central to our moral and practical reasoning. And impacts on health—our own and our community’s—have the potential to shape our lives in dramatic ways. In the simplest case, of course, an extreme reduction in health can end your life. Likewise, the person who didn’t care about health at all—who gave no thought to their health in any way—would in all likelihood wind up dead quite quickly. But illness, as well as what we do to avoid illness, can also have a dramatic effect on how we live.

For something so central to our lives, though, we’re fairly confused about what exactly health is—at least when you scratch the surface. At the time of this writing, much of the Western world is emerging from, and dealing with the fallout of, lockdown measures put in place to slow the COVID-19 pandemic. These measures were enacted both to protect health and to prevent the devastating consequences—economic, social, political—of widespread loss of health. But as debate emerged over which measures were warranted, and for how long, it became clear that health, and loss of health, can often be hard to quantify.

There is perhaps no clearer or more obvious threat to health than infectious disease. You get a virus. You get sick. You might die. And so to preserve health, we try to prevent the spread of the disease. And yet some of the measures put in place to prevent the spread of disease have negative consequences—short and long term—for our health. Stuck at home, we don’t exercise as much. We don’t see friends, and struggles with depression and isolation worsen, especially for those living alone. We don’t make routine medical appointments, or schedule preventive testing. Jobs and income are lost, widening socioeconomic divides that are major predictors of poor health outcomes. Schools go online, raising fears of a widening socioeconomic divide in educational attainment—when education is one of the best predictors of health status across a person’s lifetime.¹

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We have a relatively good understanding of what it takes to slow the spread of infectious disease. The question of what it takes to promote health is far murkier. When does the toll of isolation and loneliness shift from compromising your wellbeing to genuinely harming your health? What’s the relationship between mental health and physical health? How, if at all, can we distinguish between the social determinants of health (socioeconomic status, education) and health itself? How do we quantify the toll that acute conditions take on health compared to the toll that long-term chronic conditions take on health?

We need to evaluate questions like these to establish good policy—to establish which measures are justified, in what context, and for how long. But in order to do this, we need to have some workable sense of what health is. We need to be able to quantify it, to compare it, to weigh up different aspects of it. And if the morass of public debate surrounding various lockdown measures is any indication, we don’t have much idea of how to do that—even though we all care about health, and we’re all familiar with loss of health.

To be very clear, I am not a policy expert, and the goal of this book is not to provide practical, concrete recommendations for policy. The task, rather, is to explore the foundational philosophical issues that I think underlie the web of confusion we find when it comes to quantifying and measuring health. I am not attempting to provide a cure for that confusion, but rather a diagnosis.

In a nutshell, the problem is this: health is weird. You can think of this book as an extended argument for the claim that health is philosophically distinctive, and indeed philosophically weird. As such, it’s striking that philosophical discussions of health are so often relegated to the margins of “applied” philosophy. We all care about health—our own and others. But we don’t know how to define it, how to quantify it, or how to relate it to other familiar things we care about (wellbeing, happiness, etc.). Philosophy, in short, has health problems. And if I can convince you of nothing else in the course of reading this book, I hope to convince you that those problems are fascinating.

1. The Distinctive Biological Importance of Health

Part of what makes health so interesting is that it has distinctive, sometimes competing axes along which it matters to us. To begin with, health has obvious biological significance. The normal function of the immune system is to attack pathogens within the body. If you have multiple sclerosis (MS), your immune system—for reasons we don’t yet understand—attacks your central nervous system. The resulting process of demyelination is a clear case of physiological dysfunction. Your body’s central nervous system—and thus its overall functioning—is objectively impaired.
Processes like these are of clear relevance to understanding the biology of the human species. Part of what we talk about when we talk about what is healthy for a human organism is how our bodies maintain their functional status, their homeostasis, and their viability over time. Part of what we talk about when we talk about loss of health are reductions in objective functional status, threats or compromises to homeostasis, and reduced longevity.

There is a biological reality to health—and to loss of health—that is independent of how we think and speak about it. Even when some cases of MS were classified as a form of hysteria, even when neurological disorders in general were blamed on demonic possession, the underlying demyelination process was still there, and it still reduced the health of the person involved. And even if society completely changed our attitudes to MS—if we somehow decided that the process should be sought after or celebrated—it would still compromise the function of the central nervous system, still reduce life expectancy, and so on. A degenerative demyelinating disease reduces the health of the person who has it simply because of the type of process it is—regardless of how we conceptualize it and regardless of our attitudes to it.

2. The Distinctive Normative Importance of Health

While the biology of the human organism is a major part of what matters to us when we talk about health, it’s far from the only thing that matters. And that’s why we can’t simply defer to scientists (or philosophers of science) to tell us what health really is. Health also has distinctive normative significance. If you have MS, you lose function in parts of your central nervous system. But you also lose something harder to quantify—something related to value, to goodness, or perhaps to wellbeing. Many changes in biological status are morally neutral. As you age, your skin loses elasticity and slows its rate of regeneration. That’s why a baby’s skin is soft as their own proverbial bottom, and yours is not, no matter how many gallons of moisturizer you slather on it. Your hair follicles will also produce less melanin over time, creating that lovely salt-and-pepper effect that you may or may not cover up with hair dye. Changes like these might be socially devalued, they might be minor annoyances, they might even turn you into an absolute silver fox. But absent social stigma or social meaning, they are not themselves morally significant. Loss of health, however, is morally significant. It’s not just a change in functional status; it’s a way of being harmed.

As debates raged over which lockdown measures were appropriate and for how long, one thing always stayed relatively fixed in the background: people care about health. We may have different ways of prioritizing health relative to other things we care about, we may have different attitudes to risk, we may have different beliefs about what we owe to others, and we may disagree about the practical
implications of policy, but there is near-universal consensus that health is important to us. And surprisingly few things share this level of endorsement. Beautiful music can transport and move us, but some people just aren’t into music. Friendships can enrich our lives, but some people are natural loners. Sex can be fun, but asexual people often prefer to go without it. You’d be hard pressed, though, to find someone who simply doesn’t care about their health at all. Indeed, the active desire to be unhealthy—and to reduce one’s own health—is often classified as a form of mental illness (e.g., Munchausen’s syndrome). People can choose to disregard their health for the sake of something else they value, and people can want to safeguard their own health yet act akratically. But it’s often taken as something like a Moorean fixed point that people care about their own health, at least to some degree.

Health, in short, is something we almost always value. It’s not the only thing we value, and you can live a good life in reduced health or a terrible life in glorious health. But health is distinctively valuable—bound up as it is in how we feel, what we can do, our physical and psychological integrity, how we’re viewed by others, and our place in society.

3. The Distinctive Political Importance of Health

Health is also something that matters in distinctive ways to our societies, as well as to us as individuals. There is a distinctive political axis of importance to our discussions of health: part of what matters to us when we talk about health are political issues of public health. Major political problems within our societies—socioeconomic disadvantage, lack of access to education, lack of access to fair housing, pollution and environmental degradation—often have health disparities among their bleakest consequences. It is not a coincidence that black and brown Americans died from COVID-19 at significantly higher rates (when adjusted for age) than white Americans, for example. Likewise, many public policy interventions—lowering carbon emissions, raising the minimum wage, providing free school lunches—have positive health outcomes among their key goals. People lose health partly in response to social problems, and this is generally understood as one of the worst aspects of those social problems. (The issue in Flint, MI isn’t that the water tasted bad; it’s that kids got sick.) And similarly, improving health and reducing health inequalities is generally understood to be one of the best results that can come from public interventions.

Importantly, though, the political significance of health doesn’t derive merely from its normative significance, or from the role it plays in the wellbeing of individuals. Health also has distinctively public, collective value, much of which stems as much from its biological significance (its role in the functioning of the human organism) as from its normative significance. A pandemic like COVID-19
didn’t threaten countries merely by threatening to harm their citizens (by making them ill, and possibly killing them). It also threatened massive political destabilization. If people are acutely ill, they can’t go to work. If large numbers of people can’t go to work, supply chains and basic services are interrupted. Prices increase. Jobs are cut. Resources become scarcer. You’re a few short steps away from widespread chaos, no toilet paper, and a black market for hand sanitizer.

Health is inevitably political. You do not maintain your health on your own. You need basic goods and services, you need housing, you need healthcare. And the more we learn about health, the more we understand that you also need things such as education, socioeconomic security, community and supportive relationships, and freedom from constant social stressors.

Likewise, your own behavior affects the health of others—whether they like it or not. Measures such as mask-wearing and vaccination aren’t important, during an outbreak of infectious disease, merely to protect yourself. If you get vaccinated, you increase the risk that you spread disease to someone at higher risk of serious illness than you are—and so that person is affected by your choices. If you don’t vaccinate your kids as a “personal choice,” the kids they go to school with are at increased risk of disease outbreak. And so on.

Part of what matters to us when we talk about health is this public dimension, this political dimension. Health is not just something we view as a personal good; it’s also something we view as a public good, and as something that’s shaped by our public life.

4. The Distinctive Phenomenological Importance of Health

There is also a curiously distinctive phenomenological aspect to what we care about when we talk about health. This is, of course, related to the normative significance of health (people value feeling good and disvalue feeling bad), as well as the biological significance of health (specific physiological processes make you feel specific kinds of ways). But it isn’t fully captured by either. If the idea of catching COVID-19 weighed on your mind, you probably thought about existential issues such as the possibility of death, what would happen to your family if you were hospitalized and couldn’t see them, how you’d manage being out of work, and whether you’d recover your strength and functioning. But you probably also had, at the forefront of your mind, what it would feel like to be ill.

There are specific and immediately salient experiences we associate with loss of health—nausea, fatigue, lightheadedness, pain. Not all loss of health causes such sensations (an illness might be symptomless) and not all such sensations are caused by loss of health (you might feel a twinge of nausea when you’re embarrassed). But we associate specific ways of feeling with reduced health, and those distinctive experiences are part of what’s most salient to us when we talk about health.
Moreover, they’re salient to us in ways that go beyond either the biological or normative importance of health. If you get punched in the face, it’s going to hurt. A normally functioning nervous system will (absent a ton of adrenaline or other defeating factors) induce pain after a solid punch to the face. But how much it hurts, and how much the pain affects your functioning, isn’t something for which we can give a fully reductive physiological explanation. Maybe you’re a boxer, so the pain is expected, and voluntary, and something you’re very used to—you get punched in the face a lot. Maybe you’re into that kind of thing and getting punched in the face, in controlled and consensual circumstances, is your idea of good fun. Factors like these will affect how you feel, and how you function. Likewise, while we can all grant that causing someone pain is in general a way of harming them, there isn’t a neat correlation between amount of pain and reduction of wellbeing. The boxer might take not-so-secret pleasure in the pain of a good punch—it shows her toughness, it reminds her that she can take whatever’s coming her way, it makes her feel alive. Sensations like pain—how intense they are, how bad they are, how distressing they are, how they feel to us—are invariably subjective.

And yet they’re also a major part of what we care about when we talk about health. When told we have a disease, we want to know what it will feel like. Will it hurt? Will our bodies feel strange and alien? Will our limbs feel heavy and wooden? And while the answers might be different for everyone, nearly everyone is invested in those answers.

5. Ameliorative Skepticism

Spoiler alert: the main thesis of this book is that there is no coherent, unified account of health that can do all of this work for us. That is, there is nothing that can adequately explain all the ways in which health matters to us, at least in part because the ways that health matters to us often pull against each other. And there is no one thing in the world—no physiological state of the human organism, no natural resemblance class, no relationship between an organism and its environment—that we’re tracking when we talk about health. Our concept of health is confused and lacks internal consistency. We talk about health in many different, often incompatible ways, depending on the context and our goals.

But the upshot shouldn’t be error theory. Error theory is best suited to cases in which we have wholesale reference failure. “Witches” attempted to pick out women in league with the devil, and it emerged upon investigation that there are no such women. We shouldn’t then use “witch” to refer to single women who live with multiple cats, and say that this is in fact the thing we were tracking with our use of “witch” all along, just with some false beliefs attached. Rather, we should grant that there are no witches—nothing in the world plays the role that our beliefs and language required in order for there to be witches.
In contrast, the things we care about when we talk about health are very real, and obviously so. “Philosopher discovers there is no such thing as health” is a headline that borders on parody. We all experience fluctuations in health. We all care about health. We have all seen the devastation that can occur when health is lost.

We’re tracking real parts of the world when we talk about health. More specifically, we’re talking about parts of the world that are interwoven in distinctive ways, which is why we need to talk about health as a unified whole, rather than just focusing on the underlying factors that determine it. Moreover, health has an ingrained moral and political importance. People are not going to stop speaking about health, or caring about health, because philosophers point out tensions in our basic understanding of it.

The goal of this book is thus to argue for something I am calling ameliorative skepticism. Following the influential work of Sally Haslanger (2012a), there has been growing philosophical interest in the idea of ameliorative projects. There are many different ways of understanding the scope of ameliorative projects, but the basic idea is that some of our ways of speaking, concepts, and theories need to be altered to better suit our legitimate goals (especially political goals). There is, for example, probably no one thing that is the reference magnet of all our different ways of speaking and thinking about gender. But Haslanger argues that we can move from that observation to the question “what do we want gender to be?” That is, what is the best way of understanding gender given our moral and political goals?

What I hope to motivate over the course of this book, however, is the idea that sometimes the best route forward is the skeptical path. I am going to argue that there is no specific, coherent thing that health is; no specific theory or concept or definition of health that can do everything we require. But I also don’t think that there’s a conceptual fix for this—I don’t think there’s something better we should mean by “health,” or some more effective way we should understand what it means to be healthy. Rather, I think that health is an irretrievable mess, and yet it is also real, and something we need to theorize. We’re tracking real aspects of the world—many of which are entangled and interdependent on each other in complex ways, such that we need a theory of how they fit together—when we talk about health. But the things we care about are confusing, imprecise, and often in tension with each other.

Our best way forward, I’ll argue, is to accept this messiness, rather than try to clean it up or replace it with something neater. An ameliorative skepticism tries to explain why our understanding of health is a mess, and how it might still be useful and helpful to talk about health in spite of this inherent messiness.

6. In Praise of Messiness

As philosophers, we value clarity and consistency. We favor theories that are elegant, precise, and parsimonious. But part of taking social reality and the nature
of the social world seriously involves allowing that some of the ways the world is are that way because they have been shaped by the way we think and speak about them. And the way that we think and speak is often inconsistent, imprecise, or otherwise confused. It’s thus a mistake, I suggest, to expect that our theories of what social categories and social kinds are will yield simple and elegant results.

We can aim for precision, consistency, clarity, and parsimony in how we theorize about social categories such as health. But that is different than expecting that we should wind up with a theory that says that what we are theorizing about is precise, consistent, clear, or simple. Many things in the social world are a mess. They’re vague, they’re strange, they’re complicated. And that’s because we made them that way. To take seriously the idea that our thought and talk shapes social reality means taking seriously the idea that social reality might inherit some of the vices of how we think and speak.

To fully understand a socially embedded category such as health, we need to be able to theorize the ways in which health is messy. We can give clear and precise accounts of some categories—what it is for a number to be prime, what it is for an element to have an atomic weight. We can give clear and elegant explanations even of categories that admit of borderline cases (what it is to be a mammal, what it is to be conscious). We have a clear understanding of what these categories are, and what it takes to be a member, even if it’s not always clear whether those conditions are met.

Health, I’ll argue, doesn’t work like that. And part of a successful theory of health needs to explain the way in which health is a mess. Appreciating this messiness, rather than trying to eliminate it, will give us a better understanding of health—what it is and why it matters to us.

In pursuing this tactic of ameliorative skepticism, I hope to offer a model for messy theories of social reality. This book is about health specifically, but you can also read it as a kind of illustrative example case of a more general strategy for how we might approach the philosophy of a messy, fragmented, amorphous social world. That is, you can think of it as an attempt (no doubt imperfect) to model clean theorizing about messy reality.

### 7. A Reader’s Guide: Outline and Overview

This book can be divided into roughly three main sections. Section 1 (Chapter 1) gives a general overview of the current philosophical literature on health, Section 2 (Chapters 2–4) motivates some specific puzzles about the nature of health, and Section 3 (Chapters 5–6) uses those puzzles to motivate my own view.

We’ll begin (Chapter 1) by looking at extant theories of health and examining their shortcomings. This section lays the necessary groundwork for the argument I’m making—if I want to make the case that we need to take a new approach to
talking about health, I first need to argue that current approaches are lacking. (Be forewarned: it’s a strange and complicated literature to wade through, and if generating counter-examples isn’t where you philosophical joy lies, it’s okay to skim over this section.)

After looking at the places where extant views get into trouble, we’ll use those difficulties as a springboard toward a more general discussion (Chapters 2, 3, and 4) of some of the major puzzles for any adequate theory of health. The puzzles I’ll focus on are the relationship between health and wellbeing, the relationship between objective and subjective dimensions of health, and the relationship between health and disability.

And finally (Chapters 5 and 6), I’ll outline my own favored approach to theorizing health, given the complexities involved. These two chapters, taken together, outline the approach I’m calling ameliorative skepticism. And while they’re focused, in this context, on health specifically, I’m hopeful that the model of dealing with philosophical messiness—especially in the social world—can be of broader interest to a range of debates.

Here, then, is an overview in slightly more detail.

Chapter 1: Theories of Health

In this chapter, I survey the philosophical landscape of theories of health—accounts of what it means to be healthy, to have a disease, and so on. I aim to show that each major family of theories has significant problems, and that these problems can’t be solved simply by combining or slightly modifying those theories.

Chapter 2: Health and Wellbeing

One of the most perplexing aspects of health is its relationship to wellbeing. Contra some accounts, I argue that health and wellbeing are not the same thing, nor is good health a necessary condition of wellbeing. And yet the two are intimately related, much more so than many other things we value and that contribute to our wellbeing. I then examine the common claim that health is valuable because and insofar as it contributes to our wellbeing, and argue that this claim is also too simplistic. A plausible account of the relationship between health and wellbeing needs to be able to say that a person can have high levels of wellbeing but be in poor health (or be in good health but have poor wellbeing). It also, more strongly, needs to be able to say that someone who has lost health has lost something valuable, even if they still have a high quality of life. To argue this point, I make an analogy to grief and the relationship between grief and overall wellbeing.
Chapter 3: Health, Subjectivity, and Capability

Another perplexing aspect of health is its relationship to subjectivity and objectivity. “Objective” and “subjective” can mean many different things in different contexts, and in this chapter I’ll first try to specify what I’ll mean by them in this context. Then I’ll argue that they have a distinctive relationship to how we think about health. Loss of health can objectively impair our body’s functioning, and some have argued that the distinctive value of health comes from its role in preserving functional capability. But whether and to what extent a person’s functional capacity is limited by a health condition is partly determined by their subjective experience of (and reaction to) that health condition. And, more strongly, some aspects of our health—including those that are objectively important to our overall health and that can be important limitations on our ability to function, such as pain and fatigue—are inherently subjective. The net result is that subjective and objective aspects of health are often interdependent, and ignoring either (or the connections between them) leads to misjudgments about health. I argue that in order to fully understand the relationship between subjective and objective components of health, we need to develop an understanding not just of the social determinants of health but also of the social constituents of health.

Chapter 4: Health and Disability

In the third “it’s complicated” chapter, I examine the relationship between health and disability. Not all loss of health leads to disability, and disability can’t be understood or explained simply in terms of loss of health. And yet there is an intimate connection between being disabled and having reduced health. An increasingly common view within the disability rights community is that disability is a “mere difference”—it is something that makes you different but not something that (by itself) makes you worse off. A “mere-difference” view of health, however, looks both implausible and politically disastrous. This chapter attempts to find a way through this apparent tension. I appeal to the puzzle of the statue and the clay, arguing that the same physiological condition can appear to have a different character depending on whether it is viewed as a socially embedded phenomenon or a biomedical pathology. I then argue that David Lewis’ proposed solution to the statue/clay puzzle can be usefully adapted to the case of social kinds such as disability, arguably with fewer drawbacks than Lewis’ own application of it to material constitution.

As an Appendix to this chapter, I survey the extant empirical literature on the relationship between disability and quality of life/subjective wellbeing. The basic takeaway message of this survey is that asking “what is the relationship between disability and quality of life?” is in general not a very helpful question, since a wide
range of things can be meant by “disability,” which seem to have substantially different impacts on subjective wellbeing, at least according to current empirical evidence.

Chapter 5: Ameliorative Skepticism and the Nature of Health

In the final two chapters, I develop my own approach to theorizing health—based on the idea of ameliorative skepticism. I defend a characterization of health that falls between views such as error theory, fictionalism, and eliminativism, on the one hand, and metaphysical realism, on the other. Our understanding of health, I argue, is inherently unstable. And this is both because of how we conceptualize health and because of the underlying nature of the things we’re tracking when we talk about health. More strongly, health is, I suggest, a case in which tensions and confusions in our concepts might plausibly create tensions and confusions in social reality itself. If we take seriously the idea that social reality is in a significant way shaped by our collective norms, beliefs, and practices, and we also take seriously the idea that sometimes those norms, beliefs, and practices can be incomplete, confused, or inconsistent, then we should expect some aspects of social reality to inherit those confusions. Health, I argue, is one of those confusing places. We should reject error theory or eliminativism because the things we’re tracking when we talk about health are real, and entangled in such a way that we wouldn’t be better off replacing talk of health with talk of some more specific determinants or realizers. And yet, because of the nature of what we’re trying to capture, there is no stable, consistent account of health we can offer that will adequately answer the question “what is health?” or give us everything we need from a theory of health.

Chapter 6: Ameliorative Skepticism, Shifting Standards, and the Measure of Health

There is no one standard by which we can evaluate how healthy someone is, or whether one person is healthier than another. But this doesn’t mean we should abandon the idea of health or replace it with something more precise. We can best understand discussions of health, instead, as serving particular pragmatic interests in particular contexts. Whether someone is healthy—and how healthy they are—depends on why we care about health in that context, and what work we need our talk of health to do. To explain this idea, I appeal to Delia Graff Fara’s approach to vagueness. A salient feature of Fara’s model is that imprecision can sometimes be helpful to communication. And, likewise, in making things more precise, we can sometimes lose as much information as we gain, such that we’re not always making things better or clearer.
Using the insights of Fara’s model, I argue that often what matters most for particular evaluations or discussions of health is the salient role we need health to play in that context. On the view I’m defending, there are no deep or context-independent facts about what health is. It’s also possible for two people with different aims and goals to disagree with each other about health, and yet for neither to be making a mistake. And yet, I argue, this is compatible with health being something that’s real, valuable, and important, and compatible with there being facts about health.

The overall picture this book seeks to defend is one in which health is a mess—but an important, interesting, and useful mess. And the best way forward, I suggest, is to appreciate the ineradicable messiness rather than to precisify. Philosophical skepticism is often viewed as an entirely negative enterprise—it says why every answer is wrong, why every view has a counterexample, but provides no better alternatives. What I hope to model in this book is a way in which a kind of skepticism can be therapeutic rather than antagonistic. It’s helpful to be clear about why things are so confusing, and instructive to see why debates can be so intractable. Step one, as they say, is admitting you have a problem. And so I see this book as a loving exploration of philosophy’s health problems.
1
Theories of Health

1. Welcome to the Jungle

The philosopher W. V. Quine famously argued that good theories should resemble desert landscapes—bare, austere, uncomplicated. The philosophical literature on health is a jungle. And it’s a jungle where it can be very hard to see the forest for the trees (and the vines, and the quicksand, and the giant mosquitos). Nor is there a single debate here. Philosophers come at the question “what is health?” from various different literatures, including philosophy of science, bioethics, philosophy of wellbeing, and political philosophy.

So many traditions have a stake in this conversation because health is an issue that matters so broadly. It matters to public policy, to scientific practice, to ethical understanding, and to personal flourishing. And perhaps more distinctively, health is a place where the theory of a thing matters substantially to the practice of that thing. Philosophers might not be able to agree on the necessary and sufficient conditions for something being a table, and yet we can all sit down and eat our dinner just fine—theoretical questions notwithstanding. With health, though, we cannot separate theory and practice quite so easily. Your doctor can, of course, prescribe antibiotics for your infection or monitor your blood pressure without giving much thought to the question “what is health?.” But health is, invariably, something we need to quantify and measure. We need to assess whether a given health intervention is effective. We need to compare the health of different groups and different populations. And so on. Which invariably leads down the path of finding a workable answer to the question “what is health?.”¹

In what follows, I attempt a big-picture overview of the extant philosophical literature on health. I will, in doing this, by no means be able to address all approaches or discuss all views, nor is an exhaustive literature survey the goal of this chapter. What I am attempting, instead, is to motivate the idea that it is hard—surprisingly hard—to give anything like an adequate, informative answer to the question “what is health?.” Most extant approaches have obvious virtues but also serious—and on my view irremediable—vices. To make this case, I’m going to examine the broad landscape of views: the ways in which philosophers have

¹ That’s not to say that a successful measure of health must exactly mimic our best philosophical theory of health. But theories of health inform which measures of health we find most plausible, and different measures of health provide strikingly different results.
tended to approach the question “what is health?” and the kinds of answers they have tended to give. My aim, in doing this, is skeptical. I want to show that the current approach to the question “what is health?”—in which we attempt to define or give necessary and sufficient conditions for health—is doomed to failure.

In order to motivate this skeptical project, the discussion in this chapter explores pretty far into the weeds of some theories of health. This is, after all, a jungle. If you’re like me and you like getting into the weeds, come along for the ride. But if theory-chopping details don’t hold your interest, it’s fine to take the moral of this section to be ‘it’s complicated’ and go straight to Chapter 2.

Much of the current dialectic surrounding philosophical theories of health is, in many ways, a long series of responses to the attempt to say that health (or, more specifically, pathology/disease) is something purely naturalistic or biological—something that we can explain without reference to our values, our feelings, our norms, or our social conventions. A series of views—mostly based around the idea of normal species functioning—attempt to explain health in these terms. So we’ll first look at such views, the key problems they run into, and some of the main options they offer for addressing these problems. We’ll look, that is, at the best case to be made for naturalistic theories of health.

Finding such theories wanting, however, many in this debate have argued that we have to add something normative or evaluative in order to explain health. As we’ll see, though, “add something normative” doesn’t give us a recipe for turning water into wine. There are many different places we could look for the normative secret sauce that will give us a satisfactory theory of health, and each of them, I’ll argue, faces problems as significant as those encountered by naturalistic approaches. The result is a dialectic littered with views that seem to be getting at something interesting and something significant about health, but failing—in serious and substantial ways—to actually provide a workable theory of health.

Here’s the gameplan. After a methodological overview (section 1), I’ll begin with a deep dive into species function-based accounts (section 2). The appeal of these accounts is that they explain health in biological terms—making it an appropriate source of study and discovery for the natural sciences. But as we’ll see, serious worries arise about their explanatory adequacy. From there, I examine attempts to fill this explanatory gap, looking first at views that attempt to explain what health is by appealing to wellbeing (section 3), then at views that appeal to a distinctive type of phenomenological experience (section 4), and then at views that appeal to social norms and conventions (section 5). Finally, I consider so-called “hybrid” views, which attempt to combine various aspects of other views to offer a more explanatorily rich account (section 6).

If my analysis is correct, then the reason that each of these families of views gets into so much trouble isn’t that we need to tweak one of them until it works. Rather, it’s that they’re engaged in an explanatory project that, by its nature, isn’t going to work.
1.1 Targets of Analysis

It’s important to note from the outset that there are many different debates, and different philosophical conversations, that can be seen as attempting to answer the question “what is health?” There is not a single body of literature here or a single shared set of terms or methodological assumptions.

Given how divergent they can be in approaches and assumptions, it might be tempting to suggest that the various philosophical attempts to explain what health is are simply talking past each other.² They don’t mean the same thing by “health,” and they aren’t engaged in the same project. But I think this would be a mistake. Philosophical theories of health start from a wide range of presuppositions, differ on terminology, and often lack a shared literature. They’re relatively united, though, in the basic phenomena that they’re trying to explain.

To begin with, they have the same basic constraints of extensional adequacy and agree on most paradigm cases. Someone with stage 4 liver cancer is not healthy—indeed, they are very unhealthy. Someone with moderate coronary artery disease has reduced health because of that condition, but their health is not as compromised as the person with liver cancer. While there will be debates about some famous test cases that present puzzles for specific models, philosophical theories of health tend to converge in judgments about such paradigm cases. More strongly, they take themselves to be constrained by such paradigm cases. The naturalist and the phenomenologist alike, for example—although they differ dramatically in methodology, and even in what they take the primary target of their analysis to be—agree that amyotrophic lateral sclerosis (ALS) compromises health, and that any theory that delivered the result that someone with ALS was fully healthy would therefore be an unsuccessful theory.

More substantially, I think that we can see commonality in theories of health by looking at what work these theories are trying to do. Philosophical theories of health diverge in their methodological approaches and in the concepts they employ. But the distinctive roles we need health to play still constrain the success of any such theory. As discussed in the Introduction, there are distinctive ways that health matters to us and distinctive work we need an answer to the question “what is health?” to do for us. We can thus see any theory of health as being constrained by its ability to ground explanations of:

² For an in-depth argument that such theorists are, in fact, talking past each other, see especially Plutynski (2018). I’m very sympathetic to Plutynski’s view, since we agree—as I’ll argue in defending my own view in Chapter 6—that what matters most are our aims and purposes in talking about health, and these can shift dramatically depending on the context. I don’t think these differences in aims and purposes, however, are sufficient to make it the case that theorists are in fact trying to describe different things when giving a theory of health—I just think this variation is a feature of the inherently slippery thing all parties are trying to explain.
(1) The distinctive biological importance of health
(2) The distinctive normative importance of health
(3) The distinctive political importance of health
(4) The distinctive phenomenological importance of health.

Any successful theory of health needs to be able to explain the biological significance of health—why our objective functional status as organisms is directly related to our health; why compromise in health can often lead to objective loss of functional capacity (up to and including death); why conditions that affect our health can be studied by epidemiologists, geneticists, virologists, and so on. A theory that renders health entirely subjective, or entirely orthogonal to the investigation of the natural sciences, would simply change the subject. And in doing so it would fail to engage with much of what is obviously relevant and obviously matters to us about our health. But an answer to the question “what is health?” also needs to be able to ground the normative significance of health—why health is something that is valuable to us, why reduction is health is often a distinctive form of harm, why health has a close relationship to wellbeing, and so on. A theory of health that says that health is something that is biologically significant but not something that has any particular connection to what we care about, to what harms or benefits us, or to our wellbeing has again simply changed the subject.

Likewise, any successful theory of health needs to provide grounds for the distinctive political and the distinctive phenomenological importance of health. Part of what we care about when we talk about health is the public role that health plays—both in terms of the social impacts that loss of health can have and in terms of the distinctive political implications of health inequalities. A theory of health that renders health entirely individual or personal—with no connection to public impact—would be a non-starter. Similarly, part of what we care about when we talk about health is our own subjective experience—how we feel, how we experience our minds and bodies, how much pain or distress we undergo. And we want some account of the connection between these experiences and our health.

To be clear, theories of health don’t need to directly engage these questions. A purely naturalistic theory of health, for example, won’t talk about our values or our political goals, and that’s not an obvious mark against it. But it’s a constraint on the success of any account of what health is that it can serve as an adequate grounding for the distinctive roles that health occupies.

It’s insofar as they’re addressing that same basic issue that they share common constraints. An epidemiologist, a hospitalist, and a public health policy wonk will have very different approaches and perspectives in thinking about health, but when they come together on a panel to discuss what COVID-19 mitigation measures will be best for overall health outcomes, we don’t think their differing approaches and methodologies mean they’re talking past each other or engaged in
different conversations. Rather, they’re all interested in the same core issues, but coming at them from slightly different directions. Similarly, I’m suggesting that what unifies—and constrains the success of—the various philosophical theories of health is the subject matter. Insofar as they’re all trying to explain what health is, they’re all trying to address the same basic issue, though from different perspectives and with different presuppositions about what’s needed to tackle the issue. Likewise, insofar as they’re all trying to explain what health is, they’re constrained by the extent to which they can account for the distinctive biological, normative, political, and phenomenological importance of health.

1.2 Terminology and Methodology

Before proceeding further, let’s work through a few more preliminary clarifications. First and perhaps most importantly, as already noted, this discussion is by no means an exhaustive literature survey. I’m not intending to offer a completionist discussion of every attempt to explain the nature of health. Rather, I’m attempting to give an overview of the major styles of view available, and to discuss (what I take to be) the most influential theories. My aim is to show, in broad strokes, how the various styles of view get into trouble with at least some aspects of the work we need a theory of health to do.

In doing this, I will try, whenever possible, to offer objections that can be seen as objections within the framework of the view in question. It’s not a particularly compelling objection to a naturalistic view that such a view doesn’t appeal to ‘lived experienced’ in characterizing health; nor is it a particularly interesting objection to a phenomenological view that it doesn’t present a theory of illness that would be useful to epidemiologists. That’s not the project either approach is engaged in—even if you think that ultimately it’s the project they should be engaged in. So where possible, I will try to offer objections to the views under discussion that can be seen as objections by the lights of people who hold and defend those views.

This means that, throughout the subsequent discussion, there will be some slight shifts in terminology as well as in focus. I’m going to highlight a few of the major ones here—though readers should note that this is mostly to explain how I’ll be using these terms as I discuss these views, and I don’t take all that much to hang on any of these distinctions.

For some theories, the primary project is to explain what health is, and then to characterize ways in which we can have lost or reduced health. For others, it’s to explain what disease is, and then to understand health as the relative absence of disease. I’ll call the former projects positive theories of health and the latter projects negative theories of health. These two approaches can lead to interestingly different conceptions of health. Positive theories of health try to give some sort of specific criteria for or analysis of being healthy, over and above the absence of
pathology. For negative theories, you’re healthy just in case there’s nothing wrong with you. The only way you can be healthy to greater or lesser degrees, on these views, is how substantially or seriously you are affected by pathology.

It’s also worth clarifying what we’re trying to characterize when we talk about what detracts from health. Some authors use the term “disease,” but disease is a relatively specific concept, at least as it’s employed in biomedical contexts. Lots of things can detract from health that are not, strictly speaking, diseases—if you are poisoned, for example, you will be in poor health, but you won’t thereby have a disease, at least in the usual understanding of “disease.”³ Some opt for “illness” instead—you don’t have a disease if you’re poisoned but you’re most definitely ill. Again, though, “illness” is probably too restrictive. Many things that affect health—injuries, most especially—aren’t well classified as illnesses. And so for what follows I’m going to use the expansive term “pathology”—which can be used to mean, roughly, any deviation from healthy condition, encompassing diseases, injuries, malformations, and similar.⁴ Thus, as I understand it, the first major divide in theories of health is between theories that are trying to give an account of pathology and theories that are trying to give an account of health, where health is understood as something more substantial than a relative absence of pathology.⁵

The second main divide in theories of health is between those that seek to give a purely non-evaluative or descriptive account of health and those that maintain that we need at least some normative or evaluative concepts to explain what health is. Let’s call the former non-evaluative theories of health and the latter evaluative theories of health. I am not foolhardy enough to attempt to define what it takes for a theory to count as evaluative (or non-evaluative). In the literature on health, non-evaluative theories are often described as those that appeal only to things that are within the remit of the biomedical sciences. But I think it’s a mistake to assume that the practice of science—especially social and biomedical science—is value-free. For the purposes here, I’ll simply assume that normatively laden concepts are things like: good, better, right, beneficial, harmful, and so on. That is, they’re concepts that are explicitly evaluative rather than descriptive. As I’m using the terms, a theory of health succeeds in being non-evaluative if it doesn’t need to appeal—explicitly or implicitly—to normative concepts to explain what health is.

³ See Kingma (2010) and Hausman (2011) for discussion.
⁴ Unsurprisingly, the term “disability” is often included alongside illness, disease, and pathology when theorizing health, but as I’ll explain in Chapter 4, I think the relationship between health and disability is far more complicated. So I’m going to omit discussion of disability specifically for the remainder of this chapter, and focus on it in more detail later. I’ll be discussing plenty of physical conditions that give rise to disability, but not disability per se.
⁵ One further clarification to make is that I am using the term ‘pathology’ in a morally neutral way. Something might be pathological in the biomedical sense without being bad or harmful to the overall wellbeing of the person who has it, for example. We’ll discuss (Chapters 2 and 4) the relationship between health and wellbeing in far more detail later.