Physical Disability and Well-Being

By Thomas Crawley

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Introduction

It is commonly assumed that disability makes life worse. Both laypersons and philosophers have typically taken disability to be a significant detriment to well-being. Non-disabled people estimate the well-being of disabled people to be extremely low (Amundson, 2010: 374) and philosophers often point to those with disabilities as archetypal examples of people who can never achieve a good level of well-being, or one similar to that of non-disabled people. For example, Sen (1973: 16-17) asks us to imagine 'a case where a person *A* derives exactly twice as much utility as person *B* from any given level of income, say, because *B* has some handicap, e.g., being a cripple'. Similarly, Dworkin (1981: 299-300) likens disabled people to 'the wretched' and criticises Equality of Welfare views because they licence almost unlimited redistribution to disabled people to bring them as close as possible to the well-being level of non-disabled people (Stein, 2002: 1-2). And Nagel asks us to consider a person with a painful disability who, with special education and healthcare, will not achieve happiness and will only be 'less miserable' (Nagel, 1979: 124).

This common view of disability has recently been challenged. Beginning with the Social Model of disability in the 1970s, disabled people and disability rights campaigners have increasingly rejected the so-called 'Bad-Difference View' (BDV) of disability. Movements like disability rights, disability pride and Deaf Gain challenge the common assumption that disability is bad for well-being.[1] Often, it is argued (along with the Social Model) that disability and the disadvantages associated with it are caused by unjust social practices. For example, one disability rights group famously said that '[d]isability is something imposed on top of our impairments, by the way we are unnecessarily isolated and excluded from full participation in society' (1975 Union of the Physically Impaired Against Segregation statement reprinted in Oliver, 2004: 19). More recently, philosophical work has defended similar claims. In influential work, Barnes (e.g. 2009a, 2016b) rejects the BDV in favour of the so-called 'Mere-Difference View' (MDV) of disability. In short, she argues that the MDV is true because disability is akin to gender and race in that, if we discount the effects of unjust discrimination, disability does not make someone worse off.

So, is physical disability a harm or – in the absence of discrimination – is it merely a way of being different?[2] Answering this question will be my focus in this thesis.[3] Not only is it

[1] For definitions of each disability mentioned in this thesis, see the appendix containing a glossary of disabilities (page 192).
[2] It's worth mentioning at the outset that one might endorse a Good-Difference View (GDV) of disability, which says (roughly) that disability improves well-being. I know of no one who endorses the GDV, but it takes up an important part of logical space.
[3] In chapter 2, I explain why I restrict my scope to physical disabilities.

independently interesting, this question is also plausibly relevant to many important normative debates and real-world, applied issues. For example, some take the connection between disability and well-being to be relevant to questions concerning what justice requires. Quality Adjusted Life Years (QALYs) are often taken to be an appropriate metric for health-based utility. Health-based utility scores are used to determine the just division of healthcare resources (Franklin, 2017: 65). The idea is that we should distribute resources such that they produce the most utility. QALYs take the additional number of years a given healthcare allocation will produce, and the quality of those years, as relevant to determining its utility. Clearly, then, the quality of disabled people's lives is relevant to which allocations produce the most QALYs and, as such, to which healthcare allocations are viewed as just. Other relevant debates include those about how appropriate it is to pity or 'feel sorry for' disabled people (cf. Campbell and Stramondo, 2017: 171-74), those concerning public policy such as whether we ought to prioritise environmental alterations that reduce the negative impact of disability (Amundson, 2010: 376-377) and – perhaps most prominently – those concerning the moral status of prenatal selection for disability and non-disability.[4] Those who think that disability is a harm sometimes claim that allowing or selecting for disabled births is to 'increase unnecessarily the amount of net suffering or harm in the world' (Harris, 1992: 94) or that we should prevent disabled births 'for the sake of less overall suffering and limited opportunity in the world' (Buchanan *et al.*, 2000: 251). Unsurprisingly, those who think that disability is merely a way of being different oppose measures to prevent disabled births as, to them, these seem impermissibly similar to preventing gay, female or black births (cf. Barnes, 2014).[5]

Although these normative questions are extremely interesting, I will not be exploring them. The debate between the MDV and the BDV is so new and underdeveloped that significant discussion is needed to properly characterise the views before we can set about arguing for either. Moreover, arguments for and against each view rarely have been subjected to rigorous philosophical scrutiny.[6] As such, significant groundwork must be completed before we can set about examining in any detail the normative implications of the relationship between disability and well-being. This groundwork will be my focus. This thesis will offer a sustained and detailed examination of the debate between the MDV and BDV. I will concentrate on characterising the best understandings of the views, explaining how to determine their truth values, examining prominent arguments for both, presenting arguments of my own, and bringing

[4] For examples on both sides of this debate, see (Anstey, 2008; McMahan, 2005; Barker and Wilson, 2019).
[5] For discussion of the moral status of selecting for disability, see (Anstey, 2002; Spriggs, 2002).
[6] Perhaps one exception is the literature on causing and preventing disability.

this all together to present a defeasible argument for a BDV of physical disabilities. This work is important both in itself and because it will (hopefully) inform the normative debates that follow, perhaps also having ramifications for real-world policies and practices.

I will examine the relationship between physical disability and well-being using philosophical methods. Disability and well-being are established philosophical topics. However, questions about the well-being of different groups are in part empirical, and there might be other methods of answering them, such as through empirical investigation. I will not argue that philosophical investigation is the best way of answering these questions, in general. Nor do I take what I say to be the definitive word on the nature of the connection between physical disability and well-being. My aim is to contribute to this ongoing debate, hopefully furthering the discussion.

This thesis runs as follows. In chapter 1, I discuss how I understand disability, advocating a Hybrid Account (cf. Shakespeare, 2013: 74-75). In chapter 2, I argue that the best understandings of the views are that they make probabilistic claims about the all things considered well-being value of disability compared to non-disability in the nearest non-disablist worlds. I also discuss my reasons for restricting my enquiry to physical disabilities and mention some worries for those conducting enquiries into disability as a broad class. In chapter 3, I present a methodology for making reasonable judgements about the average well-being prospects of members of large groups in idealised worlds. In chapter 4, I examine Barnes' influential arguments on disability and well-being. I argue, first, that she rejects an uncharitable interpretation of the BDV. As such, she misses the opportunity to attack the most plausible version. Next, I explore Barnes' Testimony Argument for her version of the MDV, arguing that an analogous argument cannot establish my preferred version. In chapter 5, I explore an intuitive argument for the BDV – the Options Argument, which says that disability is bad for well-being to the extent that it reduces valuable options. I defend the Options Argument against a common reply and argue that it appears to be sound. In chapter 6, I discuss the relationship between technology and the well-being of disabled people, presenting a novel technology-based objection to the MDV – the Frivolous Funding Objection – and offering reasons for pessimism that the most promising MDV reply succeeds. Finally, in chapter 7, I bring my discussion to a close by presenting a defeasible argument for a BDV of physical disabilities and suggesting a new, more useful and more respectful approach that the debate might take.

Chapter 1 – Understanding Disability

To properly investigate the connection between disability and well-being, I must first characterise the subject matter of this debate. This involves settling on an understanding of disability.[7] There are multiple ongoing debates concerning the best definition of *disability* that I cannot adequately discuss here. I thus confine myself in this chapter to identifying a good way of understanding disability for those (including myself) who want to investigate the connection between disability and well-being, arguing that the Hybrid Account of disability (as I call it) is good to use in this context. However, I do not argue that the Hybrid Account is impervious to objections nor that it is *overall* the best understanding of disability. I present it as a working definition that is sufficiently descriptively adequate and allows me to investigate the relevant issues. Ultimately, though, nothing major turns on this specific account of disability. So long as an account satisfies two important desiderata that are presented below, it will be satisfactory for my purposes. Even so, a somewhat detailed discussion of the nature of disability is helpful, as it facilitates presentation of useful things that are relevant to later chapters, such as distinctions between impairment and disability, and medical and social disadvantages.

In §1.1, I discuss two prominent models of disability: the Medical Model and the Social Model. In §1.2, I present two important desiderata for an account of disability used when adjudicating the debate between the MDV and BDV. In §1.3, I present the Hybrid Account of disability, argue that it adequately satisfies these desiderata, and discuss my preferred solutions to two potential problems with it. Finally, in §1.4, I explain why I do not use Barnes' Solidarity Account of disability, which she uses in a prominent investigation of the connection between disability and well-being.

1.1 – Two Models of Disability

The best definition of *disability* is hotly debated.[8] The bulk of the debate has historically taken place around two models of disability. The *Medical Model* understands disability as a characteristic of – or a problem with – the bodies of particular individuals (Wasserman *et al.*, 2016: §2). This characteristic is typically identified as an *impairment*, which is often understood as a negative

[7] I use 'model', 'definition', 'theory', 'understanding' and 'account' of disability interchangeably.
[8] I use italics to indicate when I talk of the concept of *disability* (and for emphasis in other cases). In this chapter, I am proposing a definition of *disability* in the hope that this sheds light on the phenomenon of disability. To do so, I will be primarily discussing the nature of the phenomenon.

deviation from species-typical functioning (e.g. Boorse, 1977: 555).[9] On the Medical Model, the limitations or disadvantages faced by disabled people are understood as arising solely from intrinsic features of their impairments. That is, the fact that a paraplegic person cannot access a given public accommodation is thought, on the Medical Model, to result solely from this person's inability to move their legs. The best response to these disadvantages – according to this model – is thus medical intervention or, in normative language, to 'cure' disability. The Medical Model is not seriously defended, but is said to be 'often adopted unreflectively by health care professionals, bioethicists, and philosophers who ignore or underestimate the contribution of social and other environmental factors to the limitations faced by people with disabilities' (Wasserman *et al.*, 2016: §2).

Something like the Medical Model was likely the accepted understanding of disability until the 1970s. It was then that the *Social Model* began to emerge. The Social Model defines disability, somewhat roughly, as the social oppression of people with impairments (Wasserman *et al.*, 2016: §2). The first exposition of the Social Model came in The Fundamental Principles of Disability by the Union of the Physically Impaired Against Segregation (UPIAS):

> In our view it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society (UPIAS statement reprinted in Oliver (2004: 19)).

On the Social Model, the disadvantages or limitations of disability are understood as resulting solely from society's unfair treatment of disabled people (Shakespeare and Watson, 2002: 10; Terzi, 2004: 143; Anastasiou and Kauffman, 2013: 443). This follows from understanding disability as an entirely social phenomenon that has 'nothing to do with the body' (Oliver, 1996: 35). A Social Model advocate, if presented with the example of a wheelchair user who cannot access some public accommodations, would thus argue that the sole cause of this disadvantage is society's failure to provide adequate wheelchair access and, further, that this failure constitutes an injustice against disabled people. That is, the Social Model doesn't merely imply that the disadvantages of disability are caused by social practices, but also that these practices ought not to be the way that they are.

The Social Model was the first view similar in spirit to the MDV. In fact, it seems appropriate to call it the first version of the MDV, for the Social Model raised the ideas that i)

[9] For criticism of this understanding, see Amundson (2000) and Kingma (2010).

the conditions that we call disabilities are not themselves bad for well-being, and ii) the badness associated with these conditions is caused by unjust social factors. Both (i) and (ii) are central tenets of the MDV, as we will see in chapter 2. It's worth noting, though, that, strictly speaking, disability is bad for well-being, according to the Social Model, as disability is understood, not as a condition, but as social oppression that imposes disadvantage.[10] However, *impairments* – or the bodily conditions which are the basis of the social oppression – are neutral for well-being on the Social Model. As such, despite the oddity of defining disability as a kind of oppression, it appears reasonable to understand the Social Model as the first version of the MDV. Just like the MDV, it says that the relevant bodily conditions are neutral for well-being and that any disadvantage resulting from these conditions that causes a well-being deficit in disabled people is caused by unjust social practices. (This will become clearer in chapter 2.)

The Medical and Social Models represent two ends of a spectrum and, clearly, neither is correct. The Medical Model is not genuinely defended by any philosophers. It's obviously false, since at least some of the limitations faced by disabled people are not *solely* caused by intrinsic features of impairments. Obvious examples are the stigma associated with disability and the preferential hiring of non-disabled employees. Both things disadvantage disabled people and are (at least somewhat, perhaps completely) social in nature. In fact, almost all limitations faced by disabled people are *somewhat* social. After all, these limitations are embedded in a social world. The social landscape will therefore almost always have a role in causing disability limitations, whether this is because of people's attitudes towards disability, the design of the built environment or something else.[11] We can see that this is true because we can always imagine some social arrangement (however fantastical) where a given impairment is not disadvantageous, or is advantageous, to the person who has it. For example, Deafness would be an advantage in a world of excessive disturbing noise where people communicate exclusively through visual means.

An equally important point is that – contra the Social Model – the nature of the limitations faced by disabled people is not *entirely* social either. Many disabilities involve physical pain, fatigue or discomfort. These are not solely caused by social oppression. Neither is the inability of wheelchair users to traverse uneven terrains (like mountains or bogs) or the inability of Blind people to read non-verbal cues (French, 1993).[12] Thomas (2010: 37) introduces the term

[10] I thank Zach Hoskins for bringing this to my attention.
[11] This is why Social Model advocates must maintain that disability limitations are caused by *unjust* social arrangements, not merely by social arrangements.
[12] Although the fact that non-verbal cues are an important means of communication is social, intrinsic features of Blindness cause one to be unable to read these cues, and it is not plausible that we ought to stop communicating non-verbally.

'impairment effects' to capture things like these – which she understands as 'the direct and unavoidable impacts that impairments (physical, sensory, intellectual) have on individuals' embodied functioning in the social world'. By 'direct and unavoidable' she means that these disadvantages would remain even if social oppression of disabled people were eradicated. If disadvantaging impairment effects are part of the experience of disability, which it seems that they are (Shakespeare, 2006: 199), then the Social Model is false.[13] The apparent falsity of the Social Model has led some (e.g. Shakespeare, 2006: 198-199) to suggest that, while it is politically useful, it is not a plausible candidate understanding of disability.[14] Certainly, the model was politically successful in liberating disabled people by introducing the idea that social factors play an important role in shaping disabled people's experience (Shakespeare, 2006: 198-199).

The Social Model has also been criticised on grounds other than its failure to account for impairment effects. In particular, Morris (1991: 10) says that understanding disability as entirely social obscures important aspects of disabled experience:

> While environmental barriers and social attitudes are a crucial part of our experience of disability – and do indeed disable us – to suggest that this is all there is, is to deny the personal experience of physical and intellectual restrictions, of illness, of the fear of dying… [Social Models] present impairment as irrelevant, neutral and, sometimes, positive, but never, ever as the quandary it really is.[15]

In light of these points, most philosophers now accept that disability involves a medical characteristic (a physical or mental impairment) *and* a limitation associated with that characteristic which is always or nearly always somewhat social in nature (Wasserman *et al.*, 2016: §1; Putnam *et al.*, 2019: §2). To me, this seems the sensible way to go and, as such, I will utilise an account of this nature.

Before moving on, it is worth saying a little more about how the Social and Medical Models relate to the MDV and BDV. As I have presented it, the Social Model entails the MDV; it says that disability (or, more carefully, impairment) is neutral for well-being and that all the disadvantages of it are caused by unjust oppression. Likewise, as I have presented it, the Medical Model seems to imply the BDV; it says that disability is a 'problem with' disabled bodies – which

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[13] Note that Thomas (e.g. 2004: 29) attempts to accommodate impairment effects within the Social Model. Her modified view is similar to the one that I advocate below.

[14] Wasserman *et al.* (2016: §2) also suggest that these extreme forms of the models primarily serve to map potential relationships between impairment and disadvantage. Even so, discussing them is useful as it helps bring to light important issues, concepts and distinctions.

[15] See also Terzi (2004), Anastasiou and Kauffman (2013) and Shakespeare and Watson (2002).

implies that disability is negative with respect to well-being – and rejects the idea that disadvantages of disability are unjust and socially imposed: on this model, they are caused entirely by the impairment. However, acceptance of the MDV doesn't imply acceptance of the Social Model; one might think that disability is neutral for well-being without accepting that the nature of disability is entirely social, that impairments are neutral for well-being or that to be disabled is to be oppressed in the right kind of way.[16] Nor does acceptance of the BDV imply acceptance of the Medical Model; one can think that disability is bad for well-being while accepting that the nature of disability is somewhat social and that many disadvantages of disability are imposed by unjust social practices.

It's also worth mentioning that I have discussed strong versions of the models, which respectively identify the nature of disability as *entirely* medical or social. However, weaker versions exist, which respectively state that the disadvantages of disability are caused *primarily* by medical or social factors (Wasserman *et al.*, 2016: §2). These weaker versions also do not entail the MDV or the BDV.[17]

1.2 – My Desiderata for a Model of Disability

Before presenting the model of disability that I will use, I will present two important desiderata for a model used when adjudicating the debate between the MDV and BDV.[18] These desiderata sit alongside more general and familiar theoretical virtues such as internal consistency and simplicity.

i) The model must not preclude meaningful investigation into the relationship between disability and well-being.

The folk understanding of *disability* has descriptive and evaluative elements (Kahane and Savulescu, 2009: 17). The descriptive element outlines the conditions that a person must meet to count as disabled. Being disabled is also most often taken to be a bad thing, a misfortune befalling the disabled person. Some (e.g. Kahane and Savulescu, 2009; Harris, 2001) build this evaluative element into their accounts of disability. These accounts say, roughly, that disability is a condition that harms the individual or reduces their well-being. A model used in this context

[16] An MDV advocate could accept that impairment on its own is bad for well-being but argue that justice (or non-discrimination) requires social compensations that mitigate this negative (compare §2.2).
[17] I have not considered these views, as the primary cause of disability disadvantages is not particularly important for my purposes.
[18] I share desiderata (i) with Barnes (2016b: 10-13).

must not define disability as negative for well-being, as this would render the BDV trivially true, preventing any meaningful investigation into whether it is. Our model also must not entail that the MDV is trivially true.[19] It must maintain, as far as is possible, the descriptive elements of *disability* while minimising evaluative elements.

ii) The model should be descriptively adequate.

People are competent in talking and thinking using the concept of *disability*. We say things like 'Bob is disabled' and 'if you are unhealthy during pregnancy, your baby has increased chances of being disabled'. Call the pre-theoretic concept used in statements like these the ordinary concept of *disability*. We want a theory that produces a concept that is recognisable as, or at least appropriately similar to, our ordinary concept of *disability*, because we do not want to alter the intended subject matter of this debate. That is, we want the discussion to be about the connection between disability (as opposed to some other phenomenon) and well-being.

What is the descriptive content of our ordinary concept of *disability*? I'll briefly discuss four more intuitively important, but normatively neutral, elements. First, it is part of our ordinary concept of *disability* that it involves some limitation or loss of ability. After all, disability is intuitively, first and foremost, a dis-*ability* (Gregory, forthcoming; Schramme, 2013: 73). Second, a successful model should capture the common intuition that sometimes people with a condition *C* are disabled in one context but not disabled in others. That is, for example, it should be able to capture the intuition that someone who is severely near-sighted would have been disabled before glasses were readily available, but is not disabled in modern day western societies where they are. More generally, it is a familiar thought that whether one is disabled is contingent upon various contextual factors and an account of disability should respect this thought.

Third, to be disabled is intuitively to be in some way non-standard when compared to the appropriate population. One is not disabled *simpliciter*; one is disabled relative to a given reference class. We determine an individual's reference class by looking at features such as their species, life-stage and sex. New-born humans have an extremely low level of eyesight between 20/200 and 20/400.[20] Even so, we would not class new-born humans as disabled, nor do we class bats or moles as disabled because they are Blind (cf. Campbell, Nyholm and Walter, forthcoming). In contrast, we do class adult humans with eyesight equivalent to that of a bat or a new-born as disabled. When we say that '*S* is disabled', then, we are uttering an elliptical sentence that must be fleshed out with reference to the appropriate class. Sandy, who cannot see, is a disabled *adult*

[19] We'll see later that using the Social Model does just this.
[20] https://kidshealth.org/en/parents/sensenewborn.html (accessed 25/05/20).

human woman at least in part because her abilities are abnormal for an adult human woman.[21] Likewise, if the majority of humans were Deaf, then Deafness would not be classed as a disability amongst humans. It is thus part of our ordinary concept of *disability* that disabled people's bodies or abilities must be in some way non-standard when compared to the appropriate reference class.

How do we determine an individual's appropriate reference class? In principle, we might do in various ways, and the class chosen will affect whether someone counts as disabled. For example, perhaps a new-born infant who cannot see is not disabled relative to other new-borns but is disabled when compared to humans generally. And perhaps the single-leg amputee is disabled when compared to adult humans but not when compared to Quadriplegic people. I won't argue for a principled method of determining appropriate reference classes. A pragmatic approach is to let intuition guide us. That is, we can use our robust intuitions about what conditions count as disabilities to guide our choice of reference classes. Given our desire for descriptive adequacy, we want adult human amputees to count as disabled, so this suggests that the appropriate reference class for them is more likely adult humans than adult Quadriplegic people. Similarly, we don't want Blind new-borns to count as disabled, which gives us a clue that the best reference class in this case is likely other new-born babies rather than adult humans. I'll assume throughout this thesis that there are reference classes that provide the right results in each case, and that these classes remain fixed. That is, I won't consider the implications of fluctuating reference classes. I believe that this is an acceptable assumption, given that I am not attempting to define disability from a highly theoretical perspective; I am merely trying to understand it in a plausible way that allows me to consider relevant issues for the right kinds of conditions.

Fourth, as discussed in §1.1, the nature of disability clearly is not entirely medical or entirely social. Whether one has a disability is something to do with what one's body is like (Barnes, 2016b: 37, 47; Howard and Aas, 2018: 1130) but this is not the *entire story*; social elements matter too. Respecting this element of descriptive adequacy is important not only because we want our model to accurately reflect reality, but also because leaving it open that the nature of disability is partly medical and partly social allows questions to be asked about how both intrinsic features of bodies (impairments) and social factors (injustice; oppression) affect

[21] This is not to say that her abnormal abilities are the *entire reason* why she is disabled. It will become clear below that I think that more than atypical physiology is needed to be disabled.

disabled people's well-being. Our definition of disability shouldn't prevent us from asking these important questions.

So, an account of disability must meet at least these four conditions to be descriptively adequate. One good way of testing an account's descriptive adequacy is to consider whether it delivers the correct verdicts on paradigm cases (cf. Barnes, 2016b: 10). There are paradigm cases of disability (Blindness, Deafness, Paraplegia etc.) and paradigm cases of non-disability (average intelligence, being a woman, not being an astronaut etc.). As far as is possible, we want our model to imply that paradigm cases of disability are, in fact, disabilities and that paradigm cases of non-disability are not. If a model implies counterintuitive things about many paradigm cases, then this indicates that it is not sufficiently descriptively adequate and, thus, that we haven't really identified a model of disability at all, but of something else.

1.3 – The Hybrid Account of Disability

I have set out the desiderata that an account of disability used in this context should satisfy. In this section, I present the model of disability that I will use and argue that it adequately satisfies these desiderata. I then discuss how it fares when dealing with hard cases.

The model of disability I will use is:

> **Disability (Hybrid Account)**: a condition in which a person has atypical bodily or psychological features (for the appropriate reference class) which, in interaction with other intrinsic features of the person (e.g. their personality, attitudes, abilities etc.) and features of their environment (built, social or attitudinal), cause them limitations in regular activities.[22]

Four things about the Hybrid Account need explanation. First, I replace 'impairment' with 'atypical bodily or psychological features' for two reasons. First, because 'impairment' has negative connotations. Second, because impairment is typically cashed out as *negative* deviation from typical functioning (e.g. Boorse, 1977: 555). But it is hard to see how to cash out negative deviations without introducing evaluative elements, and I want to minimise evaluative elements in my understanding of disability. The primary difference between 'impairment' and 'atypical bodily or psychological features' is thus that 'atypical features' also encompasses people with

[22] This model is consistent with the general consensus on what disability is (Wasserman, 2001: 225) and is similar to many others, e.g. Shakespeare's Interactionist Account (2013: 74-75), the Nordic Relational Model (Gustavsson, 2004) and the World Health Organisation's understanding (2001).

positive departures from typical functioning (or so-called 'super abilities') such as abnormally high levels of strength or speed. I am happy to accept that people with 'super abilities' are disabled if their super abilities interact with our features to cause them limitations in regular activities. I would class as disabled someone too strong to hold objects without damaging them. But I think it just so happens that greater than average abilities rarely cause limitations in the relevant activities.

Second, for two (or more) things to cause something *in interaction with one another* is for them to jointly cause that thing where they would not have caused it individually. An example might help clarify. Will's Paraplegia (an atypical bodily feature) interacts with the fact that the public transport around Will isn't accessible for wheelchair users (an environmental feature) to cause Will a limitation. Namely, Will is limited because he cannot travel on public transport and he would not have been limited in this way if his body or environment were suitably different. Also notice that Will might have had other abilities that could have compensated for his Paraplegia to allow him to use public transport, e.g. he might have been able walk on his hands or to mobilise via levitation. As such, Will experiences a limitation that he would not experience if his body, environment or other abilities (which are other intrinsic features of him) were relevantly different.[23]

Third, 'limitation' is used in a broad sense to encompass the abnormal difficulty of doing something (perhaps because one experiences abnormal pain or discomfort as one does it), abnormal cost of doing something (e.g. in terms of time, effort etc.), and the inability to do something.

Fourth, I understand 'regular activities' to be the activities (specified with appropriate granularity) that ordinary people within a society typically partake in unaided on a regular basis (e.g. walking, hearing, traveling on public transport, reading, going shopping, feeding oneself, going to the toilet etc.). Note, then, that 'regular activities' is a statistical rather than normative term.

I do not know of a metric to determine the appropriate level of granularity for specifying regular activities; I think this will have to be determined on a case by case basis. One suggestion is that we might 'reverse engineer' appropriate granularity, reflecting on what conditions intuitively count as disabilities and using this as a clue to suggest what level of granularity is

[23] We can now see why disability always occurs when a person's atypical features interact with other intrinsic features of them *and* features of their environment. The intrinsic lack of compensatory abilities is always relevant, as are features of the environment such as types of assistive and medical technologies available.

appropriate. For example, when wondering whether walking or mobilisation is the appropriate specification of a regular activity, we might reflect on the intuition that people who cannot walk but can mobilise (like Paraplegic wheelchair users) count as disabled as an indication that specifying the relevant regular activity as walking is better. Note that this is similar to my strategy for determining appropriate reference classes. Again, it relies on intuition so that we end up reasoning about the connection between the conditions that we usually think of as disabilities and well-being, which is what I aim to investigate.

The Hybrid Account adequately satisfies my desiderata. It satisfies (i) as it contains no evaluative elements, so allows meaningful investigation into the connection between disability and well-being. It also satisfies (ii). It respects the intuition that disability always involves some sort of limitation, which can take the form of a lack of ability or the abnormal cost or difficulty in doing something that most other people can do. Moreover, it respects the intuition that to be disabled is to be non-standard when compared to the appropriate reference class. Further, the Hybrid Account understands disability as being caused by an interaction between intrinsic features of impairments, other intrinsic features of a person and features of that person's society/context, so it respects the contextual nature of disability and doesn't imply that its nature is entirely medical or entirely social. In fact, on this account, disability is *never* caused solely by intrinsic features of impairments. Social factors are always relevant to whether someone is disabled, as they always play a role in determining the limitations a disabled person faces. This might seem counterintuitive for certain disabilities. For example, Fibromyalgia is characterised as a condition that involves chronic pain and fatigue.[24] It might seem like this disability is entirely medical, such that intrinsic features of impairment cause all the limitations involved in it. However, in my view, social factors are relevant even to this disability. Fibromyalgia would not cause limitations if sufficiently sophisticated medical technologies existed. Again, we can imagine a society where Fibromyalgia (or any disability) causes no limitation. As such, I think all disabilities (even those like Fibromyalgia) are *somewhat* social in nature.

The Hybrid Account also seems to deliver the correct verdicts on many paradigm cases. It implies that paradigm disabilities such as Deafness, Blindness, Paraplegia, MS, Cystic Fibrosis and Muscular Dystrophy are all disabilities, as each involves statistically atypical features that cause limitations when embedded in modern-day social contexts. What about paradigm cases of non-disability? It is not entirely clear whether the Hybrid Account implies that *all* paradigm cases

[24] https://www.fibromyalgiapatienteducation.info/what-are-fibromyalgia-symptoms/?gclid=EAIaIQobChMIwoaYiuSb5QIVTdTeCh1lUwqiEAAYAiAAEgJbFvD_BwE (accessed 25/05/20).

of non-disability are, in fact, not disabilities. It does well with some cases. Failing to be an astronaut is not a disability on the Hybrid Account because being an astronaut is not a statistically typical feature of any reference class. Being a woman (or man) doesn't seem to be a disability on this account either, as we can build sex into reference classes such that one's sex *cannot be* a disability. Moreover, we intuitively *should* do this, given that females and males often have different abilities – women can gestate whereas men cannot, men are typically physically stronger than women etc. A young woman who cannot give birth *might* be disabled for this reason, but we certainly don't want a man who cannot gestate to count as disabled for that reason! If we use sex to specify reference classes, then one is disabled *for a woman* or *for a man*. So, no men or women would be statistically atypical for the appropriate reference class merely because of their sex.

The Hybrid Account also does well with some tougher cases; a favourite example in the literature is Michael Phelps (e.g. Barnes, 2016b: 14; Howard and Aas, 2018: 1119). He has a statistically atypical body that makes it ideal for swimming (long limbs, large hands and feet etc.) but, intuitively, Michael Phelps is not disabled. The Hybrid Account respects this intuition. Although he has an atypical body, Michael Phelps doesn't experience any limitations in regular activities because of these features. As such, he does not count as disabled on the Hybrid Account.

Other hard cases are less straightforward. I'll discuss two that potentially present problems for the Hybrid Account and my preferred solutions for each. First, having a crooked nose is a statistically atypical trait that is paradigmatically thought not to be a disability. However, having a crooked nose might cause limitations in regular activities; perhaps one's nose is so crooked that others find it unpleasant to look at, which prevents one from securing employment or finding a partner. It might seem, then, that the Hybrid Account counterintuitively implies that having a crooked nose can be a disability in the right social context.

When thinking about this case, it's important to keep in mind an important feature of the Hybrid Account: few specific levels of functioning for a particular trait are fixed within the human population. That is, for a given trait, there will usually be some variation in what we consider 'normal' or 'typical' for a given reference class. For example, '20/20 vision' is a term commonly used to mean 'normal eyesight'. To have 20/20 vision is to be able to see clearly from twenty feet what normally can be seen at that distance.[25] But not everyone whom we would class

[25] I will ignore the potential circularity in defining 20/20 vision with reference to what a person with normal vision can see.

as having 'normal eyesight' has 20/20 vision. Our concept of *normal vision* tolerates some (upwards and downwards) deviation from 20/20, such that we would consider as typical a person with 20/21 or 21/20 vision. The statistically typical function of the eyes is thus *a range* of visual acuity (as well as a range of various other things such as level of peripheral vision, depth perception etc.). Those within the relevant range are considered, on the Hybrid Account, to be statistically typical, and those that fall outside the range are considered statistically atypical.[26] The same goes for most traits, such as one's hearing ability or the strength in one's legs. There is a normal range – as opposed to a specific normal level – for these traits.

Nose-straightness is another trait that is not fixed within a population. That is, it is not truly statistically typical to have a *completely* straight nose. Just as most people's faces are non-symmetrical, most people's noses will be *somewhat* crooked. There doesn't seem to be a *particular level* of nose-straightness that is statistically typical within the human population. Typical nose-straightness is a range. Thus, those with crooked noses that fall within the statistically typical range could not count as disabled on the Hybrid Account. It might still be, though, that people with *very* crooked noses (that fall outside the relevant range) could count as disabled if they experience limitations in regular activities because of this feature. In this case, I lean towards accepting that these people would be disabled, just as I would accept that those with facial disfigurement are disabled in a society that limits opportunities for those with facial abnormalities.

So, having a severely crooked nose might count as a disability on the Hybrid Account, which some might take to be counterintuitive. This would be a more serious problem if I were presenting the Hybrid Account as the best account of disability *per se*. If one thought it extremely counterintuitive that severely crooked noses could count as disabilities in the right contexts, then they would have reason to reject the Hybrid Account as an account of disability. But I don't think that this problem warrants the rejection of the use of the Hybrid Account *in this context*. This is because the fact that facial abnormality might count as a disability doesn't affect my discussion in practice. As we shall see in chapter 2, both the MDV and the BDV discount harms arising from unjust discrimination against disabled people or so-called 'disablism'. So, limitations caused entirely by people's unjustified adverse reactions to atypicality (or disability) – such as discrimination based on facial abnormality or abuse experienced because of disability – do not enter into my discussion.

[26] Where the relevant thresholds sit is something I will not consider here. This is likely best left to medical professionals and statisticians.

Another problematic case for the Hybrid Account might be homosexuality. Homosexuality is a statistically atypical trait which can cause limitations in regular activities. Gay people cannot conceive naturally with their romantic partners and, in homophobic societies, homosexuality might prevent one from finding employment or from being able to appear in public with one's romantic partner without experiencing abuse. But, again, homosexuality is a paradigm case of non-disability. This also seems like a problem for the Hybrid Account.

Some of what I said previously is relevant here. If the limitations associated with being gay are caused entirely by discrimination (as most are) then they won't practically affect my discussion. However, discrimination is not what causes some limitations of homosexuality, for example, that of being unable to conceive naturally with one's romantic partner. My preferred solution when it comes to homosexuality is thus to build sexuality into one's reference class. It is uncontroversial that reference class is relative to species, life-stage and sex. And I submit that we might also relativise it to sexuality. Again, this might be a case where we determine what features make up a person's reference class through consideration of what fits with our ordinary conception of disability. The differences between gay and straight people seem just as striking to me as the differences between (e.g.) young and middle-aged women, so it doesn't seem implausible that sexuality could be a feature which determines an individual's reference class. And if we determine someone's reference class with reference to their sexuality, then homosexuality (and heterosexuality) cannot count as a statistically atypical trait for any reference class. In this case, homosexuality caused limitation would not count as a disability on the Hybrid Account.[27]

I have briefly offered my preferred solutions to two problematic cases for the Hybrid Account. You might be sceptical that they succeed, or you might think that they are ad hoc moves to prevent counterexamples to the Hybrid Account. Certainly, more discussion is needed before we can conclusively say whether either solution works or, more generally, whether these problems with the Hybrid Account can be solved. Unfortunately, all accounts of disability are open to counterexamples. There is no consensus on the best account of disability partly because none uncontroversially implies that all the right conditions are (and are not) disabilities. I present the Hybrid Account primarily to provide a working definition of disability to use in this thesis that is more precise than the pre-theoretic ordinary concept of *disability*, and to make clear that I am not endorsing the Medical or Social Models. I do not claim that it is a flawless account that is

[27] Another possible solution is to let medical practitioners decide what functions count as atypical. This would seem to fix the problem, given that homosexuality is no longer considered a pathology by the majority of western doctors (cf. Howard and Aas, 2018: 1120).

impervious to objection. I am not wedded to the Hybrid Account, nor do I think it essential that the reader endorses it. My discussion will be of interest as long as the reader endorses an account which satisfies my desiderata, because my understanding of disability will not play a major role in my arguments. I will not be performing conceptual analysis of the concept of *disability* offered by the Hybrid Account. As such, my arguments run on most accounts that satisfy (i) and (ii).

Moreover, I will be focusing on paradigm cases of disability that every plausible theory should imply are disabilities and I won't be discussing borderline or controversial cases, for my aim is to investigate whether *the things that we think of as disabilities* are detrimental to well-being. For the purposes of my discussion, then, I am going to assume that the Hybrid Account could be appropriately modified to avoid overgeneralisation problems or, alternatively, that another account satisfies my desiderata and implies that the right conditions are disabilities.

1.4 – The Solidarity Account and Why I Don't Use It

I have presented the Hybrid Account of disability, which I will use throughout this thesis. In her book *The Minority Body* (2016b), Elizabeth Barnes also investigates the connection between disability and well-being. She, however, uses a different account of disability. In this section, I present her account and briefly explain why I choose against using it.

Barnes' *Solidarity Account* says that a person, *S*, is disabled in a context *C*, iff:

(i) *S* is in some state *x*

(ii) The (actual, present) rules for making judgments about solidarity employed by the disability rights movement classify *x* in *C* as among the conditions that they are seeking to promote justice for (2016b: 46).[28]

The idea is that a group of people with various conditions noticed the similarities between themselves and formed the disability rights community to fight for justice for people like themselves. This disability rights community uses a set of rules to determine whether a given condition is amongst the conditions that they seek justice for. And this set of rules determines whether a condition is a disability.[29] Individual interpretations of the rules can be mistaken; the disability rights community might not be actually seeking justice for a condition which, according

[28] Note that Barnes intends her account to include only physical disabilities. I have made it more general.
[29] Barnes never provides details of the relevant rules. She says, and I agree, that it 'doesn't matter' (2016b: 14) for her purposes.

to their rules, they ought to be, but this doesn't mean that said condition is not a disability on Barnes' account. On the Solidarity Account, a condition is a disability if the rules say it is, whether or not this is recognised by individual members of the disability rights community. This account also holds that whether a condition is a disability in other worlds or at other times depends on what is implied by the actual, present rules employed by the disability rights movement.

Given that I am investigating the same question as Barnes, and that I will engage with much of her work (primarily in chapter 4), it might seem sensible for me to use the same understanding of disability as her. However, I think that there are some serious Euthyphro-style worries for the Solidarity Account that motivate me against using it. It doesn't seem plausible to me that the rules used by the disability rights movement *determine* what conditions count as disabilities. If this were the case, then any condition would be a disability if the rules implied that it is. And we would not be able to evaluate accounts of disability on any grounds other than whether they cohere with the views of the disability rights movement (Gregory, forthcoming). We could not criticise an account for being (e.g.) descriptively inadequate. But, surely, we can do this. And, moreover, the disability rights movement is made up of fallible individuals whose rules might be mistaken about which conditions count as disabilities (cf. Gregory, forthcoming) and it is not clear why the judgements of only disability rights activists matter (Lim, 2018: 986-87). For these reasons, it just doesn't seem right that these rules infallibly determine what conditions count as disabilities. A much more plausible thought is that the rules are reliable at picking out conditions which are disabilities *for independent reasons*. But, if this is the case, then the rules happen to pick up on something external to the disability rights movement – the thing that is disability – that they might not have picked up on, and we could, in theory, cash out the nature of this thing without any reference to the rules employed by the disability rights movement.[30]

For these reasons, I think that Barnes' Solidarity Account is false and choose not to use it. However, the Solidarity Account does do a good job at getting the extension of the term 'disability' right. It correctly implies that paradigm cases of disability are disabilities and that paradigm cases of non-disability are not. It also makes clear that whether one is disabled is relative to context and depends partly on what one's body is like and partly on one's (social) context. The Solidarity Account hence satisfies (i) and (ii) and shares many of the admirable features of the Hybrid Account. As such, I think that the Solidarity Account is an alternative on which my arguments run. Therefore, my discussion will be of interest to those that endorse the

[30] See Lim (2018: 982-87) for other criticisms of Barnes' account.

Solidarity Account, as well as those who endorse other accounts that satisfy my desiderata, such as Shakespeare's Interactionist Account (2013: 74-75), the Nordic Relational Model (Gustavsson, 2004) and the World Health Organisation's (2001) understanding of disability.

Conclusion

In this chapter, I have presented the Hybrid Account of disability that I will use throughout this thesis:

> **Disability (Hybrid Account)**: a condition in which a person has atypical bodily or psychological features (for the appropriate reference class) which, in interaction with other intrinsic features of the person (e.g. their personality, attitudes, abilities etc.) and features of their environment (built, social or attitudinal), cause them limitations in regular activities.

In §1.1, I discussed the Medical and Social Models. In §1.2, I presented two important desiderata for an account of disability used when adjudicating the debate between the MDV and BDV. In §1.3, I presented the Hybrid Account of disability and argued that it adequately satisfies these desiderata. I also discussed my preferred solutions to two potential problems with the Hybrid Account and argued that not much turns on whether I utilise the Hybrid Account or others that satisfy my desiderata, as I will be focusing on paradigm cases of disability. Finally, in §1.4, I explained why I don't use Barnes' Solidarity Account but noted that my arguments also run on her understanding of disability.

Chapter 2 – The Mere-Difference View and the Bad-Difference View

In chapter 1, I explicated how I understand disability. In this chapter, I cash out the views which are my focus: the MDV and the BDV. These views are not so widely discussed that a consensus exists on how to best understand them. I will argue that the best versions are probabilistic, focus on the overall value of disability and non-disability, and discount negative effects arising from disablism. That is, they each make comparative claims about the all things considered lifetime well-being prospects of disabled and non-disabled people in the closest non-disablist worlds.

In §2.1, I present the desiderata that I will use to identify the best versions of the MDV and BDV. In §2.2, I discuss why the views discount harms arising from unjust discrimination against disabled people (or 'disablism') and offer some idea of what the closest non-disablist worlds are like. In §2.3, I shift my focus to identifying the best version of the BDV, which illuminates the best version of the MDV. In this section, I argue that the best version of the BDV is probabilistic and compares the all things considered well-being value of disability and non-disability. This allows me to present the versions of the MDV and BDV that are my focus and to begin sketching how we can go about determining which view is true. After this, in §2.4, I consider three potential problems with my understandings.

Developing a proper understanding of the BDV and MDV is important. From a philosophical perspective, the debate is new and underdeveloped and it's important that it gets off on the right footing with clear and precise understandings of the views. This will improve the debate in many ways, for example by preventing BDV and MDV proponents from talking past each other (cf. Schramme, 2013: 86-7). Moreover, the BDV is often endorsed but rarely defended, and most who discuss it do so primarily to criticise it (e.g. Barnes, 2016b; Campbell and Stramondo, 2017). Articulating the strongest account of the BDV from a more charitable perspective is something missing from the literature that will be of interest to many philosophers. This issue is not only important for philosophers, however. This debate arose in response to the real concerns of disabled people who wanted to change common conceptions of disability. They too have an interest in these views being properly understood. From a practical perspective, questions about disability's relationship to well-being are plausibly relevant to many contemporary normative debates and real-world, applied issues. Understanding the natures of the MDV and BDV thus may lead to progress in these other debates and have ramifications for real-world policies and practices.[31]

[31] Although see Schroeder (2018) for scepticism about the importance of the connection between disability and well-being to selection debates.

2.1 – Two Desiderata for Identifying the Best Versions of the Views

Roughly speaking, BDV proponents (e.g. McMahan, 2005; Shakespeare, 2013; Singer, 2005) believe that disability makes one worse off. For example, Singer (2005: 113) holds that 'other things equal, it is better not to be disabled', and Shakespeare (2013: 103) says that '[d]isability makes it harder to have a good life.' On the other hand, MDV proponents (e.g. many disability rights activists; Amundson, 2005; Barnes, 2009a, 2016b) think, roughly, that disability does not make one worse (or better) off. For example, Barnes (2016b: 78) says that '[h]aving a disability is something that makes you different, but not something that by itself makes you worse off'.

Essentially, each view makes a claim about disability's relationship to well-being. The BDV claims that disability has some kind of negative effect and the MDV claims that it has a neutral effect. How do we identify the best versions of each view? We can use two desiderata. Given that we are attempting to characterise views endorsed by various thinkers, our first desideratum is *charity*. Charity requires that we assume that MDV and BDV proponents are reasonable and rational. So, it requires that the views be interpreted in their strongest, most plausible, and most persuasive forms. This means that (if possible) we must interpret the views as being prima facie internally coherent and consistent with facts not in dispute.

There are, however, some constraints on charity. It is not strictly about *maximising* plausibility for, if it were, we might end up interpreting virtually all views as true. Charity requires that we maximise plausibility of the MDV and BDV within at least three confines. First, and most importantly, the views must be interpreted as incompatible. This is both because their proponents take them to be incompatible and because, otherwise, there is no genuine debate. This relates to the second confine, which is that the views should be interpreted such that we bring out genuinely interesting disagreements between them. We should not take the maximisation of plausibility so far as to make the debate philosophically uninteresting or to interpret it as though proponents of each view are talking past each other. And, finally, charity also requires that the views be interpreted, as far as is possible, as consistent with what their proponents actually say. To properly utilise charity thus requires consideration of plausibility, incompatibility, interestingness, and the expressed views of advocates of both views.

Charity must be balanced with a second desideratum: *appropriate normative relevance*. As mentioned, thinkers engaging in this debate typically hold that the relationship between disability and well-being has normative implications. For example, the BDV and MDV are often taken to have implications for the (im)permissibility of selecting for or against disability via reproductive

technologies.[32] And some thinkers take the connection between disability and well-being to imply certain things about distributive justice – specifically the fair distribution of healthcare provision and social support (e.g. Singer *et al.*, 1995). For example, Quality Adjusted Life Years (QALYs) are commonly taken to be an appropriate metric for health-based utility, which is used to determine the just division of healthcare resources (Franklin, 2017: 65). The idea is that we should distribute resources such that they produce the most utility. QALYs take the additional number of years a healthcare allocation will produce, together with the quality of those years, to determine its utility. Clearly, then, the quality of disabled people's lives – that is, whether the BDV is true – affects the number of QALYs produced by allocations that result in additional years with a disability, and thus which healthcare allocations are viewed as just (cf. Bickenbach 2016). The best interpretation of the views will make sense of the moves being made in the debate. That is, it will adequately explain why whether the MDV or BDV is true is (at least prima facie) relevant to these kinds of normative issues. If it cannot, then it will seem to have changed the subject.[33]

Note that the charity desideratum doesn't imply that the views must turn out, after more work has been done, to be internally coherent and consistent with the facts. After we identify the best versions of both views and scrutinise them closely, it might turn out that either one is false, incoherent or unsupportable. But it would be bad philosophical practice to *start out* by characterising the views as such, if possible not to. Also note that the desideratum of appropriate normative relevance doesn't require that the MDV or BDV be interpreted such that they have any of the specific normative implications sometimes argued for by proponents of each view (e.g. that it follows from the BDV that disabled people have less claim to scarce medical resources). Even if the BDV or MDV is true, whether these claims are also true is an open question. The point is that the views should be interpreted such that they appear at least prima facie relevant to the normative issues, understood generally, to which people take them to be relevant: they should be prima facie relevant to selection debates, rather than imply anything specific about the normative status of selecting for a given disability.

So, the two desiderata I'll use for identifying the best versions of the MDV and BDV are charity and appropriate normative relevance. These desiderata must be balanced: loss in one

[32] See, for example, McMahan (2005), Barker and Wilson (2019) and Anstey (2002, 2008).
[33] This second desideratum might be thought of as an element of charity, as it seems charitable to assume that proponents of the views aren't mistaken in taking their view to be relevant to these areas of normative enquiry.

might be acceptable if necessary for gain in the other. The best interpretation will thus be the one that best balances charity and relevance.

2.2 – Discounting Disablism

I will spend the rest of this chapter identifying the best versions of the views using my desiderata. In this section, I explain why the views discount the negative effects arising from disablism and offer some explanation of what the closest non-disablist worlds would be like.

Upon encountering the MDV, one might think it obviously false. Disabled people are often subjected to unjust discrimination or 'disablism' (Wolbring, 2008; Wasserman, 2013; Putnam *et al.*, 2019).[34] I assume without argument that many of disability's negative effects on well-being are caused by disablism – including (e.g.) being stared at in public, treated as infantile, and discriminated against in the job market . This has been long-established in disability scholarship[35] and is accepted by thinkers on both sides of the dialectic (e.g. Singer, 2001: 56; Barnes, 2016b: 5).[36] Given that disablism is rife in the actual world, it seems extremely likely that disability has a negative effect on well-being in the actual world. However, following Barnes (2016b esp. ch. 2), I take the views to be discounting the negative effects of disablism. That is, I take them to be making claims about how disability would affect well-being *if disablism were eradicated*.

I take disablism to be, somewhat roughly:

> **Disablism**: unjust discriminatory, oppressive or abusive attitudes or behaviours directed towards disabled people in virtue of the fact that they are disabled (cf. Miller, Parker and Gillinson, 2004: 9).[37]

I assume that the MDV and the BDV discount disablism for two reasons. First, because everyone agrees that disability tends to hinder well-being in disablist worlds, just as everyone agrees that being black tends to make someone's life worse in racist worlds. Second, because this debate originated in the claims of disabled people that, *absent prejudice*, disability would not be bad

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[34] Some (e.g. Barnes, 2016b) prefer 'ableism'. I prefer 'disablism' for reasons stated in Wolbring (2008). This makes no difference to my arguments.
[35] See, for example, Finkelstein (1981) and Oliver (1996).
[36] See the Experiences and Expectations of Disabled People (Office for Disability Issues, 2007) and The Papworth Trust (2018) for various statistics that suggest the disablist nature of our world. For more detailed discussions of disablism, see Campbell (2008, 2012) and Miller *et al.*, (2004).
[37] I discuss disablism in more detail below and in §6.3. See Brown (2019: 333) an alternative understanding.

for well-being.[38] Discounting disablism thus respects the origins of this debate, and is more interesting and charitable to the MDV.

I thus take the MDV and BDV to be considering what well-being levels would be like *in non-disablist worlds* to tell us what disabled lives would be like in the actual world if we eradicated disablism. However, there are myriad ways a world could be non-disablist. And many non-disablist worlds are so dissimilar to the actual world that the well-being levels of their inhabitants bear little relevance to our normative situation in the actual world – e.g. worlds with no disabled people or no people at all. The MDV and BDV are supposed to be relevant to various normative issues in the actual world, though. So, we need to restrict in some way the non-disablist worlds that we reason about. One way of doing so is to focus only on *the closest* non-disablist worlds. That is, the set of non-disablist worlds that are most similar to the actual world;[39] the possible worlds that are identical to the actual world in every respect apart from those which must change to eliminate disablism.[40] Henceforth, I will call this set of worlds W_1. It is W_1 that we will look at to tell us whether the MDV or BDV is true. I will explain further how we go about determining this in §2.3.4, chapter 3 and §4.2.

Before that, though, I will sketch the nature of W_1. The worlds in W_1 are different from the actual world only in the ways needed for them to be non-disablist. Features which must be shared by the W_1 worlds and the actual world thus include: the nature of particular disabilities, the amount and type of natural resources, the laws of nature, people's (non-disablist) preferences, and the level of technological development. Importantly, we should assume that the worlds in W_1 are exactly as technologically developed as the actual world unless given good reason to think that i) failure to develop a particular technology that we, in fact, do not possess is disablist, or that ii) if our world were not disablist, we would not have developed a technology that we have, in fact, developed. This is because the level of technological development in a world and the well-being of disabled people in that world are, intuitively, closely linked. Through developing better medical technologies (such as improved pain relief) and better assistive technologies (such as superior prosthetic limbs) many (non-disablist) disadvantages that disabled people experience can be eradicated. We can imagine a non-disablist world so technologically superior to our own that disabled people never experience any limitation or disadvantage because of their disability. It might be interesting to investigate the connection between disability

[38] See work on the Social Model (e.g. Oliver, 1996).
[39] I follow Lewis (1979) in understanding similarity as the appropriate metric of closeness.
[40] I assume for simplicity that these are not worlds with no disabled people or no people at all. I thank Barnes (2016b: 67) for pointing out that this assumption is needed.

and well-being in these technologically superior worlds. But, once again, we want the views to be relevant to appropriate normative issues in the actual world and to tell us what well-being levels would be like *in our world* if we eliminated disablism, so the level of technological development should remain the same in W_1 as it is in our world unless we find compelling reasons for thinking that (i) or (ii) is true.[41]

There is a presumption that all features of W_1 are the same as the actual world, unless there is good reason to think that a feature must be different for the worlds of W_1 to be properly non-disablist. As such, many features of W_1 will be similar to the actual world. However, many features will not be. How does W_1 differ from the actual world? More specifically, which disadvantages of disability present in the actual world will not obtain in W_1? Broadly speaking, at least four things disadvantage disabled people in the actual world. First are so-called 'impairment effects'. Recall, these are 'the direct and unavoidable impacts that impairments… have on individuals' embodied functioning in the social world' (Thomas 2010: 37). They include, for example, the inability of Paraplegic people to move their legs and the pain experienced by people with Fibromyalgia. Given that these disadvantages are, by definition, not caused by disablism, they remain in W_1.

A second source of disadvantage is the behaviour of others.[42] Behaviours that harm disabled people include (e.g.) other people avoiding interaction with them, experiencing abuse because of disability, being treated as incompetent, being turned down for a job in favour of a non-disabled person who is no more qualified, and so on. These, and many others, are prime candidates for disablist behaviours, so would not occur in W_1. However, not all behaviours that disadvantage disabled people are disablist. For example, failing to hire a Blind person for a role as an airline pilot or proofreader might disadvantage them, but is not disablist. Nor is it obviously disablist to prefer a non-disabled lover. It seems, then, that many (probably most) behaviours that disproportionately disadvantage disabled people in the actual world will not be present in W_1, for these are disablist behaviours, but that disabled people will likely still be disadvantaged by at least some non-disablist behaviours in W_1. Unfortunately, I can think of no rule that lets us easily discern whether a given disability-disadvantaging behaviour is disablist (I discuss this further in chapter 6). As such, whether a given behaviour is disablist is likely going to have to be decided on a case by case basis.

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[41] I discuss the connection between technology and the well-being of disabled people in more detail in chapter 6, exploring whether it is disablist to fail to have developed better technologies.

[42] I don't mention attitudes here as I am assuming that disablist attitudes only have negative effects via motivation of disablist behaviours.

A third source of disadvantage is disabled people's negative feelings about themselves, their disability, or disability generally. Disabled people sometimes internalise negative stereotypes about disabled people being, say, infantile or worthy of pity (Brown, 2019: 336-37). This is known as *stereotype threat*. Negative feelings about oneself are plausibly bad non-instrumentally and instrumentally. They can lead to anxiety and underperformance (Schmader *et al.*, 2008) (perhaps due to a self-fulfilling prophecy) and pose a legitimate threat to well-being (Silverman and Cohen, 2014). Negative stereotypes about disability and the behaviours that they motivate are disablist, so stereotype threat would not disadvantage disabled people in non-disablist worlds. This is not to say that disabled people wouldn't have any negative views about their disability if disablism were eliminated. They would not internalise negative stereotypes, but they might feel annoyance or frustration about being unable to do certain things (for non-disablist reasons) or about the impairment effects of their disability. Thus, in W_1, disabled people might still be disadvantaged by their own negative feelings about their disabilities, but these feeling will not be as common as they are in the actual world, as other people won't harbour negative stereotypes about disability, treat disabled people as infantile, or in other disablist ways.

The fourth thing that disadvantages disabled people in the actual world is environmental barriers. There are vast numbers of environmental barriers for disabled people, including lack of adequate public transport provision, lack of ramps to access public accommodations and lack of braille translations of written texts. Again, many disability-disadvantaging environmental barriers are disablist, including all of those just mentioned and many others. However, disabled people will still experience *some* environmental barriers in W_1. This is, first, because some environmental barriers appear irremediable. Natural terrains such as sandy beaches, bogs, steep hills and mountain ranges will be inaccessible to wheelchair users and unsafe for the Blind whether or not the world is disablist (Shakespeare, 2013: 36). Second, for some environmental barriers that are remediable, it is unclear whether it would always be disablist to fail to remove them. This is because doing so might be extremely costly (Amundson, 1992: 27) and we can assume that economic factors constrain the inhabitants of W_1 in the same way as they do the inhabitants of the actual world. It is not plausible that non-disablism requires the elimination of all environmental barriers, no matter the cost. It seems likely, then, that considerations of cost would render some remediable disability-disadvantaging environmental barriers non-disablist. Third and finally, there will remain some environmental barriers in W_1 because the needs of different disabled people sometimes conflict:

> [W]heelchair users demand level access. Yet people with mobility issues who do not use wheelchairs may find that steps are safer and easier for them than ramps. Blind people

> may find that kerb cuts which liberate wheelchair users make it difficult for them to differentiate pavement from road, and leave them vulnerable to walking into the path of a vehicle. Wheelchair users may have problems with tactile paving which gives locational cues to visually impaired people . . . Partially sighted people may request large text on white background: people with dyslexia may prefer black print on yellow paper. Some people will prefer rooms to be dim, others will prefer them to be brightly lit (Shakespeare, 2013: 37).

Moreover, which environmental changes people with the same disabilities prefer is highly individual (Stark, 2001: 47). Hence, there are cases where what is disadvantage-alleviating for people with one disability is disadvantage-creating for people with another (or even the same) disability. So, it seems impossible to remove all environmental barriers for disabled people and non-disablism cannot require that we do impossible things.

Importantly, this discussion has brought to light that theorising about non-disablist worlds does not mean that the only disadvantages relevant to this debate are intrinsic features of disability. We have seen that disabled people might experience socially-mediated disadvantages even in non-disablist worlds, as not all social disadvantage is unfair or unjust (Amundson, 2005: 114; Howard & Aas, 2018: 1129; Barclay, 2011).

Given these considerations, the most complete description I can give of W_1 at this point is: W_1 is a set of worlds where no one thinks that disabled people are inherently inferior or marks them out as objects of pity. Disabled people are thus made to feel no shame in their non-standard embodiments. Negative stereotypes about disability don't exist, so don't negatively affect disabled people's well-being, or non-disabled people's interactions with them. It is a set of worlds where public accommodations (restaurants, libraries, shops, transport systems, public buildings etc.) are built with the access needs of disabled people in mind or are properly modified to accommodate disabled people when this is not prohibitively costly. This implies that disabled people have access to most, if not all, of the public accommodations that non-disabled people do, although perhaps not with similar ease. Disabled people might remain unable to access *some* public accommodations, but only if there exists an extremely good reason for this – e.g. that installing a lift would ruin a building's historical integrity. It is a set of worlds where employers modify job roles and purchase equipment, as far as is reasonably possible, to allow people with different disabilities to perform these roles as effectively as non-disabled people. It is also a set of worlds where disabled people are proportionately represented in all forms of media and are depicted as being capable of flourishing. Even so, in these worlds, disabled people might

still experience some disadvantages because of i) impairment effects, ii) their own negative feelings towards their disability, iii) non-disablist environmental barriers, and iv) the non-disablist actions of others. I recognise that this is a far from exhaustive specification, but I hope it provides a reasonably good description of what the worlds I am reasoning about are like.[43][44]

I have said that those partaking in this debate theorise about W_1 to discern whether disabilities would be detrimental to well-being in the actual world if we eradicated disablism. However, the conditions that are disabilities in W_1 might not reflect those that are disabilities in the actual world, for presumably fewer limitations exist in W_1 for those with atypical bodily features. As such, there might be certain atypical conditions which cause limitations – and thus count as disabilities – in the actual world, but don't cause limitations (and so don't count as disabilities) in W_1. An important point, then, is that, when thinking about disabilities in W_1, we must *rigidly designate* the conditions that are disabilities in the actual world. That is, the well-being levels in W_1 of (e.g.) Deaf people are relevant to our discussion even if Deafness causes no limitations in W_1.[45]

We rigidly designate, first, because we are interested in whether the conditions that are disabilities *in our world* are detrimental to well-being (minus disablism). Second, because failing to rigidly designate would seem uncharitable to the MDV. A primary thought behind the MDV is that many disadvantages experienced by disabled people are caused by the unjust treatment of disabled people (Barnes, 2016b: 70). Thus, the MDV plausibly implies that some conditions that count as disabilities in our world – specifically, those whose limitations are exclusively caused by disablism – would not count as disabilities in W_1. To discount these conditions from our discussion would be to reason about only conditions which, by hypothesis, cause limitations for reasons other than disablism, which seems to unfairly tip the scales in favour of the BDV. Third and finally, to discount these conditions would require answering difficult questions about which disabilities (in the actual world) only cause limitations because of disablism. But I see no way of

[43] I consider the nature of W_1 further in §6.3.

[44] A question remains about how far in the past we should imagine that W_1 became non-disablist. A world in which disablism *never* existed likely would be extremely different from our own, perhaps so different that theorising about it could not tell us much of interest about our world today. Moreover, I do not want to venture into the difficult realms of historical counterfactual speculation. As such, I will imagine that W_1 became non-disablist fairly recently. A reasonable, non-arbitrary year to imagine that W_1 became non-disablist is 1990, with the passing of the American's With Disabilities Act. Thus, I will imagine that history developed in W_1 as it did in the actual world until 1990. It may well be worth considering in detail what our world would have been like if disablism never existed, but that is not something I will do in this thesis.

[45] Rigid designation provides another reason why it would be bad to use the Social Model in this context. According to this model, all of disability's negative effects are solely caused by unjust discrimination. This means that, on this model, it is trivially true that the things that are disabilities in the actual world would not be detrimental to well-being in non-disablist worlds.

answering these questions prior to investigating what lives would be like in W_1, which is exactly what I intend to do.

In sum, in this section I have argued that the MDV and BDV both discount harms arising from disablism and do so by considering what lives would be like in W_1. I also began explicating the nature of W_1 and noted that we must rigidly designate the conditions which are disabilities in the actual world.

2.3 – Instrumentality and Probability

I have discussed why both views discount disablism, but more work needs to be done before we can properly specify the nature of the MDV and BDV. In this section, I turn to discussing two other issues central to identifying the best versions. These are whether the views are probabilistic (the issue of probability) and what kind of value they focus on (the issue of instrumentality). I argue here that the best versions of the views are probabilistic and focus on all things considered value.

In this section, I focus on identifying the best version of the BDV using the above desiderata. Afterwards, I will be able to explicate the best version of the MDV by altering the appropriate aspects of the BDV. The history of the views motivates me to do things this way around. To understand the debate, it is important to understand the order in which the views arose. The BDV came first. It was the common understanding of disability until the Social Model. The Social Model can be appropriately understood as the first version of the MDV and it arose *as a response to* the BDV. That is, the MDV arose due to the concerns of disabled people and disability rights activists who wanted to change the common view that disability (or impairment) is a bad-difference. As such, if there were no BDV, then there plausibly would have been no need for an MDV. This explains why there is no equivalent of the MDV for traits which are commonly assumed to be neutral, such as hair colour or food preferences, but that there are equivalents for other traits which were once (or still are) considered detrimental, such as gender and race (cf. Barnes, 2016b: ch. 2). The order in which the views arose provides a reason to first get a grip on the best version of the BDV before using this as a guide to understand the best version of the MDV. As such, I will first focus on explicating the BDV before reintroducing discussion of the MDV below.

In my attempt to explicate the best version of the BDV, my starting point is work by Campbell and Stramondo (2017: 154-55). They present three candidate interpretations:[46]

1. Disability is non-instrumentally bad for well-being.
2. Disability is instrumentally bad for well-being.
3. Disability is comparatively bad for well-being.

If disability is bad for well-being, it must be so either instrumentally, non-instrumentally or both. Something is instrumentally bad if it is bad *in virtue of its causal consequences*. Something is non-instrumentally bad if it is bad *in itself* or *independently of its causal consequences*. Pain is typically taken to be non-instrumentally bad. If it is, then the things that cause pain (e.g. stubbing a toe) are taken to be instrumentally bad.

(1) says that disability is bad for well-being non-instrumentally – that is, *in itself*, not considering its causal consequences. It says that disability is more non-instrumentally bad than good such that it is, overall, non-instrumentally bad (Campbell and Stramondo 2017: 154). (1) makes no claims about disability's instrumental value.

Another way of saying that something is non-instrumentally bad for well-being is that it is non-instrumentally *harmful*. Harm has been understood comparatively and non-comparatively (Bradley, 2012). On non-comparative accounts, disability is non-instrumentally harmful (roughly speaking) iff (when discounting its effects) it puts one in a non-instrumentally bad state (Bradley, 2012: 398-401) – where 'bad' is understood in the absolute sense. My well-being is bad in an absolute sense if it falls below some threshold of neutrality such that I have a life not worth living. So, (1) understood non-comparatively appears to be saying that, discounting disability's effects, disabled lives are not worth living. But BDV proponents don't seem to be saying this. First, because this claim is utterly implausible. Second, because when understood non-comparatively (1) is consistent with disabled lives being non-instrumentally *better* than non-disabled lives. That is, on the non-comparative understanding, (1) is true if disability is *slightly* (non-comparatively, non-instrumentally) bad for well-being but non-disability is *extremely* (non-comparatively, non-instrumentally) bad for well-being. But we would hardly say that this situation exemplifies a *bad*-difference view of disability.

[46] In fact, they present a fourth understanding, that having a disability tends to make someone's life on the whole bad. I will not discuss this alternative, as it is clearly false so is not the best version of the BDV.

Comparative accounts of harm say (roughly) that disability is non-instrumentally harmful iff (when discounting disability's effects) I am worse off with a disability than I would have been without (Bradley, 2012: 396; cf. Brown, 2016). This is a claim about *worseness* rather than absolute badness, and so it would be false if disability is non-instrumentally bad and non-disability is non-instrumentally worse. This seems like the right result. Moreover, it is at least somewhat plausible that disability is non-instrumentally, comparatively worse for well-being than non-disability. These considerations speak in favour of understanding (1) as utilising a comparative account of harm. In any case, the debate is more interesting if understood as comparative.[47][48]

(2) focuses on disability's instrumental value: what it causes. Something is instrumentally good if it causes non-instrumental goods or prevents non-instrumental bads, whereas something is instrumentally bad if it prevents non-instrumental goods or causes non-instrumental bads. This causation can be direct or indirect. For example, unemployment is typically understood to be merely instrumentally bad as it does not seem bad in itself but it does sometimes cause plausibly non-instrumentally bad things (e.g. unhappiness) and prevent plausibly non-instrumentally good things (e.g. personal achievement). (2) says that disability is bad instrumentally, that it *causes* more badness than goodness such that it is, overall, instrumentally bad (Campbell and Stramondo 2017: 155). (2) is silent on disability's non-instrumental value.

Again, (2) is best understood as comparative. Instrumental value concerns what something causes, and causation is typically understood as comparative (e.g. Lewis, 1973). That is, something is instrumentally valuable if it causes me to be better off *than I would have been without it*. To determine whether disability is instrumentally bad, then, we need to compare the effects of disability with the effects of non-disability.

(3) considers instrumental *and* non-instrumental value or the *all things considered* value of disability. (3) makes the comparative claim that a person's well-being is all things considered *worse* with a disability than it would have been without (Campbell and Stramondo, 2017: 155). Note that a disability *D* might be overall non-instrumentally good but comparatively bad, if *D* is overall instrumentally bad to a sufficiently large extent. Likewise, *D* might be overall instrumentally good but comparatively bad. Both (1) and (2) must be true to guarantee (3). Also

[47] Campbell and Stramondo do not discuss the difference between comparative and non-comparative understandings of (1). Another reason for thinking that they implicitly understand (1) as comparative is that – because (2) is also best understood as comparative and (3) is explicitly comparative (see below) – understanding (1) as non-comparative would mean that they have not provided a neat way of carving up the territory. Rather, it would seem as though their disambiguation ran together comparative and non-comparative value with pro tanto and all things considered value. I thank Chris Woodard for bringing this to my attention.

[48] See Schramme (2013: 86-89) for discussion of comparative and non-comparative evaluations within the disability context.

notice, crucially, that all candidate interpretations are compatible with many, most or all disabled people having overall good lives. They make no claims about the absolute well-being levels of disabled people.

So, Campbell and Stramondo present three candidate interpretations of the BDV, two that focus on the pro tanto value of disability and one that considers its all things considered value.[49] Once we've determined whether the BDV is interested in instrumental, non-instrumental or overall value, however, at least one more important question must be answered before we can fully characterise it. A BDV proponent might think that disability is *always* bad for well-being, or they might take a probabilistic approach, thinking that disability is typically, or most often, bad for well-being.[50] Given this, I think that there are at least six plausible candidate interpretations of the BDV (here I suppress clauses common to all views, which I reintroduce below):

1*. Disability is *always* non-instrumentally bad for well-being.

2*. Disability is *typically* non-instrumentally bad for well-being.

3*. Disability is *always* instrumentally bad for well-being.

4*. Disability is *typically* instrumentally bad for well-being.

5*. Disability is *always* all things considered (overall) bad for well-being.

6*. Disability is *typically* all things considered (overall) bad for well-being.

I will now evaluate (1*)-(6*) with my desiderata in mind.

2.3.1 – Always non-instrumentally bad?

I start by arguing that (1*) – the view that disability is always non-instrumentally bad – is an uncharitable interpretation of the BDV because it appears incompatible with many major theories of well-being.

Different theories of well-being take different things to be non-instrumentally bad. I will briefly introduce the three major philosophical theories here, before discussing them in more

[49] It is unclear why Campbell and Stramondo describe (3) as the view that disability is 'comparatively bad for well-being' given the comparative nature of (1) and (2). As such, I will henceforth refer to views that consider disability's instrumental value together with its non-instrumental value as considering its 'all things considered' or 'overall' value (which I think are clearer labels).

[50] Campbell and Stramondo (2017: 168) mention that probabilistic versions of the BDV are possible, but they don't consider probabilistic versions of all the candidate understandings.

detail in chapter 3. These are hedonism, the desire theory and the objective list theory (Parfit 1984: 491-503). Hedonism claims that well-being consists in experiencing the largest net-sum of pleasurable mental states minus painful mental states (Parfit 1984: 493). According to the desire theory, well-being consists in getting what one non-instrumentally desires and ill-being consists in having one's non-instrumental desires frustrated (Heathwood 2006: 541). And objective list theories claim that well-being consists in the attainment of certain objectively valuable things (Parfit 1984: 499).

On hedonism, painful mental states are the only non-instrumental bads and pleasurable mental states are the only non-instrumental goods. The hedonist will thus endorse (1*) only if they think that disability *always* contains (as opposed to causes) less net pleasure than non-disability.[51][52] But there appears to be no good motivation for this belief. What is the non-instrumental value of non-disability, according to hedonism? Recall, we are discussing only physical disability here.[53] On one plausible understanding, physical non-disability is merely the lack of any physical disability. If so, it seems that non-disability doesn't itself contain any pleasurable or painful mental states; it doesn't appear to contain any mental states at all! If this is a good understanding of non-disability, then non-disability is always non-instrumentally neutral, and we would need *only one case* of a non-instrumentally neutral (or good) disability to show that (1*) is false on hedonism. And it seems likely that there are many such cases. Some disabilities – e.g. Fibromyalgia and Rheumatoid Arthritis – do involve painful mental states. But others do not. For example, Deafness and Achondroplasia don't appear to always involve painful mental states, so seem best characterised as at least sometimes non-instrumentally neutral. Given these points, (1*) seems false according to hedonism.

If there, in fact, are mental states involved in both disability and non-disability, then (whatever they are) they might be experienced as net pleasurable, painful or neutral. Inherently painful disabilities might always be experienced as net painful. But the mental states involved in non-painful disabilities are plausibly experienced as neutral or even net pleasurable in some cases. This seems especially likely for disabilities like Deafness and Blindness that involve a completely different way of experiencing the world. Some Blind people might take pleasure in their unique sensory experience and some (totally) Deaf people might take pleasure in the silence involved in

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[51] Throughout this thesis, I use '*x* involves *y*' and '*x* contains *y*' to mean that '*y* is a non-instrumental feature of *x*'. I take *y* to be a non-instrumental feature of *x* when it is a feature of *x* in virtue of which *x* has non-instrumental value. Most straightforwardly, this occurs when *y* is an intrinsic feature of *x*. However, something can also have non-instrumental value in virtue of extrinsic features (as can be the case with sentimental value).

[52] I take net pleasure to be pleasurable mental states minus painful mental states, adjusted for intensity.

[53] I explain why I restrict my scope in §2.4.

their condition, or other elements of it.[54] Likewise, the mental states inherent in non-disability (if there are some) might be experienced as pleasurable, painful or neutral. Perhaps it is rare for non-disability to be experienced as painful, but it plausibly happens sometimes. Perhaps those with Body Integrity Identity Disorder (who desire to be disabled (Bayne and Levy, 2005)), or some with newly acquired cochlear implants, experience pain in the mental states involved in non-disability.[55] It is even more likely that at least some people experience the mental states involved in non-disability as non-instrumentally neutral. Many people take pleasure in instrumental benefits of non-disability – perhaps they like climbing mountains or watching sunsets[56] – but it seems likely that at least some people don't experience the mental states involved in non-disability *itself* as pleasurable, such that non-disability would improve their well-being even if it had no instrumental benefits. If anyone experiences non-disability as non-instrumentally neutral, then (1*) appears false on hedonism because it seems overwhelmingly likely that disabilities are at least sometimes experienced as neutral or net beneficial.

Broadening our understanding of 'pain' to include all unenjoyable states doesn't seem to help the hedonist. There appears to be no reason why, for example, congenital Deafness must always *non-instrumentally* involve more net unenjoyment than non-disability. The general point is that what people enjoy depends on their unique psychologies. As such, it appears likely that disability and non-disability are each experienced in some cases as net enjoyable, unenjoyable or neutral. Thus, it seems implausibly strong to say that disabilities *always* involve more net unenjoyment than non-disability. Perhaps it is more plausible that disability always *causes* more unenjoyable states than non-disability, but (even if true) this would be irrelevant for the person who endorses (1*) as (1*) focuses on *only* non-instrumental value. Given these points, (1*) seems false on hedonism whether or not we think that there are mental states involved in non-disability (cf. Schramme, 2013: 82).

For a desire theorist to endorse (1*), they must believe that disability *always* involves less aggregate desire satisfaction than non-disability.[57] But, again, there appears to be no good

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[54] This seems to be part of the thought behind the Deaf Gain movement. Moreover, many disabled people report to enjoy their experience of disability (e.g. Barnes, 2016b: ch. 4).

[55] For testimony from those who dislike the effects of cochlear implant surgery, see https://www.entandaudiologynews.com/features/ent-features/post/cochlear-implants-recipient-stories (accessed 25/05/20), https://www.hearwellcenter.com/my-cochlear-implant-journey-to-hell-and-back/ (accessed 25/05/20).

[56] The things count as instrumental benefits *according to hedonism*, as neither activity is a pleasurable mental state, but they sometimes cause pleasure. However, they might count as non-instrumental benefits on other theories of well-being. It's difficult to give uncontroversial examples of instrumental and non-instrumental value. See note 63 for more discussion of this.

[57] I take aggregate desire satisfaction to be non-instrumental desire satisfaction minus non-instrumental desire frustration, adjusted for desire intensity.

motivation for this belief. Of course, *some* disabilities involve desire frustration. This is plausibly true for chronically painful disabilities, as most agents non-instrumentally desire to avoid pain. But I see no reason to believe that disability *always* involves less aggregate desire satisfaction than non-disability. For some people, disability might involve large amounts of desire satisfaction, if they non-instrumentally desire to live in a world of calming silence or to share experiences with their disabled friends. Moreover, it seems too strong to say that disability always frustrates desires. Perhaps disability would often frustrate the desires of non-disabled people. But people often adapt their preferences to suit their capabilities – the phenomenon of so-called 'adaptive preference' (Mitchell, 2018) – which implies that many disabled people might not possess desires to be non-disabled or to do things that their disability prevents them from doing.[58] For these reasons, there don't appear to be good grounds for the claim that disability *always* involves less aggregate desire satisfaction than non-disability.

Besides, it's simply not in the spirit of the desire theory to endorse non-probabilistic claims like (1*). The point of the desire theory is that well-being is dependent on pro-attitudes, which vary from person to person. The nature of different disabilities also varies considerably. Desire theorists are thus unlikely to think that all (or even the vast majority of) the disparate conditions labelled 'disabilities' (from Deafness to Spina Bifida to Muscular Dystrophy) are uniformly non-instrumentally worse for well-being than non-disability (cf. Schramme, 2013: 84). This would fly in the face of a primary thought behind the desire theory: that what well-being consists in varies depending on idiosyncratic desires. The desire theorist will thus accept that disability and non-disability might each be non-instrumentally good, bad or neutral, depending on a subject's desires. Hence, it seems that the non-probabilistic (1*) is false on the desire theory.

Perhaps (1*) is more plausible on idealised versions of the desire theory – on which well-being consists in getting what an idealised version of you would want (Heathwood 2014: 212). Those that think so might think that, although disability doesn't always involve less aggregate satisfaction than non-disability of people's *actual* desires (perhaps because of adaptive preferences), it always involves less aggregate satisfaction of people's *idealised* desires (where they are fully informed and making no mistakes in reasoning). Whether this is true will depend on how we understand idealisation. Without getting too far into the various kinds of idealisation, an important point is that the desire theory is a subjective theory of well-being – which is to say that, on the desire theory, the particular things that are good for you are not always good for me,

[58] I am not assuming that adapted preferences are undesirable or sub-optimal (cf. Barnes, 2009b). See §5.4.1 for a little more discussion of this phenomenon.

and vice versa, because what is good for us depends on our unique psychologies. If our chosen method of idealisation maintains this feature, then it's still unlikely that disabilities will involve less aggregate desire satisfaction for every idealised agent, because even idealised agents will have idiosyncratic desires. If, however, the chosen method of idealisation makes it such that all idealised agents possess the same set of desires then, on this version of the desire theory, (1*) might be true. But I would contend that this theory is not a desire theory at all. It would, I think, instead be an objective view in subjective clothing. If so, then what I have to say about objective list theories is relevant.

It's more plausible that objective list theorists would endorse (1*) than hedonists or desire theorists because, on objective list theories, what well-being consists in is the same for everyone and not dependent on experiences or attitudes.[59] So, on this view, it might be that disability always involves more objective bad and/or less objective good than non-disability, such that it's always non-instrumentally worse for well-being. But, again, this non-probabilistic claim doesn't appear plausible. It's entirely unclear that disability always involves less objective good and/or more objective bad than non-disability. This will depend on what people take to be objectively good but, for any plausible list, it seems possible that disability might involve more than non-disability.

Why might people think that disability is always objectively non-instrumentally worse than non-disability? No objective list that I know of includes non-disability.[60] And the presence or absence of many putative objective goods – such as knowledge, achievement, friendship etc. – is not a *non-instrumental* feature of disability or non-disability. One might think that pain is objectively bad, and that disability always involves more pain than non-disability, but I have already rejected this. The other way in which (1*) might be true on an objective list theory (that I'll consider) involves appeal to ill-health. Some objective list theories maintain that health is non-instrumentally good (e.g. Finnis, 1979: 86; Nussbaum, 2011: 33). And one might think that disability entails ill-health whereas non-disability doesn't contain any objectively bad features, so disability is always non-instrumentally worse than non-disability. This thought is more promising,

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[59] That is, unless the list includes pleasure or getting what one wants. I will ignore this issue as I have argued that neither consideration of pleasure nor desire satisfaction provides reasonable grounds for endorsing (1*).

[60] Nussbaum famously altered her list of central human capabilities to be more inclusive to disabled people. In early work (e.g. Nussbaum, 1992), she includes moving 'from place to place… with our very own bodies' (218) and 'being able to use the five senses' (222). In later work, she includes being able to 'move from place to place' and 'use the senses' (Nussbaum, 2011: 33). It's hard to escape the notion that these changes were made so that her Capabilities Approach doesn't preclude people with certain disabilities from flourishing. It's also worth noting that some include disability on lists of non-comparative harms (e.g. Harman, 2009: 139). However, these are theories of harm rather than theories of well-being, and utilising such a theory would prejudice this discussion. In any case, I have argued that the comparative account of harm is best to use in this context (see §2.3).

as it is plausible, on some conceptions of health in tandem with some conceptions of disability, that disabled people are necessarily unhealthy.

I won't define 'health' here, as this is beyond my scope, but two things are worth noting. First, it's common for disabled people to reject the identification of ill-health and disability (Wendell, 2001). Second, on some accounts of health – such as Carel's (2008), on which to be healthy is, roughly, to feel in harmony with one's body – disabled people needn't be unhealthy. However, one might endorse an account on which disability does entail ill-health. On that view, (1*) could be true.

So, (1*) *is* compatible with certain objective list theories. Notice, though, that for (1*) to be compatible with a person's views they must believe: i) that an objective list theory is true; ii) that health is an objective good; iii) that disabled people are necessarily unhealthy; iv) that disabilities *never* involve enough counterbalancing non-instrumental good(s) to make them non-instrumentally better than non-disability, and v) that non-disability *never* involves enough non-instrumental bad(s) to make it non-instrumentally worse than disability.[61]

(1*) would therefore only be endorsed by the presumably small set of people that satisfy (i)-(v). Thus, it is an uncharitable understanding of the BDV. All of (i)-(v) are contentious. So, characterising the BDV as (1*) increases the contentiousness of the presuppositions of BDV proponents.[62] It's more charitable, other things equal, to characterise the BDV as having less contentious presuppositions, such that it relies on none of (i)-(v). In particular, it is more charitable to characterise it as being consistent with a larger proportion of the major theories of well-being. And it is possible to do this, as I'll argue below. As such, (1*) is not a charitable understanding of the BDV. (In §2.3.3, I'll argue that (1*) also falls foul of the desideratum of appropriate normative relevance.)

2.3.2 – Always instrumentally bad?

I will now consider (3*): the view that disability is always instrumentally bad.

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[61] Some theories of health might imply that ill-health is non-instrumentally bad on subjective theories of well-being. Nordenfelt (1995) defines ill-health as a state in which your body frustrates your vital goals, which are defined relative to preferences. On this account, ill-health might be non-instrumentally bad on preference accounts of well-being. However, on these accounts, it's also unlikely that disability entails ill-health.

[62] If someone thought that disability always involves some objective bad other than ill-health, then their reasoning would be slightly different (in particular, (ii) and (iii) would change), but no less controversial. And I do not know what this objective bad might be.

Disability often is instrumentally bad (Campbell and Stramondo, 2017: 157-160). This is, first, because it sometimes causes non-instrumental bads. Many bads caused by disability are presumably due to disablism. However, not all are. For example, the pain and discomfort caused by some disabilities would exist in virtually all social environments (Shakespeare, 2013: 75). People also sometimes feel distressed by their disability preventing them from doing certain things. This seems especially relevant for people who acquire disability who must adjust to their new condition, which might include the 'transition costs' (Barnes, 2016b: 148) that often accompany coming to terms with being unable to engage in activities important to them, or to pursue goals that involve the use of certain abilities they no longer have (McMahan, 2005: 95). Disability can be instrumentally bad, second, by preventing goods. For example, while Deafness is likely not bad in itself, it can prevent one from communicating effectively, which might prevent one from attaining as much friendship as one could have if not Deaf; disabilities that shorten lifespan (e.g. Cystic Fibrosis) can prevent one from attaining goods (pleasure, achievement etc.) that they would have if they lived longer, and so on.[63][64]

However, disability also can be instrumentally good (Campbell and Stramondo, 2017: 161; Barnes, 2016b: 65). For example, disability might cause a person to have a more positive attitude towards life and enjoy it more; it might help one find friends or mature as a person; it might prevent someone from being conscripted, or allow access to certain disability-exclusive goods – such as becoming a member of the disabled community or experiencing the enhancement of one sense as another diminishes (Barnes, 2016b: 57). In fact, disabled people often report the instrumental benefits of disability. For example, Harriett McBryde Johnson

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[63] The reader may disagree with some of my characterisations of instrumental and non-instrumental value. It is difficult to give uncontroversial examples because whether disability is understood as non-instrumentally or instrumentally bad depends on two contentious issues: i) our chosen theory of well-being, and ii) whether we think certain things (e.g. pain, ill-health etc.) are intrinsic features or causal consequences of disability. If disability itself has no bad features, then it must be merely instrumentally bad, if it is bad at all. However, if disability does contain bad features, then we need to decide whether these features are instrumentally or non-instrumentally bad. Only if they are non-instrumentally bad on our chosen theory of well-being would disability count as non-instrumentally bad. For example, disability counts as non-instrumentally bad *according to hedonism* only if it contains, as opposed to causes, more painful mental states than pleasurable ones. As such, even if a shortened lifespan is an intrinsic feature of a disability (which is debatable for many disabilities) that is bad, hedonists will understand this to be an instrumental bad, as it is not a painful mental state but might cause one. Similar remarks apply to objective list theorists: few understand a shortened life to be objectively bad, but it may prevent one from attaining objective goods or cause objective bads. So, shortened lifespan counts as an instrumental bad on objective theories too. On the other hand, desire theorists would count a shortened life as a non-instrumental bad, if one possessed a non-instrumental desire to live longer. It's easy to see, then, that there is significant scope for debate about whether disability is instrumentally or non-instrumentally (dis)valuable. I will not try to settle either of these contentious issues here. Throughout this thesis, I try to give plausible examples of instrumental and non-instrumental value which will be acceptable to many, but not all. This doesn't affect my arguments as I ultimately argue that the MDV and BDV should consider both kinds of value. Here, I have tried to provide examples where disability causes (rather than contains) the loss of plausibly non-instrumental goods (e.g. friendship, pleasure and achievement).

[64] I discuss in more detail the goods that disability might prevent in chapter 5.

(2003) reports to experience 'great sensual pleasure' in zooming around in her electronic wheelchair. And Sarah Eyre says that her MS causes her to experience bouts of euphoria (Barnes, 2016b: 92).[65]

The key point is that disability can be instrumentally good and instrumentally bad, and there is no evidence that its instrumental badness *always* outweighs its instrumental goodness. In fact, it's implausible that it does. *Just one case* where disability causes more goodness than badness would show that (3*) is false, and it seems probable that there are many such cases, given the number of disabled people and multitude of potential instrumental benefits of disability.

Given that the instrumental value of disability depends on various contextual factors, the view that it is *always* overall instrumentally bad is implausible. Thus, (3*) is not the best interpretation of the BDV, as it would be uncharitable to charge BDV proponents with endorsing an implausible view inconsistent with the fact that disability can be (and often is) instrumentally valuable. In the next section, I discuss another reason to reject (3*).

2.3.3 - Focusing on one kind of value

In this section, I argue that all candidates that focus on either instrumental or non-instrumental value are not good interpretations of the BDV.

Suppose that a recluse *A* acquires a painful disability that causes her to become an active member of the disabled community. *A*'s disability, although non-instrumentally bad, is instrumentally good as it brings her friendship and pleasure. Suppose further that *B* has a disability that involves no non-instrumental bad but causes him to become depressed due to changes in his self-conception: *B*'s non-instrumentally neutral disability is instrumentally bad. Now, it would be misleading to say that *B*'s disability is better for him than *A*'s is for her merely because *B*'s disability is *non-instrumentally* better. This claim – although true on one reading of 'better' – might lead someone to think that priority should be given to allocating resources to fund treatments for *A*'s disability before *B*'s, that it's worse to select for *A*'s disability than *B*'s etc. But these normative conclusions might be erroneous, because focusing on one kind of value can obscure important things.

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[65] For more examples, see Barnes (2016b: 91-93, 119-43), Schramme (2013: 72), https://www.xojane.com/healthy/disabilitys-unexpected-silver-linings (accessed 16/02/18) and http://www.cracked.com/blog/5-ways-my-disability-actually-improved-my-life/ (accessed 25/05/20).

The point is that the BDV would not be as relevant to normative issues if it focused on one kind of value. Doing so can provide a misleading picture, as certain non-instrumentally bad disabilities (e.g. Fibromyalgia) might correlate with instrumental goodness or neutrality, while certain non-instrumentally neutral disabilities (e.g. Quadriplegia) might correlate with instrumental badness. More generally, something can be non-instrumentally bad but all things considered good, or instrumentally good but all things considered bad.

There appears to be no good reason for the BDV to focus on one kind of value when considering both kinds offers a more comprehensive picture of disability's relationship to well-being. Consider the issues to which the BDV is taken to be relevant. If proponent wanted to use the BDV to argue that selecting for disability is impermissible (as McMahan (2005) does), then surely both instrumental and non-instrumental value are relevant. That a condition is non-instrumentally or instrumentally valuable, disvaluable or neutral is not all that matters for whether we ought to select for or against it. If some non-instrumentally neutral disability *D* were reliably correlated with large amounts of instrumental badness, then this appears to provide a defeasible reason to select against *D*. Likewise, if some mildly non-instrumentally bad disability *F* were reliably correlated with large amounts of instrumental goodness, then there would be no good reason to select against *F* – there may even be good reason to select *for F*. What is relevant to the selection debate, and other relevant debates, seems to be overall value, not instrumental or non-instrumental value *alone*. Focusing on one kind of value thus hinders the BDV's relevance to appropriate normative issues.

In sum, considering both kinds of value provides a fuller picture of disability's effect on well-being that is more relevant to appropriate normative issues, and views that consider only one kind of value don't licence the normative conclusions argued for by BDV proponents. Therefore, all candidate interpretations that don't consider both kinds of value should be rejected. So, we should reject (1*), (2*), (3*) and (4*) for this reason, as well as those mentioned above.

2.3.4 – Always or typically all things considered bad?

I have argued that (1*) and (3*) are uncharitable interpretations of the BDV because of their non-probabilistic natures (§2.3.1 and §2.3.2), and that all of (1*)-(4*) should be rejected as considering only one kind of value hinders the BDV's appropriate normative relevance (§2.3.3).

This leaves versions that focus on overall value. Does the best version of the BDV maintain that disability is always ((5*)) or only typically ((6*)) all things considered bad for well-being?

What I said above is relevant here. Disability doesn't always involve non-instrumental bads and its instrumental value depends on circumstances. Thus, it appears implausible to say that disability is *always* overall bad. This speaks to a general problem with non-probabilistic versions of the BDV: they make extremely strong claims that are implausible and easily refuted. Just one case where a disabled life is *not* instrumentally, non-instrumentally or overall bad would be all that's needed to show that non-probabilistic versions of the BDV are false, and (again) it seems likely that there are many such cases, given that disability is not always non-instrumentally bad (at least on many theories of well-being) and can have instrumental benefits. Moreover, any reasonable, rational person would make room in their theory for the mere possibility that someone could do better with a disability by, for example, avoiding conscription. Thus, non-probabilistic versions of the BDV are implausibly strong, so are not charitable interpretations. This provides reason to reject (5*).

One candidate interpretation remains:

(6*): Disability is typically all things considered bad for well-being

Elaborating and reintroducing clauses suppressed above:

> **BDV**: discounting the effects of disablism, a person is (ceteris paribus) typically (likely to be) overall worse off with a disability (in virtue of their disability) over the course of their life than they would have been without.

This view says that, discounting the effects of disablism, a disabled person is (other things equal) likely to have lower lifetime well-being (in virtue of their disability) than they would have done if they were non-disabled. It follows that, discounting the effects of disablism, a non-disabled person is (other things equal) likely to have higher lifetime well-being than they would have done (in virtue of their disability) if they were disabled.

Regarding the desiderata: (6*) is a charitable interpretation. This is because disability is sometimes non-instrumentally bad and sometimes instrumentally bad, and it is prima facie plausible that these bads often, *but not always*, outweigh disability's goods. Moreover, (6*) is not committed to any of the contentious claims (i)-(v). It might be true on any major theory of well-being and doesn't imply that disability *always* involves or causes non-instrumental bads. (6*) is compatible with some cases of disability being overall non-instrumentally or instrumentally good or neutral. It also allows that disabled lives can sometimes be overall *better* than relevantly similar

non-disabled lives. In short, (6*) makes no blanket claims about the quality of disabled people's lives, so is compatible with the heterogeneous nature of disability and the complicated nature of the relationship between disability and well-being. As such, (6*) is more charitable than all non-probabilistic interpretations. In terms of appropriate relevance, the fact that it considers both kinds of value increases the BDV's relevance to appropriate normative issues, as this gives a more comprehensive picture of disability's effect on well-being. Given this, (6*) is more relevant to appropriate normative issues than all views which merely consider pro tanto value.

That concludes my argument that (6*) is the best version of the BDV. The MDV is the denial of the BDV and the GDV (Barnes, 2016b: 69). In light of my arguments here, we can cash the GDV out as:

> **GDV**: discounting the effects of disablism, a person is (ceteris paribus) typically (likely to be) overall better off with a disability (in virtue of their disability) over the course of their life than they would have been without.

I know of no one who endorses the GDV, but it takes up an important part of logical space. Its existence thus complicates this debate, as one cannot argue for the MDV merely by arguing that the BDV is false, and vice versa.

Having explicated the best versions of the BDV and GDV, it is now a simple task to characterise the MDV:

> **MDV**: discounting the effects of disablism, a person is not (ceteris paribus) typically (likely to be) overall worse off or better off with a disability (in virtue of their disability) over the course of their life than they would have been without.

Before moving on, some additional points need explanation. First, because they are probabilistic, the views each make a claim about the difference having a disability is *likely to have* on a person's well-being. Hence, they are claims about well-being *prospects* as opposed to actual well-being levels.[66] I understand *S*'s prospects for well-being, roughly, to be how likely *S* is to have a given level of well-being. I take idealised subjective probability to be the relevant notion (cf. Jackson, 1991: 463-65). That is, *S*'s prospects are determined by the prediction of *S*'s well-being a rational agent would make if they considered all relevant evidence.

Second, each view is concerned with *lifetime* well-being prospects. We might be interested in whether disabled people are likely to have equal or worse well-being over a given timespan –

[66] One might also think it a bit odd to talk about actual well-being levels of non-actual individuals inhabiting W_1.

perhaps during childhood or adolescence – but our desideratum of appropriate normative relevance provides one good reason for thinking that the MDV, BDV and GDV are all interested in lifetime prospects. These views are thought (amongst other things) to imply certain things about the ethical statuses of pre-natal selection for or against disability. The views are most relevant to these issues when understood as focusing on lifetime well-being prospects. What matters for the ethics of selecting for or against disability is how well-off a potential child is likely to be over the course of their life. It is unclear why well-being prospects over a particular timespan would make a normative difference over and above their contribution to lifetime prospects.[67] In addition, for any given timespan shorter than a lifetime, the question can be asked: why is this timespan more worthy of enquiry than any other, in particular that which covers the individual's lifetime? I can think of no good reason to focus on a shorter timespan. For these reasons, I take it that the views are interested in lifetime well-being prospects.[68]

Third, the MDV claims that, minus disablism, disabled people are likely to be *neither worse nor better off* than they would have been if they were non-disabled. If interpreted as meaning 'exactly as well off as', then the MDV might seem a priori unlikely (Andric and Wundisch, 2015: 12) as it is less likely, ceteris paribus, for two values to exactly equal one another than for there to be some difference between them. This is true, but we can interpret the MDV charitably such that it tolerates small discrepancies in the well-being prospects of relevantly similar disabled and non-disabled individuals in W_1. We should thus interpret the MDV not as the claim that prospects of disabled and non-disabled individuals are *exactly equal* in W_1, but rather that they are roughly equal or *on a par*. What that means is that there is *no significant difference* between the prospects of disabled and non-disabled people (cf. Stoner, 2016: 930; Shepherd, 2018: 3). We can say that there is a significant difference between the prospects of *A* and *B* when possession of all the information about the prospects of *A* and *B* provides a rational agent with a significant reason to prefer the life of either *A* or *B*. If consideration of this information provides only a weak reason, or no reason at all, such that we think the individual would be better served basing her preference on other factors about the lives – perhaps on their aesthetic or moral value – then we will say that the prospects of *A* and *B* are on a par. For example, if we knew that the only difference between lives *A* and *B* is that *A* will find ten pounds whereas *B* will fail to notice this money, then we would say that the prospects of *A* and *B* are on a par even if we accept that finding ten pounds slightly improves *A*'s comparative well-being prospects, as we would hardly

[67] However, on non-additive account of well-being, some timespans contribute more than others (cf. Wasserman and Asch, 2013: 145-46). I will not discuss non-additive accounts.
[68] Henceforth, I use 'well-being' to mean 'lifetime well-being' unless stated otherwise.

consider the fact that *A* will end up, over the course of her lifetime, ten pounds richer than *B* as a significant reason to choose *A*'s life rather than *B*'s.

Putting this all together: The BDV claims that disability would have a negative effect on lifetime well-being prospects in the actual world even if we eliminated disablism, while the MDV claims that, in this situation, disability would have a neutral effect. I've already said that to determine whether this is true, we must theorise about W_1. More specifically, we must gather relevant information about the nature of disabilities, the actual world, well-being and disablism. Putting this information together will provide a reasonable idea of the nature of the closest worlds without the actual world's disablist features and of the well-being levels of disabled and non-disabled people in them. This picture needn't be absolutely comprehensive to motivate reasonable judgements about the views (more on this in chapters 3 and 4). We can form these judgements by carefully considering the relevant information to see whether we can identify significant and systematic differences in the distribution of prudential goods amongst disabled and non-disabled people in W_1. We are looking for *systematic* differences because we are trying to identify whether there is a discrepancy in the average well-being prospects of two large groups. Differences between particular individuals thus are not our focus (more on this in chapter 3). Identifying whether there are significant and systematic differences between the groups in access to prudential goods will allow us to get an idea of whether the average well-being prospects of disabled and non-disabled people in W_1 are on a par. Using this probabilistic information, we can infer whether *a given individual* is likely to have lower well-being (has lower well-being prospects) with a disability than without in W_1, or whether their well-being is likely to be on a par.[69] And this, in turn, will give us an indication of whether people *in the actual world* are likely to be worse off with a disability than without (minus the effects of disablism).[70]

The above is merely a sketch of the process by which we can go about determining whether the MDV or BDV is true. Completing this process certainly appears difficult and there are further questions about it that I have not answered, but there seems to be no reason why we cannot in principle complete it. I will supplement this sketch in chapters 3 and 4, providing more

[69] Given that we are trying to make reasonable judgements about individuals from information about averages, the relevant averages seem to be mean well-being prospects. The mode or median well-being might be interesting for other reasons, but will not be my focus.

[70] This methodology is inspired by Lewis' (1979) influential analysis of counterfactual dependence. He suggests that to determine whether a counterfactual 'if *A* were the case then *B* would be the case' is true we need to look at the closest (most similar) worlds where *A* obtains and see whether *B* also obtains. In a sense, I am trying to evaluate the counterfactual 'if non-disablism obtained then the well-being prospects of disabled and non-disabled people would be on a par'. To do so, I need to look at the most similar worlds where non-disablism obtains and see if those are worlds where prospects are on a par. If they are, then the counterfactual is true. If the closest worlds are ones where non-disabled people typically have better prospects, then the counterfactual is false and the BDV is true.

detail about how we can perform this process and responding to the objection that doing so is impossible.

2.4 – Three Worries

In the previous section, I explicated and defended my understandings of the MDV, BDV and GDV and sketched how we can go about determining which view is true. In this section, I will discuss three potential worries with my understandings.

First, I said that the BDV and MDV make claims about how well off a person is likely to be with a disability compared to without. These understandings raise issues about identity. If disabilities are identity-determining, we cannot compare *a particular person's* prospects with a disability and without (Campbell and Stramondo, 2017: 161). I won't discuss whether disabilities are identity-determining. What I'll say is that 'a person' and 'they' in the definitions above needn't rigidly designate the same numerically identical person. If disability is identity-determining, we may be comparing the prospects of two metaphysically different but relevantly similar people. And we needn't think numerical identity must be preserved for a comparison between individuals to bear relevance to moral considerations (Kahane & Savulescu, 2009: 37). As such, I'll assume that the relevant comparisons are possible and at least potentially morally relevant. This assumption seems dialectically warranted, as all who understand the views as comparing the well-being (prospects) of individuals with disabilities and without face similar issues (e.g. Barnes, 2016b: 86-88).

Second, I said that we determine whether the MDV or BDV is true by identifying average well-being prospects of the disabled and non-disabled groups in W_1 and using this probabilistic information to determine whether a given individual is or is not likely to have lower well-being because of a disability. One might worry about whether the broad focused, coarse-grained approach of averaging across *all disabilities* will lead to illuminating results. After all, what is true of a population on average is often not true of particular members of that population (Stramondo and Campbell, 2018: 5), especially when members of that group are heterogeneous. The nature of different disabilities and the social and physical environments in which they exist *is* strikingly heterogeneous. As such, generalisations about this broad group might not to apply to any (or many) of its members. For example, it might turn out that disability, on average, is a mere-difference, whereas no single case of disability is. Call this the *Problem of Averages*. One might think that the Problem of Averages motivates a narrower, more fine-grained, enquiry.

It seems likely that a more granular approach would be less prone to mischaracterise the prospects of particular individuals. This raises the question of just how granular an analysis would be best. We might try to categorise disabilities into broad groups and conduct separate enquiries into the well-being prospects of each group; we might consider individual disabilities; or we might even consider particular people with particular disabilities in particular contexts.

Every level of granularity faces difficulty. As mentioned, more coarse-grained methods seem more likely, ceteris paribus, to misidentify an individual's prospects when reasoning from probabilistic evidence. However, more fine-grained enquiries are less practical. And, unless we choose to conduct extremely fine-grained enquiries into each disabled person, it's always possible that generalisation about a group of any size do not apply to many of its members. This is a problem faced by anyone making particular inferences from information about averages.

It seems that we are stuck between a rock (the Problem of Averages) and a hard place (impracticality) when choosing a level of granularity. I have, as mentioned, chosen to conduct a relatively broad focused enquiry into whether physical (including sensory) disability is bad for well-being. Why do I restrict to physical disabilities? I choose this tactic over more fine-grained enquiries, first, because of its practicality. It is not realistic for a PhD thesis (or for most other projects) to conduct separate enquiries into each disability or, a fortiori, into each disability in each social context. And I can think of no reason why particular disabilities are more worthy of enquiry than others.

I choose to conduct a broad investigation into physical disabilities, second, and more importantly, for dialectical reasons. In general, debates about disability tend to take place at a broad level. Thinkers tend to discuss 'disability' rather than particular disabilities, and even less discussion takes place about particular disabilities for particular people in particular contexts. When thinkers do discuss particular disabilities, this is typically to motivate a more general point about disability as a whole. There are not currently separate debates about different disabilities (although, perhaps there should be). I want my work to fit within and add to the ongoing debates about disability. More specifically, I want to engage with the work of Elizabeth Barnes. She is my central foil in this thesis, and she conducts her enquiry into the connection between disability and well-being with a broad focus (more on this below). Moreover, the claims of MDV-supporting disability rights activists tend to focus on disability generally. They do not tend to claim that a given disability is a mere-difference, rather they say that disability *in general* is a mere-difference. For example, disability rights activist Harriet McBryde Johnson (2003) writes '[a]re we [disabled people] worse off? I don't think so'. This suggests that at least many advocates of the

MDV understand the debate as taking place at a general level, meaning that my coarse-grained strategy (although vulnerable to the Problem of Averages) coheres with how this debate – and others in disability scholarship – is being conducted.

Third, although there is always the risk of error when making specific inferences from from probabilistic judgements, it doesn't follow that inferences about particular cases from probabilistic evidence cannot be illuminating. That is, I do not see the Problem of Averages to be so serious as to outweigh the practical and dialectical reasons for a broad focus.

It is for these reasons that I choose the broad focus of physical disabilities. Given these points, however, one might wonder why I restrict my scope *at all*. Why focus on physical disability rather than disability generally? Again, my primary reason is dialectical. Barnes (e.g. 2016b) explores the broad question of whether physical disability is bad for well-being, and she is the thinker that I most want to engage with. As such, it is best to frame my question as she frames hers. This allows me to meet the existing debate where it stands and heads off one reason to worry that my later criticisms of her arguments (see esp. chapter 4) are off the mark.

There are also practical reasons for restricting my scope to physical disabilities. To identify the relationship of disability to well-being, we must have some reliable method of making reasonable judgements about the well-being of disabled and non-disabled people (more on this in chapters 3 and 4). However, it is entirely unclear how we might evaluate the well-being of people with certain non-physical disabilities, particularly severe cognitive or intellectual ones. On the other hand, it seems more likely that we can evaluate the well-being of those with purely physical disabilities in ways similar to non-disabled people (e.g. by taking first-person reports). In addition, I discuss (in §4.3) whether disability positive testimony from disabled people is good evidence for the MDV. It's difficult enough to discern whether testimony from physically disabled people is reliable in this context. But there are separate and complicated questions concerning the reliability of testimony from people with psychological (cognitive, intellectual) disabilities that cannot possibly be tackled in this thesis (cf. Barnes, 2016b: 3).

Finally, focusing on physical disabilities significantly reduces the heterogeneity of the group that I am reasoning about. A final reason for narrowing my scope, then, is that doing so somewhat mitigates the Problem of Averages.[71]

[71] I recognise, though, that the problem is not completely solved by restricting my scope (see below in this section and §7.2).

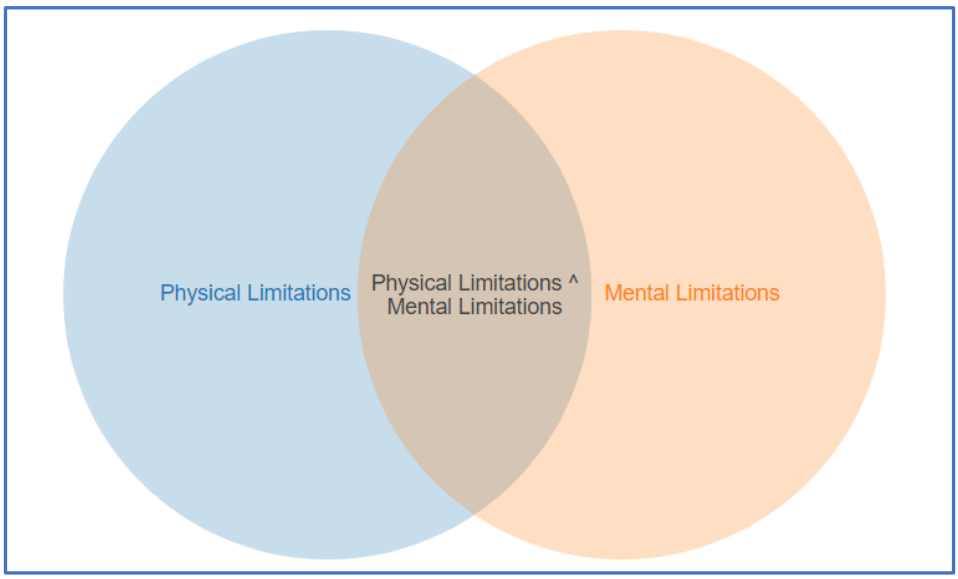
I have motivated my decision to discuss only physical disabilities. Now, there may be questions about how to draw the physical/non-physical distinction and worries that, however we draw it, the distinction doesn't stand up to scrutiny.[72] It is beyond the scope of this thesis to settle the debate about how to distinguish physical and non-physical disabilities, and surprisingly little philosophical literature discusses this issue. Thus, all I can do is say something about how *I* understand the distinction, in order to specify the subject matter of this thesis, without claiming that this is the best understanding.

It seems to me that there are (at least) two reasonable candidates for distinguishing physical and non-physical disabilities: the *nature* of the relevant limitation (is one limited in a mental or physical activity?) and *cause* of said limitation (is the atypical feature that causes the limitation mental or physical?).[73] Of these candidates, I'm more attracted to focusing on the nature of the limitation. If one is limited in a regular physical activity (e.g. walking) by their atypical features interacting with contextual factors, then I would say that they are physically disabled, even if the abnormal feature causing this limitation is psychological (e.g. a brain injury). Likewise, I believe that psychological disabilities occur when one is limited in regular psychological activities (e.g. learning, reasoning, remembering etc.). And, following Barnes (2016b) and others, I am counting the exercise of the senses as a physical activity.

On my understanding, then, some disabilities involve purely physical limitations (e.g. limb loss), others involve purely mental limitations (e.g. Dyslexia) and some plausibly involve both mental and physical limitations. As such, my understand of the physical/nonphysical disability distinction can be represented as a Venn Diagram:

[72] For example, Beaudry (2016) questions whether it is theoretically useful to have one concept of *disability* that captures all the different kinds.
[73] One might also combine both tactics.

Figure 1: The Physical/Non-Physical Disability Distinction



I am focusing purely on the left side or, where disabilities sit in the middle, I am focusing on the effect of physical limitations on well-being and ignoring the effects of mental limitations.

I am not going to defend this way of drawing the physical/nonphysical distinction in any detail. I will only say that one reason for focusing on the nature of the limitation is that identifying the cause of a limitation might be a difficult process, and there might be a number of causes, both physical and mental, that interact in complex ways. However, I understand that, for some limitations, it also might be unclear whether they are mental, physical or both. In fact, the very idea that we can distinguish mental from physical limitations might be misguided in many cases. For example, it is arguably unclear whether being unable to speak is a mental or physical limitation – perhaps it can be either, or both, depending on the exact kind of limitation that prevents speech (is it because one cannot control their tongue, or because one cannot select the right words?). But these are issues that I cannot discuss here.

My arguments also do not rely on my understanding of the distinction. I am going to reason about disabilities which intuitively involve physical limitations, and which are typically classified as physical by other thinkers. As such, the thought is that, on most reasonable ways of drawing the distinction, these disabilities will count as physical.

It's worth mentioning, finally, that others in the debate – e.g. Barnes (2016b: 2-3), Wasserman and Asch (2013: 143) and Putnam (2018: 306) – restrict their scope to physical disabilities without offering a neat way of carving up the territory. As such, it seems to be a presupposition of various debates in the Philosophy of Disability that we can distinguish physical

from non-physical disability. It is possible, though, that this presupposition is mistaken and that the things we think of as physical disabilities in fact have nothing that unifies them.[74]

As well as restricting my scope to physical disabilities, another feature of my enquiry somewhat mitigates the Problem of Averages: I restrict my enquiry to typical western contexts. There are striking differences between different communities in landscape, culture, technology and the daily activities of the population.[75] On the face of it, it seems easier to believe that disability would be bad for well-being (minus disablism) in cultures with little technology, where manual labour is the primary source of paid work, or where people must travel long distances by foot daily to (e.g.) collect food or water. As such, restricting my enquiry to the typically more economically and technologically developed countries of the western world appears charitable to the MDV, and to considerably reduce the heterogeneity of the contexts that I am reasoning about.

I restrict my scope in these two ways to somewhat alleviate the Problem of Averages. Of course, these restrictions do not solve the problem. It cannot be completely solved unless we reason at an extremely fine-grained level. All levels of granularity face difficulties and I will thus suggest an alternative direction that this debate could take – one that doesn't suffer from the same granularity issues – in chapter 7. Prior to that, I will conduct my discussion at a reasonably coarse-grained level. As mentioned, doing so is practical, allows for potentially illuminating findings and fits with how other debates in disability scholarship – including this one – are taking place. I will, however, note in various places the difficulties posed by this relatively broad focus.

Another worry worth mentioning at this point – the third and final one that I address in this section – concerns the combination of my broad focus and my probabilistic understanding of the views. When making probabilistic claims about a heterogeneous group, its demographics are going to significantly affect their plausibility. That is, whether a person is likely to be worse off with a physical disability will depend on the nature of the conditions that constitute the physically disabled group, and on their distribution. Some physical disabilities seem to involve few, if any, significant bads (e.g. Blindness and Deafness), whereas other disabilities seem to involve more obvious bads (e.g. Fibromyalgia and Multiple Sclerosis). The distribution of the diverse array of conditions that count as disabilities is, thus, going to affect the plausibility of probabilistic versions of the MDV and BDV. One might even think that this matters so much that, without detailed demographic information, we cannot reasonably evaluate probabilistic

[74] Henceforth, I use 'disability' to mean physical disability unless otherwise qualified.
[75] I discus technological development and its relationship to this debate in more detail in chapter 6.

versions of the views. This problem is not as serious for categorical versions which state that disability is always bad/neutral for well-being, as just one counterexample is needed to show that these are false, so demographics are less important.

In response, I would point out three things. First, to reiterate, I have chosen a broad focus primarily for dialectical reasons. And there are problems with this tactic, some of which I mention in the section and others that I note in later chapter. This is why I suggest a different, narrow focused, approach in §7.2. However, and second, a probabilistic approach is best whether we have a narrow or a broad focus. Whether we focus on disability generally or particular disabilities, we don't want a single counterexample to show that our views are false; there is likely to be at least one case where almost every disability makes life go better and one where it makes life go worse. It's true that the combination of a broad focus and probabilistic understandings raises particular (and reasonable) worries about demographics, but I take the worries about categorical versions of the views to be more serious. For one, because the demographical worry can be overcome by collecting the relevant information, whereas the single counterexample worry will pervade no matter what.

Third, it may be an exaggeration that we need detailed demographic information to assess probabilistic, general versions of the views. If we make a key assumption, we are left in a position where it is at least possible to assess these views without this information. We can assume that there are a significant amount of people with each disability, which I think is reasonable, given that I am reasoning about established disabilities, which don't tend to be conditions present in only a handful of individuals. If this assumption is correct, then the well-being value of every disability will have some effect on the average well-being value of disability in general. That is, the well-being value of every disability has the potential to pull down or lift up the well-being value of disability as a whole. This leaves open the possibility of coming to a conclusion about probabilistic, general versions of the views without knowing detailed information about distributions. For example, if we discovered that a number of disabilities are generally bad-differences, a number are generally mere-differences, but that none are generally good-differences, then we could infer that disability in general is typically a bad-difference without knowing detailed demographic information, as there would be no disabilities that counterbalance the bad ones. Of course, we *would* need demographic information if a variety of disabilities were good and bad differences, but this may not be the case. So, depending on what we discover later on in our investigation, detailed demographic information might not be needed to come to reasonable conclusions.

Conclusion

In this chapter, I cashed out the best versions of the MDV and the BDV and sketched how we can go about determining which is true. I argued that the best versions of both views make comparative claims about the all things considered lifetime well-being prospects of disabled and non-disabled people in the closest non-disablist worlds:

> **BDV**: discounting the effects of disablism, a person is (ceteris paribus) typically (likely to be) overall worse off with a disability (in virtue of their disability) over the course of their life than they would have been without.
>
> **MDV**: discounting the effects of disablism, a person is not (ceteris paribus) typically (likely to be) overall worse off or better off with a disability (in virtue of their disability) over the course of their life than they would have been without.

In §2.1, I presented the desiderata of charity and appropriate normative relevance which I used to identify the best versions of the views. In §2.2, I discussed why the views discount disablism and sketched what W_1 would be like. In §2.3, I argued that the best version of the BDV makes a probabilistic claim about the all things considered well-being value of disability as compared to non-disability in W_1. In light of this, I cashed out the MDV and began explaining how we can go about determining which view is true. Finally, in §2.4, I discussed problems of non-identity, considered whether I should conduct my enquiry with finer granularity, and discussed whether detailed demographic information must be compiled to assess my preferred versions of the MDV and BDV.

Chapter 3 – Understanding Well-Being

The MDV and the BDV each postulate a relationship between disability and well-being. I have addressed how to understand disability, the MDV and the BDV. But I have not yet specified how we can go about determining which view is true. In this chapter, I do the final preliminary work necessary to adjudicate and advance the debate between the MDV and BDV. That is, I present and defend a method of understanding well-being that allows me to make reasonable predictions about the well-being prospects of disabled and non-disabled people in the closest non-disablist worlds.

One might think that, to enter into any useful discussion of the connection between disability and well-being, one must either i) first determine what constitutes well-being, or ii) choose one theory of well-being on which to ground one's discussion. However, both strategies are problematic. There is no realistic chance of settling the well-being debate anytime soon, and certainly not within the confines of this thesis. So, (i) would leave the debate at a (possibly permanent) stalemate. On the other hand, choosing (ii) would be to take a stance on one of the more contentious issues in philosophy. This would be problematic both because those who do not endorse the chosen theory are unlikely to find my discussion useful, and because it is better (other things equal) for arguments to rely on less contentious presuppositions. In this chapter, I present and defend a third option for understanding well-being, one that allows me to examine the plausibility of the MDV and BDV while not overcommitting myself on contentious issues.

My strategy is to differentiate between *sources* and *theories* of well-being. Briefly, sources of well-being are the substantive goods in life or the things that make a life go well. Theories of well-being purport to *explain why* these things make a life go well. In adjudicating the debate, I plan to focus on the sources of well-being while remaining agnostic about the true theory of well-being. The thought is that staying at source-level uses the weakest premises necessary to establish a conclusion about the relationship between disability and well-being that would be acceptable to those who endorse different theories of well-being. Thus, my strategy provides a fair basis on which I can adjudicate the debate, while not unnecessarily committing to any theory of well-being.

First, in §3.1, I present preliminaries. In §3.2, I present and defend my strategy for understanding well-being in a way that allows me to make reasonable predictions about the well-being prospects of disabled and non-disabled people in the closest non-disablist worlds, which is to identify whether disabled and non-disabled people are likely to have equal access to the sources of well-being in these worlds. I also argue that my strategy is sufficiently neutral between

the major theories of well-being for my judgements to be acceptable to (most) supporters of these theories. Next, in §3.3, I discuss potential problems for my strategy. Finally, in §3.4, I present an illustrative, theory-neutral list of sources of well-being which can act as a fair basis on which to adjudicate the debate.

3.1 – Preliminaries on Well-Being

Well-being is the non-instrumental prudential value a life has for the person whose life it is. Before discussing my strategy for determining well-being prospects, it will be useful to offer some preliminary discussion. First, I will briefly remind the reader of the three major philosophical theories of well-being.

Since Parfit (1984: 491-503), it has become standard practice to separate theories of well-being into three camps: desire satisfaction theories, objective list theories and hedonism.[76] Hedonism holds that well-being consists in the experience of certain mental states. For hedonism, pleasure is the only non-instrumentally valuable mental state and pain is the only non-instrumentally disvaluable mental state. Thus, well-being consists in experiencing the largest net-sum of pleasure minus pain, and nothing else is a constituent of well-being (Parfit, 1984: 493).

Desire theories hold that well-being consists in the satisfaction of our desires (Heathwood, 2006: 541). Some hold that satisfaction of our *actual* desires constitutes well-being (e.g. Murphy, 1999). However, these theories commonly face two objections. First, one might desire something only instrumentally. For example, one might desire wealth only as a means to a comfortable life. And it seems like the satisfaction of our actual but merely instrumental desires is not in itself good for us (Heathwood, 2014: 212). Second, a person might be radically misinformed about what is good for them, such that they possess a desire for something which, if satisfied, would not intuitively improve their well-being – e.g. I might desire a cake that, unbeknownst to me, has been poisoned. It has thus become common for desire theories to hold that well-being consists in the satisfaction of the *non-instrumental* desires that we *would have in ideal conditions* (where we are in full possession of the facts, making no mistakes in our reasoning etc.) (Heathwood, 2014: 212-213). This *idealised desire theory* will be the desire theory on which I focus.

Finally, objective list theories hold that well-being consists in the attainment of objectively valuable things (Parfit, 1984: 499). It is, in principle, possible for anything to appear

[76] Some thinkers (e.g. Fletcher, 2013; Woodard, 2013) express worries about this tripartite distinction. I will not be exploring these issues.

on an objective list theory's list of goods. However, there is often significant overlap between different lists (Rice, 2013: 210).[77] Typically, things like friendship, personal achievement, pleasure and knowledge are included (Campbell, Nyholm and Walter, forthcoming).

Having reminded the reader of the three major theories, I will now briefly present a distinction crucial to my strategy for understanding well-being. More detail will be added below. In recent literature, some thinkers have distinguished between enumerative and explanatory theories of well-being (e.g. Woodard, 2013; Lin, 2017; Fletcher, 2013; Crisp, 2006). Enumerative theories answer the question: which *things* make life go well (Crisp 2006: 622)? To answer this question, one must present a list of the substantive goods in life. Explanatory theories, on the other hand, purport to answer a different question: what is it about these things that makes them good for our well-being? To answer this question, one must identify some good-for-making property that all the answers to the enumerative question share (Crisp: 2006: 623).[78]

Sumner (2006: 17-18) provides helpful terminology to distinguish answers to each question. He says that, when we are answering the enumerative question by identifying the things that are good for us, we are presenting a list of the *sources of well-being*; and when we answer the explanatory question by identifying a good-for-making property, we are giving a *theory of well-being*. I understand sources of well-being to be the *constituents or typical causes* of well-being. That is, the things that directly or indirectly make lives go well. For example, for hedonism, the sources of well-being would be pleasure and the things that typically cause pleasure. Below, I explain in more detail what is meant by a 'typical cause' and why I bundle together constituents and typical causes.

3.2 – My Strategy for Understanding Well-Being

In this section, I present and defend my strategy for understanding well-being in a way that allows me to adjudicate the debate between the MDV and BDV without committing to a particular theory of well-being.

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[77] See (Ross, 1930: 134-140; Finnis, 1979: 86-90; Parfit, 1984: 499; Griffin, 1986: 67-68; Kagan, 1997: 39; Nussbaum, 2011: 33-34; Fletcher, 2013: 214; Rice, 2013: 210; Heathwood, 2014: 201-02; Hooker, 2015: 19-27). Some of these theorists do not endorse the lists they postulate; they present their lists as plausible candidate objective goods.

[78] As noted by Crisp (2006: 623), this distinction is somewhat rough. In some cases, an answer to the enumerative question is also intended to be explanatory, and an explanation can sometimes be presented as an enumeration. For criticism of this distinction, see Lin (2017).

What must I do if I am to fairly adjudicate the debate? Given that I have no direct epistemological access to the comparative well-being prospects of disabled and non-disabled inhabitants of W_1, I must devise a strategy which allows me to predict with a reasonable degree of reliability how well off members of these groups are likely to be in comparison to one another. That is, I must devise a strategy that allows me to make reasonable predictions about their comparative well-being prospects. My contention is that, to do this, I need only identify a plausible list of sources of well-being. For my purposes, it only matters how well off the inhabitants of W_1 are likely to be, it doesn't matter *why* they are likely to be as well off as they are. That is, it doesn't matter what the true theory of well-being is. Plausibly, then, I can predict the comparative well-being prospects of disabled and non-disabled inhabitants of W_1 by identifying whether they have equal opportunities to access the sources of well-being.

This strategy relies on the plausible thought that a life with more opportunities to access the things which typically make a life go well is, ceteris paribus, likely to be better than one with fewer such opportunities. If this thought is true, then identifying a plausible list of sources of well-being will provide me with the tools needed to adjudicate the debate between the BDV and MDV without answering the further explanatory question of why the sources of well-being make lives go well.

Besides providing a method for adjudicating the debate, what are the other benefits of my proposed strategy? Well, it is better to rely on weaker premises in establishing a conclusion, if possible, and I contend that this strategy relies on the weakest premises necessary to establish a conclusion about the connection between disability and well-being. Relying on weak premises about the sources of well-being is appropriate because, as I will argue, there is significant consensus on the sources of well-being. As such, this strategy is sufficiently neutral between the major theories of well-being, meaning that it allows me to make predictions about the well-being prospects of the inhabitants of W_1 that (most) supporters of the major theories would find acceptable. This means that – as well as not unnecessarily committing myself on controversial issues – another benefit of my strategy is that few readers will be prevented from finding my discussion useful, as they might be if I opted for one theory of well-being.

I will now defend my claim that there is significant agreement on the sources of well-being from supporters of different theories. Something that differentiates the theories of well-being is their answer to the explanatory question: they all identify different good-for-making properties. For hedonism, the good-for-making property is (something like) being a pleasurable experience. For the desire theory, it is (roughly) being the satisfaction of a (non-instrumental,

idealised) desire. The objective list theorist might hold that all of the things on her list are good for us non-instrumentally, in which case she would think that there are many good-for-making properties which correspond to the different things on her list – such as (e.g.) being knowledge. For other kinds of objective list theories – what we might call perfectionist theories (e.g. Hurka, 1993) – the good-for-making property would be (something like) contributing towards the perfection of human nature.

Recall, though, that the sources of well-being are not *only* the things which benefit our well-being non-instrumentally; they are not only the constituents of well-being. They are also the typical causes. (I take typical causes of well-being to be the things that cause well-being *in the large majority of ordinary cases*.)[79] It is important to realise, then, that nothing precludes supporters of the three major theories from agreeing on the sources of well-being, even though they disagree on the good-for-making property. Nothing, for example, precludes the desire theorist or hedonist from including personal achievement among their list of the things which typically make lives go well. They (respectively) need only claim that personal achievement typically causes pleasure or typically satisfies our idealised non-instrumental desires.

In fact, it should be *expected* that the theories would all identify strikingly similar sources of well-being. The purpose of the theories provides one strong reason for thinking so. Each theory is trying to capture our intuitive, pre-theoretic notion of well-being (Kahane and Savulescu 2009: 29). Because of this, any plausible theory must aim to preserve to a large degree our pre-theoretic intuitions about well-being. And the most plausible theory of well-being will be the one that (other things equal) respects the largest proportion of our strongest pre-theoretic intuitions.[80] It is, moreover, more important for the theories to capture our most robust intuitions about well-being, which tend to concern the sources of well-being. Both laypersons and philosophers have an intuitive grasp of which things typically make a life go well (Stoner, 2016: 927). Perhaps people would not be able to identify them off the top of their heads. But, if given suggestions, most people would have reasonably clear intuitions about whether a given thing typically improves well-being. What people are unsure about is the *reason why* these things benefit us, and whether they do so instrumentally or non-instrumentally.

Take friendship as an example. Any reasonable proponent of any theory of well-being is going to agree that friendship is typically good for us (cf. Campbell, Nyholm and Walter,

[79] I focus on *typical* causes because, whatever one thinks are the constituents of well-being, different things will cause the constituents for different people. For example, different people desire, take pleasure in, and experience achievement from different things. More on this in this section below.
[80] There will be other desiderata, such as cohering with other beliefs, internal consistency etc.

forthcoming) because it is a strong and clear intuition that a life with more friendship is, ceteris paribus, better than one with less. Any theory that did not include friendship amongst its sources of well-being would, thus, be counterintuitive and implausible. The primary disagreement between the theories comes in *explaining why* friendship is good for us.[81]

Some objective lists include friendship (e.g. those postulated by Kagan, 1997: 39; Fletcher, 2013: 214; Heathwood, 2014: 201-02; Hooker, 2015: 27-29). Those who endorse these lists hold that friendship is good for us non-instrumentally. Other objective list theorists might hold that friendship is good for us because it is an instance or cause of personal achievement, or because it contributes towards the perfection of human nature. Idealised desire theories are likely to say that friendship benefits us because we would non-instrumentally desire it in ideal conditions. After all, an idealised desire theory would appear counterintuitive if it implied that friendship is not good for us. For hedonism and the actual desire theory, whether friendship is a source of well-being will be contingent upon a subject's attitudes towards friendship and how they experience it. Even so, most actual desire theorists and hedonists will likely agree that friendship is good for (most of) us because it typically brings us pleasure or satisfies our strong desires (Heathwood, 2014: 202). Certainly, those who do not experience pleasure from friendship, or who do not desire friendship, are few and far between.

If what I have said is correct, then friendship counts as a source of well-being for supporters of all the major theories. Each will agree that friendship contributes to well-being, even if they disagree about why. I submit that there are many other things about which we have strong intuitions concerning their statuses as sources of well-being and, as such, that the theories will agree are sources. Among these things, I think, are many other things that typically appear on objective lists, such as autonomy, personal achievement, knowledge, pleasure, and so on. I want to suggest that (most) supporters of the three major theories would accept that these things are sources of well-being, which is, as mentioned, explained by all the theories being designed to capture our robust intuitions about well-being, and by the fact that we possess strong intuitions that these things typically make lives go better. The data that these theories are trying to respect are our intuitions about well-being. As such, if they failed to imply that things like pleasure, knowledge and achievement are good for us in some respect, then this would count against their plausibility.

[81] Other disagreements occur about situations when other things are not equal, such as when a subject must trade-off one source of well-being and another. I will ignore these complications.

The purpose of understanding sources of well-being as constituents or typical causes should now be clear: doing so increases my strategy's theory-neutrality. While there is significant disagreement on the constituents of well-being, there is likely to be much greater consensus on the things that are either constituents or typical causes.

This brings me to a related point. People generally find all major theories of well-being at least somewhat plausible.[82] This suggests that there is significant overlap in the things that these theories imply are sources of well-being. A good explanation for why we find all the theories plausible is that, in most cases, they have similar implications: if given information about a subject (which does not include detailed information about her desires or what she finds pleasurable) proponents of the three theories will usually reach consensus on how well off she is likely to be. Suppose that supporters of the three major theories were told of Sarah only that she is psychologically normal, fulfilling her lifelong ambitions, has many friends and is generally enjoying her life. In this case, they will likely agree that she has a good level of well-being (while telling different stories about why). If this were not true, and the theories had different implications in cases of psychologically normal individuals like Sarah, then it would be easier to choose between the theories than it is.[83] We would possess a powerful tool for choosing between the theories: construct cases of normal individuals whom we strongly intuitively feel are doing well or badly and see whether each theory respects our intuitions. We do not possess this tool precisely because the theories have extremely similar implications in the majority of realistic cases. Their implications come apart primarily when considering abnormal individuals or situations. The best explanation for this is that there is significant consensus on the sources of well-being (for ordinary individuals) amongst these theories.[84]

In sum, we have an explanatory chain. All theories of well-being try to capture our robust pre-theoretic intuitions about well-being. This explains why they largely agree on the sources of well-being, as our most robust intuitions about well-being concern the things that make lives go well. This agreement on sources explains why the theories have similar implications for normal individuals, which explains why we find all the theories plausible and why it is so difficult to choose between them. If one wants to deny that the theories largely agree on sources, then one must i) deny this explanatory chain; and ii) explain why the theories disagree about sources of well-being *even though* they are all trying to capture our intuitions about well-being; and iii) offer a

[82] This is evidenced by the continued stasis in the debate over which theory is correct.
[83] I discuss psychologically unusual individuals below.
[84] Stoner (2016: 927) suggests that, if there were not agreement on the things that make life go well, it might be impossible to develop a theory of well-being.

different candidate explanation for why the theories have strikingly similar implications in most ordinary cases.

If what I have said is true, then the theories largely agree on what the sources of well-being are, at least for psychologically normal individuals (cf. Shepherd, 2018: 2). Note that my claim is not that there is *absolute convergence* on the sources of well-being from supporters of the major theories; it is that there is *significant consensus* that is sufficient to predict the well-being prospects of the inhabitants of W_1 in a manner acceptable to most supporters of the theories.

Other thinkers appear to agree:

> The main competing theories of well-being… offer conflicting accounts of the nature of well-being, but still largely agree about the particular things that make life go better or worse (Kahane and Savulescu, 2009: 29).
>
> Virtually all theories of the good… will assert similar lists of the things that are sources of value (Arneson, 1999: 9).
>
> Long before we begin to theorize, we can identify certain substantive correlates of lives that are good for the people living them (Stoner, 2016: 927).

As such, I submit that we can make reasonably reliable, sufficiently theory-neutral judgements about the well-being prospects of disabled and non-disabled people in the nearest non-disablist worlds by focusing on whether they have equal access to the sources of well-being.

To reinforce the notion that this is a good method of making the relevant judgments, note that others taking part in the disability debate have employed similar strategies for identifying well-being prospects. More specifically, Stoner (2016: 928) and Campbell and Stramondo (2017: 153) make judgements about disability and well-being by focusing the things which intuition has it make lives go well.

Before presenting a list of the sources of well-being that can be used to adjudicate the debate, I will offer a more detailed explanation of why the three theories converge on sources, drawing connections between the theories to clarify my view.

Consider a hypothetical objective list theory whose list includes personal achievement, friendship, pleasure and autonomy. An objective list theorist would, of course, think that these things are all constituents of well-being, meaning that they are also sources. But would other theorists also accept that these things are sources?

For the idealised desire theorist, their good-for-making property is being the satisfaction of an idealised non-instrumental desire. Anything that would be desired in ideal conditions would instantiate this property and would thus be a constituent (source) of well-being. That is, suppose that I have an idealised non-instrumental desire to become Prime Minister. Becoming Prime Minister would then be a constituent of my well-being for the idealised desire theory. So, an important question is: what are the things that would be desired non-instrumentally by idealised agents?

Very plausibly, idealised agents non-instrumentally desire the things which typically appear on objective lists. Given that objective list theories are plausible and capture many people's intuitions about which things benefit us, good candidates for the things idealised agents desire are things like personal achievement, pleasure, friendship, autonomy, and other things that often appear on objective lists. If so, then these things count as sources of well-being for the desire theorist.

It would certainly appear strange to hold that idealised agents would not non-instrumentally desire the things on the hypothetical objective list. These things appear obviously good, such that most people *actually* desire personal achievement, pleasure, friendship and autonomy. So, to believe that *idealised agents* do not non-instrumentally desire these things would be to hold either that i) people are misinformed about the nature of these things when they desire them, or that ii) these things are all desired only instrumentally. (i) is implausible. It also doesn't seem plausible that we desire pleasure merely instrumentally. But let us consider the implications of (ii) for the other postulated objective goods. For these, it is at least somewhat plausible that we desire them instrumentally because they all cause pleasure. This is, after all, what the hedonist would likely say. If personal achievement, autonomy and friendship are all desired merely instrumentally, then they will not count as constituents of well-being for the idealised desire theory. However, the thing to which these things are instrumental – in this case, pleasure – would count as a constituent (and, thus, a source) of well-being. If so, then the things that typically cause pleasure would also count as sources of well-being, and we are supposing that personal achievement, autonomy and friendship all typically cause pleasure. This means that, even if (ii) is true, personal achievement, friendship and autonomy (and pleasure) would still count as sources of well-being for the idealised desire theorist. So, the idealised desire theory's list of sources looks like it's going to overlap considerably with the objective list theory's. Moreover, the objective list theorists would likely agree that our idealised desires track what is independently good (Kahane & Savulescu, 2009: 29). After all, we are, by hypothesis, making no mistakes in our reasoning when we desire these things. So, objective list theorists might plausibly

include idealised preference satisfaction among their causes (sources) of well-being. For these reasons, it seems likely that the idealised desire theory and the objective list theory would identify similar sources of well-being.

This brings me to hedonism. For the hedonist, there is only one constituent of well-being: pleasure. To complete his list of sources, the hedonist must decide on the typical causes of pleasure. Again, prime candidates are the things which typically appear on objective lists; that is why objective list theories and hedonism are both plausible theories that share similar implications for psychologically normal individuals. Where the objective list theory claims that the things on her list – like friendship, achievement and autonomy – are good in themselves, the hedonist believes that they usually cause well-being because they are usually experienced as pleasurable. Again, it would appear implausible for the hedonist to deny this. As such, the hedonist looks likely to include on their list of sources friendship, autonomy, achievement, and the other things that typically appear on objective lists. Also note that pleasure is included on the objective list postulated above, and many others (e.g. Ross, 1930: 135; Griffin, 1986: 67; Fletcher, 2013: 214; Rice, 2013: 210; Heathwood, 2014: 201; Hooker, 2015: 19-21) and (recall) that most desire theorists will accept that we have a non-instrumental idealised desire for pleasure. This again suggests that pleasure, and the things that typically cause it, will count as sources of well-being for hedonists, desire theorists and at least many objective list theorists.

I have argued that proponents of objective list theories, idealised desire theories and hedonism would identify significantly overlapping sources of well-being for psychologically normal individuals (although I recognise that there likely would not be total consensus). But what about psychologically abnormal individuals? These might be people that (e.g.) take pleasure in non-standard things, have non-standard non-instrumental idealised desires, or realise personal achievement through non-standard activities. A version of Kraut's icicle fanatic (1994: 42) illustrates all three. She has a fully-informed, non-instrumental desire to smash icicles, takes pleasure in smashing icicles and realises personal achievement by doing so. Undoubtedly, some exist who are non-standard in some or all of the ways I describe, and more. For these people, their sources of well-being will differ from most of the population's. As such, identifying a list of sources for ordinary individuals and identifying how much access people have to these things would not be a good way of predicting *these people's* prospects. Is this a significant problem for my strategy?

I don't think so, because these unusual cases are exactly that: unusual. In normal cases, the theories have similar implications about the sources of well-being. And unusual cases are not

particularly relevant to my discussion. As noted in chapter 2, the views are counterfactual generalisations about the comparative well-being prospects of two large groups. These groups each seem likely to contain at least some individuals with non-standard psychologies, but there won't be many. And people with unusual psychologies are likely to be different from each other, as well as from ordinary people; it doesn't appear likely that there will be lots of individuals in either group who are non-standard *in the very same way*. Moreover, there appear to be no grounds for assuming that the proportions of unusual psychologies would be different in the disabled group than in the non-disabled group. For these reasons, it seems reasonable to assume that anomalous individuals will not substantially affect the average well-being prospects of either group (which I have argued is the relevant issue) when using my proposed strategy to determine this. That is, their atypicality is likely to 'wash out' when identifying the well-being prospects of large groups by looking for patterns concerning the groups' access to the sources of well-being. In addition, the things that cause well-being for these abnormal individuals (e.g. smashing icicles) won't count as sources of well-being because they do not cause well-being in the large majority of ordinary cases. For these reasons, I think I can legitimately ignore the minor effects that non-standard individuals might have on my discussion.

This is a good time to further comment on my understanding of typical causes. I defined typical causes of well-being as something that causes well-being *in the large majority of ordinary cases* because I think this is a good way of cashing out the term such that it plays the role I ultimately want it to play in this thesis. That is, if *x* is a typical cause of well-being, whether people have access to *x* is relevant to reasonably predicting the prospects of people in worlds similar to our own, such that one can reasonably judge that ordinary people or groups who have access to *x* are likely, other things equal, to have greater well-being than those who do not. I ultimately don't think it matters how I precisify 'typical causes' as long as I do so in a way such that it plays this role. It might be that, to play this role, it is not necessary that the effect obtains in the large majority of ordinary cases. However, I specify it in this way because it is very plausible that, if something is a typical cause in this sense, then it will be reasonable to take it into account in predicting prospects.

In this section, I presented my strategy for understanding well-being in a way that allows me to fairly adjudicate between the MDV and BDV, which is to examine whether disabled and non-disabled people have equal access to the sources of well-being in the nearest non-disablist worlds. I also argued that this strategy is sufficiently theory-neutral as there is significant consensus on sources between (most) supporters of the three major theories – at least for normal individuals, which is the relevant issue.

3.3 – Potential Problems

In this section, I briefly discuss three potential issues with my strategy.

First, one might worry that hedonists and objective list theorists would significantly disagree on their lists of sources of well-being, contrary to what I have argued, if pleasure is not included on the objective list. It might be thought that, even if the hedonist agrees that people generally take pleasure in achievement, friendship, autonomy etc. the objective list theorist is not going to agree that pleasure and its typical causes are sources of well-being unless they think that pleasure is valuable objectively. If they do not, then perhaps there would be significant disagreement between the objective list theory's and hedonism's list of sources.

In reply, I would say three things. First, this claim is true only if the objective list theorist does not include pleasure on her list of goods *and* thinks that pleasure does not typically cause any of the things on her list. Only then would pleasure fail to count as a source of well-being for the objective list theorist. Second, as mentioned, many objective list theories (e.g. Ross, 1930: 135; Griffin, 1986: 67; Fletcher, 2013: 214; Rice, 2013: 210; Heathwood, 2014: 201; Hooker, 2015: 19-21) do recognise the objective value of pleasure. Third, I am happy to exclude those that do not take pleasure to be somehow good for us from the scope of my discussion. Objective list theories that do not accept that pleasure is good for us instrumentally *or* non-instrumentally are, in my view, straightforwardly implausible.

Second, one might worry that there is substantive disagreement between different objective list theories about which things are objectively good. One might think that, if true, this causes difficulties for my strategy, since it relies upon the assumption that there is a significant consensus on the constituents of well-being from different objective list theories. If there is little consensus, then it is incoherent to claim that people typically desire and take pleasure in the things which *typically* appear on objective lists.

I agree that we could probably not identify a list of sources acceptable to most proponents of the major theories of well-being (or even most objective list theorists!) *if* there were an abundance of profoundly different objective lists. However, to my knowledge, this is not the case. As mentioned, there is a large amount of overlap between different objective list theories.[85] This means that there is a significant basis of agreement between them about what

[85] See references in note 77.

constitutes well-being. Moreover, where there is disagreement, it is, I think, mostly over whether a suggested good is a constituent or merely a cause of well-being. For example, some disagree about whether friendship should be included on the list or whether it is merely a species or cause of achievement.[86] It is not that some objective list theorists think that friendship is not good for us *in any capacity*. To think as much would be incredible! Given these points, I think a list of sources can be produced which pleases most objective list (and other) theorists and allows me to adjudicate the debate between the MDV and BDV in a sufficiently theory-neutral manner.

Third and finally, one might disagree with my claim that people with normal psychologies tend to take pleasure in, and non-instrumentally desire, similar things. One might think that this is obviously false, given that there is considerable variance in people's preferences. After all, some people like pop music, other prefer rock, others still like opera, and if people take pleasure in such different things, then I cannot justifiably claim that normal individuals tend to take pleasure in (or desire) similar things.

It is true that there is considerable variance in people's preferences, but I do not think that this poses a substantial problem for my strategy. From the perspective of an idealised desire theory, it is unlikely that people have *non-instrumental* desires to hear particular types of music. Their desires to hear rock or opera are likely instrumental desires. And I think that the non-instrumental desires from which these instrumental desires are derived – perhaps for aesthetic experience or pleasure - are shared by most people. This brings me to the hedonist perspective: it is true that different people take pleasure in (e.g.) different kinds of music. But these variances take place, I contend, at a fine-grained level. I think it is possible to construe of the things in which people take pleasure in a sufficiently coarse-grained manner, such that these (broadly construed) pleasures are shared by most people. Hence, I need to be careful not to specify the sources in too fine-grained a manner. If I include (e.g.) listening to rock or pop, then the list will be implausible. However, most people take pleasure in some kind of music and, even more plausibly, most normal individuals take pleasure in some kind of aesthetic experience. Thus, if I stay at an appropriately course-grained level when identifying the sources, variance at the fine-grained level shouldn't cause a significant problem.

[86] See (Hooker, 2015: 27-29) for discussion of this.

3.4 – The Sources of Well-Being

I have presented and defended my strategy for adjudicating the debate between the MDV and BDV, which is to identify a sufficiently theory-neutral list of sources of well-being and examine whether, in W_1, disabled and non-disabled people have equal opportunities to access these things.[87] More specifically, two things are relevant. The first is whether disabled and non-disabled people have opportunities to access *equal numbers* of the sources of well-being: are there some sources that members of each group are completely unable to access? The second is whether disabled and non-disabled people have opportunities to access *equal degrees* of the sources. That is, does one group have greater opportunity to access a larger amount of some of sources, such that we can reasonably expect them to experience, say, more pleasure than members of the other group? Both things are relevant because fuller realisation of a smaller number of goods is plausibly better for prospects than lesser realisation of a greater number, and vice versa.

Forming judgements about opportunities of members of the groups to access the sources of well-being will allow me to make reasonable predictions about the comparative well-being prospects of disabled and non-disabled people in W_1.[88] The final thing for me to do in this chapter is to present a theory-neutral list of sources. This list will, for the reasons above, look very similar to an objective list theory. But, crucially, my claim is that these things are generally accepted as sources of well-being, not necessarily constituents. Also note that the following list is illustrative and non-exhaustive; I merely mention some of the things that intuition has it are sources of well-being so the reader can get an idea of the *kinds of things* that I will be trying to determine whether disabled and non-disabled people have equal opportunities to access in W_1. If subsequent discussions lead me to include more on the list, or to remove things, then I will.

A list of sources of well-being (in no particular order):[89]

- Personal security/safety
- Adequate nourishment
- Personal achievement
- Close personal relationships
- Fulfilling one's lifetime ambitions

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[87] Amundson (2005: 118-19) sketches a similar methodology. See Hersch (2020) for criticism of the possibility of developing a theory-neutral account of well-being that guides well-being policy.
[88] I discuss in more detail how we can go about forming these judgements in §4.2.1.
[89] I compiled this list by examining the objective lists postulated in (Ross, 1930: 134-140; Finnis, 1979: 86-90; Parfit, 1984: 499; Griffin, 1986: 67-68; Kagan, 1997: 39; Nussbaum, 2011: 33-34; Fletcher, 2013: 214; Rice, 2013: 210; Heathwood, 2014: 201-02; Hooker, 2015: 19-27).

- Pleasure
- The avoidance of pain
- Knowledge
- Autonomy
- Engagement in social activities
- The ability to participate politically
- Health
- Other things equal, living longer
- Getting what one non-instrumentally desires
- Friendship
- Play
- Self-respect
- Happiness
- The development of personal abilities
- Rationality
- Aesthetic experience
- Being a good parent
- Sexual activity
- Relating to others as equals

I present this strategy as one that I will be using in later chapters to examine the plausibility of the MDV and BDV,[90] and as one that can be used by others taking part in this debate (and other debates involving making predictions about well-being) without committing to a theory of well-being.[91]

[90] I use this strategy primarily in chapters 5 and 7. Chapters 4 and 6 deal with different issues. Moreover, I won't be able to discuss all sources of well-being in detail. I will discuss those I take to be particularly important for adjudicating this debate.

[91] One might think that including health on the list of sources prejudices the debate. However, I don't think that it does, as I will be assuming throughout this thesis that disability is compatible with health, as it is on some accounts (e.g. Nordenfelt, 1995; Carel, 2008). Moreover, many suggest that health is an important source of well-being (e.g. Finnis, 1979; Kagan, 1997; Nussbaum, 2011; Heathwood, 2014), and intuition agrees. So, my list is more accurate, and my discussion more complete, if it includes health.

Conclusion

In this chapter, I set out and defended my strategy for understanding well-being in a manner that allows me to make reasonable predictions about the well-being prospects of disabled and non-disabled people in the closest non-disablist worlds. I first (in §3.1) presented the three major theories of well-being and distinguished between sources and theories of well-being. Next (in §3.2), I presented and defended my strategy for adjudicating the debate between the MDV and BDV, which is to identify a sufficiently theory-neutral list of the sources of well-being and examine whether the disabled and non-disabled have equal opportunities to access these things in W_1. Then (in §3.3), I responded to worries before (in §3.4) presenting an illustrative and non-exhaustive theory-neutral list of sources. Having done this, I am in a position where I can move on to the focus of this thesis: examining the plausibility of the MDV and BDV.

Chapter 4 – Engaging with Barnes

Elizabeth Barnes is one of the most prominent philosophers writing on the connection between disability and well-being.[92] In her work, she defends a version of the MDV and rejects a version of the BDV. In this chapter, I engage with this work. Broadly speaking, I argue two things. The first is that, in characterising the BDV as the view that disability is always non-instrumentally bad for well-being, Barnes attacks an uncharitable interpretation unlikely to be endorsed by many BDV proponents. She thus misses the opportunity to challenge the most plausible and relevant version of the BDV, which is probabilistic and considers overall value. Second, I examine Barnes' argument for her version of the MDV, which relies on the existence of large amounts of disability-positive testimony. After presenting and noting some interesting things about the Testimony Argument, I consider whether testimony from disabled people, or empirical evidence more generally, can settle the debate as I understand it, arguing that – although empirical evidence could in principle provide good evidence for either view – there are good reasons to be sceptical that it is currently robust enough to do so.

In §4.1, I present Barnes' understandings of the MDV and BDV and argue that, in understanding the views as she does, Barnes attacks an uncharitable interpretation of the BDV. In §4.2, I consider an objection from Barnes (2009a) against probabilistic interpretations of the MDV and BDV and offer my reply, also (in §4.2.1) providing more detail on how we can go about making reasonable judgements about probabilistic versions of the views. In §4.3, I discuss Barnes' Testimony Argument for the MDV, arguing that, although her argument might establish her version of the MDV, an analogous argument fails to establish the probabilistic version that focuses on all things considered value, which is my focus.

4.1 – Barnes' MDV and BDV

In this section, I present Barnes' understandings of the MDV and BDV an argue that, in focusing on this understanding of the BDV, Barnes attacks an uncharitable interpretation.

Recall that, in chapter 2, I set out six potential understandings of the BDV and rejected one that is non-probabilistic and focuses on non-instrumental value:

(1*): Disability is always non-instrumentally bad for well-being.

[92] See Barnes (2009a, 2009b, 2014, 2016a, 2016b).

In her work, Barnes (e.g. 2009a, 2016b) seems to understand the BDV as akin to (1*). Two considerations suggest so. The first is Barnes' language. In various places (e.g. 2009a: 338, 2016b: 6, 55) she characterises the BDV as the view that disability *by itself*, *intrinsically* or *automatically* makes one worse off. Now, the word 'automatically' straightforwardly suggests a non-probabilistic characterisation – if something automatically accompanies disability, then it occurs in every case of disability. And her understanding the BDV as the view that disability 'by itself' or 'intrinsically' makes one worse off (e.g. 2016b: 6) suggests that Barnes' interpretation focuses on disability's non-instrumental (or intrinsic) value and ignores its instrumental value.

The second, more important, consideration is her argument for the MDV (and against the BDV). Her version of the MDV is the so-called Value-Neutral Model, which she defends by arguing that disability is 'neutral simpliciter'. This is to say that disability is *not* bad or good simpliciter. Since Barnes thinks that the MDV is the conjunction of the denials of the BDV and the GDV (2016b: 69), we can infer that Barnes takes the BDV to be the view that disability is bad simpliciter and the GDV to be the view that disability is good simpliciter. Examination of Barnes' thoughts on what it is to be bad simpliciter will thus illuminate how she understands the BDV.

According to Barnes, some feature *F* is bad simpliciter iff for any person P who has *F*, *P* has a lower level of well-being in virtue of having *F* than they would have had if they lacked *F* (Barnes, 2016b: 86). Likewise, *F* is good simpliciter iff for any person P who has *F*, *P* has a higher level of well-being in virtue of having *F* than they would have had if they lacked *F* (Barnes, 2016b: 86). Notice that, for *F* to be bad simpliciter is for it to be bad for *any person who has it*, and something is only bad for any person who has it if it is bad non-probabilistically. This indicates that Barnes characterises the BDV as the non-probabilistic view that disability is *always* bad for well-being.

Barnes elaborates on what it means to be bad simpliciter: 'if something is bad simpliciter, your life goes worse *in virtue of it specifically*, even if its overall causal effects. . . make you better off' (2016b: 87 her emphasis). Barnes does not unpick what she means by 'in virtue of it specifically'. However, it is illuminating that she contrasts effects in virtue of *F* specifically with *F*'s causal (or instrumental) effects. Value must either be instrumental or non-instrumental, so if the simpliciter value of *F* discounts its instrumental value, then this suggests that it is constituted entirely by *F*'s non-instrumental value. It seems, then, that what Barnes means by '*F* is bad simpliciter' is that *F* is *non-instrumentally* bad for well-being.

Putting these points together, we can see that Barnes' characterisation of the BDV (that disability is bad simpliciter) seems akin to (1*) and her argument that disability is neutral simpliciter (that the MDV is true) seems to be an argument that disability is not *always non-instrumentally* bad (or good) for well-being (minus the effects of disablism).[93] Less strongly, her argument for the MDV is only effective against versions of the BDV that claim that disability is always non-instrumentally bad, as arguing that disability is neutral simpliciter would not falsify probabilistic versions or those that focus on instrumental or overall value.

If my interpretation of Barnes is correct, then she characterises the views as:

Barnes-BDV: Disability is always non-instrumentally bad for well-being.

Barnes-MDV: Disability is not always non-instrumentally bad (or good) for well-being.

However, recall that (in chapter 2) I argued that the following are the best versions:

BDV: Disability is typically all things considered bad for well-being.

MDV: Disability is typically all things considered neutral for well-being.[94]

In arguing for these understandings, I rejected the Barnes-BDV ((1*)) as a bad understanding. I will briefly summarise my reasons for doing so. First, the Barnes-BDV considers only non-instrumental value, which hinders the BDV's relevance to appropriate normative issues. Disability's all things considered value seems to be what is most relevant to issues such as the normative status of prenatal selection for or against disability. So, the Barnes-BDV cannot do the normative work of which BDV proponents take their view to be capable. Second, the Barnes-BDV is an uncharitable understanding because it makes an implausibly strong claim that is only compatible with the views of people who endorse various other contentious claims about well-being, including that the objective list theory is true.[95] It is better, other things equal, if we can characterise the BDV such that it relies on less contentious presuppositions, which we can, if we characterise it as the view that disability is typically overall bad for well-being. If my arguments in chapter 2 are correct then, in attacking the Barnes-BDV, Barnes fails to attack the best version.

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[93] This is curious as she (2016b: 54-77) mentions that there are various potential understandings of the BDV, only some of which focus on non-instrumental value.

[94] Here I present simplified versions with supplementary clauses removed. See chapter 2 for the full versions.

[95] Barnes (2016b: 87) acknowledges that the way she is using 'good simpliciter' and 'bad simpliciter' is very strong (cf. Hawkins, 2018: 465; Wasserman, 2018: 253). In my view, a slightly weaker version of the Barnes-BDV, that disability is *almost* always bad simpliciter, doesn't fare much better, as there will likely be many cases where disability is not.

Not only does Barnes fail to attack the best version of the BDV, she also fails to attack its best *interpretation*. That is, she fails to attack the version that its most reasonable to attribute to BDV proponents. Charity provides two related reasons for thinking that the best version and the best interpretation of the BDV coincide. First, charity requires that, absent counterevidence, we attribute to our opponents the best versions of their view. And the Barnes-BDV is not the best version (as I argued at length in chapter 2), so we should expect that BDV proponents don't endorse it. Second, charity requires that the BDV be interpreted, as far as is possible, as consistent with what BDV proponents actually say. And many BDV proponents – although they don't precisely cash out their view – make it clear that their views are not properly expressed by the Barnes-BDV. For example, Singer says:

> *I don't hold that anyone with a disability "will be necessarily disadvantaged."* That would be an absurd claim. In unusual circumstances—for example, when all able-bodied people are conscripted to fight in a dangerous war—having a disability may be an advantage. I would argue only that, other things being equal, being able to walk, to move one's arms, to hear, to see, to recognize other people and communicate with them, are advantages. (2005: 130 his emphasis)

This passage clearly indicates that Singer's version of the BDV does not consider *only* the non-instrumental value of disability; his view considers disability's instrumental value too, such as that of preventing conscription. It also shows that Singer's view is probabilistic: 'in unusual cases… disability may be an advantage'. Certainly, then, Singer's version is not the Barnes-BDV.

McMahan (2005: 96) says that:

> [E]ven if the abilities whose absence is constitutive of disability are good only instrumentally… The lack of an ability that is instrumentally valuable to those who have it is, in general, an obstacle to the achievement of the full range of goods characteristic of human life… I believe, moreover, that the value of certain abilities… is only partly instrumental. The possession and exercise of certain…capacities is intrinsically good.

Here McMahan also doesn't appear interested in only disability's non-instrumental value. He seems interested in both its non-instrumental (or 'intrinsic') value and its instrumental value. He suggests that the value of the abilities that disabled people lack is both instrumental and non-instrumental. More specifically, he says that disabled people lack instrumentally valuable abilities because of their disability, which is equivalent to saying that their disability is instrumentally bad.

The relevance of instrumental value to his discussion suggests that McMahan's version is not akin to the Barnes-BDV.

Glover (2006: 1) says that 'disabilities… often (though not always) mean that people have less good lives' and Andric and Wundisch (2015: 16 original emphasis) say that '[o]f course, it is not true in *all* cases that persons are better off if they [are non-disabled]… however, we claim that this will *typically* be the case'. Both quotations make clear that their authors endorse probabilistic versions of the BDV, and they also suggest that their versions focus on all things considered value. Neither quotation clarifies the relevant type of value. In the absence of clarification, I think it is reasonable to take 'less good lives' and 'better off' to allude to overall value rather than instrumental or non-instrumental value alone.

Now, this textual evidence isn't absolutely conclusive. It doesn't tell us that all BDV proponents do not endorse the Barnes-BDV. It tells us that many do not. And it suggests that many in fact endorse the all things considered, probabilistic version that I am focusing on, which would be unsurprising given that this is the best version of the view.[96]

If what I have argued is correct, then in rejecting the view that disability is bad simpliciter, Barnes (2009a, 2016b) doesn't attack the best version or the best interpretation of the BDV. She attacks an uncharitable interpretation that is unlikely to be endorsed by many BDV proponents. She thus misses the opportunity to challenge the most plausible and relevant version of the BDV, which is probabilistic and focuses on overall value. One important upshot of this is that one can be convinced by Barnes' arguments on this subject (which I discuss in §4.3) and still hold the best version of the BDV, as arguing that disability is not always non-instrumentally bad for well-being does not refute probabilistic versions or those that focus on all things considered value. Another is that, as it stands, the best version of the BDV remains unchallenged.

Now, it's possible that Barnes' arguments are designed to reject Welfarist Accounts of disability on which disability is, *by definition*, bad for well-being (e.g. Harris, 2001; Kahane and Savulescu, 2009). If so, then one might think it more appropriate for her to focus on rejecting the view that disability is bad simpliciter. However, it appears unlikely that this is Barnes' intention. First, because, if that were her goal, it seems likely that she would not have suggested that her goal is the broader one of rejecting the BDV, which is not dependent on the truth of Welfarist Accounts. Second, because, if that were her goal, it seems likely that she would have spent significant time defending her definition of 'disability' and rejecting Welfarist Accounts.

[96] Peter Singer has confirmed with me in conversation that his version of the BDV is probabilistic and considers overall value.

But, in her book on the subject (Barnes, 2016b), she spends little time defending her definition of disability and almost no time rejecting Welfarist Accounts, merely stating that they are not useful in the relevant context. And, finally, because her primary argument for the MDV focuses on the existence of disability-positive testimony from disabled people (more on this below). But the existence of such testimony cannot establish that Welfarist Accounts are false without additional argument that Barnes does not offer.[97] It is thus hard to see a good reason for thinking that Barnes' arguments are designed to reject Welfarist Accounts.

It is also possible that Barnes' arguments are designed to reject folk conceptions of disability, which might be akin to the view that disability is bad simpliciter. But, insofar as Barnes' arguments are designed to challenge the views of other philosophers (who do not endorse Welfarist Accounts), it seems that she misses the target by attacking an uncharitable interpretation of the BDV which seems unlikely to be endorsed by many, and that the best version of the BDV remains unchallenged.

4.2 – Barnes' Objection against Probabilistic Understandings

In the previous section, I argued that Barnes misses the target by attacking the Barnes-BDV. In this section, I present and reply to an objection from Barnes against probabilistic versions of the BDV, like the one that I argued is best. In doing so, I fill out my method for making reasonable judgements about probabilistic versions of the views.

Barnes acknowledges that the most common version of the BDV might be probabilistic:

> Perhaps what we commonly think about disability is not that having a disability *will* make a person worse off… but rather that having a disability will *likely* make a person worse off (2009a: 343 her emphasis).

But she thinks that we should not interpret the BDV as probabilistic because, according to her, there is no appropriate way of making non-question-begging judgements about whether probabilistic versions of the BDV are true. Why does she think this? Well, she believes that the relevant notion of probability in probabilistic versions is *objective chance for a given person* of doing worse with a disability than without. Objective chance is distinguished from subjective chance. One can say that a fair coin has the objective chance of 0.5 of landing heads, whereas subjective

[97] Supporters of Welfarist Accounts would likely argue that any condition that is neutral for well-being is not a disability.

chance is concerned with what agents are justified in believing, given their evidence (Hajek, 2012). Barnes argues that subjective chance – determined by looking at averages across populations – merely tells us about average well-being and nothing about whether a given individual is *objectively likely* to be worse off with a disability. She thinks that to make judgements about objective chances we need to make question-begging assumptions about the non-instrumental value of disability. In her words:

> [T]he relevant notion is objective chance *for x* at high quality of life… it's not enough to simply determine the average quality of life of persons in similar circumstances with similar disability and compare it to persons in similar circumstances without disability. Such a calculation (were it possible) would only tell us about *average* quality of life… We cannot tell what will happen to a particular person just by calculating averages. So unless we *assume* that disability is somehow intrinsically negative (which begs the question) we cannot make inferences about that person's chances at an overall high quality of life based solely on the presence of a disability (Barnes, 2009a: 343 her emphasis).[98]

I will now reply to this objection. The first question is: why does Barnes think that objective chance for an individual is the relevant notion? It is difficult to understand why Barnes thinks that probabilistic versions of the BDV must be interpreted in terms of objective chance. Perhaps the thought is that the badness of disability must be a property of the person themselves. But it is not clear why she would insist on this. One reason for being sceptical about Barnes' claim is that some thinkers are unconvinced that objective chance exists, because objective chances (other than 0 or 1) appear incompatible with determinism (Bradley, 2017). If objective chances don't exist, then it seems unlikely that the best version of the BDV appeals to them. Given this, it seems too quick for Barnes to stipulate without argument that objective chance is the relevant notion.

Putting aside these worries and allowing (for argument's sake) that objective chance is the relevant notion, I still don't think it follows that we cannot make reasonable judgements about the truth of probabilistic versions of the BDV without begging the question against the MDV. Consider the implications of Barnes' reply. Barnes' suggestion seems to be that we cannot make reasonable judgements about a particular individual's objective chance of *x* being good or bad for her based on information about averages. We must instead, according to Barnes, rely on knowledge of objective chances. But we often (perhaps always) do not have epistemic access to

[98] This objection appears to be in the same spirit as the Problem of Averages discussed in chapter 2. Each worries that looking at averages across populations will not lead to illuminating results.

objective chances. If Barnes is right, then this would licence radical scepticism about what we can reasonably believe. Multiple judgements based on expected utility would be unreasonable. We would (almost?) never be able to form reasonable beliefs about what is likely to be good or bad for an individual. But it seems clear that we can and often do form such reasonable beliefs, and that we often form them based on information about averages. I venture that most would not be sceptical that consideration of subjective chances can provide us with reasonable beliefs about what is likely to be good or bad for a given person, and this is true even if we allow that objective chance is the relevant notion. That is, when we don't have epistemic access to objective chances, we can use subjective chances to form reasonable beliefs *about objective chances,* about what is objectively likely to be good or bad for an individual.

Suppose that Joe has a deadly disease and is offered an operation. We know that 85% of relevantly similar individuals (when considering things like age, sex, medical history etc.) who have the disease and receive the operation make a full recovery while, for the other 15%, the operation has no effect. When deciding whether the operation is likely to be good for Joe, suppose that the relevant probability is the objective chance of the operation being good for him. But we do not (and perhaps cannot) know what this objective chance is. Is it true, then, that we cannot make reasonable judgements about how likely the operation is to be good for Joe? I don't think so. We can use subjective chances to form reasonable beliefs about the objective chance of Joe's operation being successful. Through our knowledge that 85% of people within the relevant population make a full recovery, we can form the reasonable belief that the objective chance of Joe's operation being successful is roughly 0.85. One way of forming reasonable beliefs about the objective chances of the success of Joe's operation is by using information about averages. And these beliefs are reasonable even though we recognise that there is a chance that they are not exactly accurate. Perhaps Joe's actual objective chance of the operation being good for him is slightly lower or higher than 0.85; there is always a chance of error when reasoning from averages, but it doesn't follow that the relevant belief was unreasonable.

Many other cases are similar. We can use averages across populations to determine that children, in general, do better in their exams if they study. Based on this, we can reasonably believe that *our child* has a better chance of doing well in her exams if she studies, and encourage her to study, even though it's possible that she is in the minority for whom studying would be detrimental. In this case, subjective chance plays an important role in our belief-forming process about an individual's chances of something being good or bad for them. It would certainly appear odd to maintain that we cannot form reasonable beliefs by this method about how good studying is likely to be for our child because subjective chances merely tell us about averages. If

so, then almost all our beliefs about probabilities would be unreasonable, and I think most would agree that many such beliefs are reasonable.

If subjective chances can play this belief-forming role in everyday cases, then there appears to be no good reason why they cannot play an analogous role in the disability case. There appears to be no good reason why we cannot form reasonable (non-question-begging) beliefs, based on averages across populations, about the objective chance of an individual doing as well with a disability as without.

So far, I've argued that making reasonable judgements about an individual's objective chance of something being good or bad for them based on information about averages needn't be problematic, as in the Joe case. However, there is a disanalogy between the Joe case and the disability case. Both require taking information about averages and extrapolating this to individual chances. However, forming judgements in the disability case requires working out average well-being prospects in the closest non-disablist worlds. No such idealisation is required for the Joe case, and perhaps Barnes thinks that it is *this idealisation* that requires question-begging assumptions. That is, perhaps it is not forming judgements about individual cases from averages that is problematic, but forming robust judgements about average well-being prospects in the closest non-disablist worlds. Perhaps doing so requires question-begging assumptions about disability's non-instrumental value. Or perhaps – as Barnes suggests in later work (2016b: 99-100) – it's 'close to impossible' to do so because we inhabit a world so imbued with disablist prejudice.

For the rest of this section, I am going to engage with this fortified version of Barnes' objection, arguing that making at least reasonably robust inferences about average well-being prospects in non-disablist worlds doesn't require question-begging, and that there is no good reason to think that it's impossible. Why might Barnes think that making the relevant judgements requires assuming that disability is non-instrumentally bad? Perhaps she thinks that everything that instrumentally (and disproportionately) disadvantages disabled people is due to disablism. If so, all instrumental harms of disability would not occur in non-disablist worlds and we *would* have to make assumptions about disability's non-instrumental value to infer the well-being of disabled people in these worlds. However, things might instrumentally and disproportionately disadvantage disabled people without being disablist (Amundson, 2005: 114; Brown, 2016: 195; Howard & Aas, 2018: 1129). For example, it might turn out that the just division of resources disadvantages disabled people, or that a reduction in lifespan instrumentally harms disabled people for reasons other than disablism (even if reduced lifespan is also non-instrumentally bad),

or that reduction of valuable options is a non-disablist harm of disability (cf. Singer 2001: 56; Kahane & Savulescu 2016: 776; chapter 5). Of course, argument would be required to show that these things are non-disablist instrumental harms of disability, but it appears possible to provide such arguments without making *any* assumptions about disability's non-instrumental value.

It is also not clear why making certain judgements about the *non*-instrumental value of disability must beg the question against the MDV. Many disabilities involve serious pain and at least some others plausibly involve ill-health (e.g. Cystic Fibrosis). On some theories of well-being, these things are non-instrumental harms. And disablism is not the sole cause of these harms. As such, an opponent of the MDV might argue as follows: the fact that some disabilities involve significant (non-disablist) non-instrumental harms such as pain or ill-health (and that non-disability does not) suggests that disability, on average, makes someone non-instrumentally worse off even in worlds without disablism, as these significant non-instrumental bads seem likely to reduce the average non-instrumental value of disability, and there don't appear to be significant compensating non-instrumental benefits of disability that are not also present in non-disability (cf. Campbell and Stramondo, 2017: 168).[99] This argument need not be question-begging as long as its proponent has independent reasons for thinking that pain and ill-health are non-instrumentally bad and that disability often involves these things. And it's plausible that they might. A belief in the BDV is not the only reason to believe these things (cf. Andric and Wundisch, 2015: 9)! As such, one might have independent, non-question-begging reasons for judgements about the non-instrumental value of disability in non-disablist worlds.

Perhaps the MDV proponent thinks that there *would be* compensating benefits of disability in the closest non-disablist worlds and that it begs the question to assume otherwise. Reasonable BDV proponents will admit this possibility. But it would not be question begging to argue that there do not appear to be sufficient offsetting benefits of disability as long as the BDV proponent made a genuine attempt to identify them. If they sincerely attempted to identify relevant benefits but failed to do so, then the onus would be on the MDV proponent to identify these benefits and argue that they plausibly offset disability's bads in non-disablist worlds. After all, MDV proponents cannot plausibly deny that *some* disabilities involve serious pain or ill-health, even in W_1. To reject the hypothetical argument above, then, it is not enough to say that

[99] I am not advancing this argument here. I do, however, advance a similar argument in chapter 7.

any claims about the value of disability in W_1 are question-begging because offsetting goods *might* exist, as they needn't be.[100]

Perhaps, though, the MDV advocate would insist that *any* judgements about well-being levels in W_1 are impossible because disablism has so thoroughly contaminated all our social relationships, practices, institutions etc. that we cannot get *any reasonable idea* of what the nearest non-disablist worlds would be like. This might be what Barnes alludes to when she says that these worlds would be 'very, very different… from our own' (Barnes, 2016b: 102).

In my view, this objection implies too much scepticism about our ability to evaluate counterfactuals. Philosophers take themselves to be able to evaluate counterfactuals with a reasonable degree of accuracy even when it is difficult to imagine the relevant possible worlds. For example, many (e.g. Lewis, 1973: 66) take the following counterfactual to be true:

C1: If Caesar had been in command in Korea, he would have used catapults.

C1 says that, if we transported Caesar and Roman technologies into the Korean War, then Caesar would have used catapults. But how are we supposed to imagine the relevant worlds, when the events that led to the Korean War fundamentally presuppose that twentieth century technologies exist? How can we keep the Korean War but transport in Caesar and Roman military tactics? It is difficult to answer these questions, perhaps so difficult that we cannot be certain what the relevant possible worlds are like. But many still think that we can evaluate the counterfactual as true because we possess key bits of information about Caesar, his tactics, and the Korean War. And this information allows us to evaluate the counterfactual as true by considering what follows from transporting Caesar and Roman tactics into the Korean War, without first answering all the tricky questions about the exact nature of the relevant possible worlds.

I submit that the same is true of determining whether the MDV or BDV is true. We might not be able to imagine all the details of the nearest non-disablist worlds, but we do know some crucial information about disability, disablism and our world. And this is enough to allow us to make reasonable judgements about disability's instrumental and non-instrumental value in the closest worlds without disablism, without first determining *exactly* what these worlds are like.[101]

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[100] Also note that the MDV proponent who thought that there would be offsetting benefits must admit that it is *possible* to make judgements about the value of disability in W_1.

[101] In chapter 7, I use this information to construct a defeasible argument for the BDV.

So far, I have argued that it is (at least in principle) *possible* to make reasonable, non-question-begging, judgements about the non-instrumental and instrumental value of disability in the closest non-disablist worlds. But this doesn't yet tell us *how* we can go about making these judgements. In the next sub-section, I will refer to my tactic for understanding well-being (discussed in chapter 3) to flesh out my method for doing so (which was discussed briefly in chapter 2).

4.2.1 – How can we make the relevant reasonable judgements?

Can we know exactly what lives in the closest non-disablist worlds are like? No. We are not in a sufficiently good epistemic position to make judgements about every aspect of life in these worlds. This is partly because we do not yet have a complete account of disablism. But, to make judgements about the MDV and BDV, we do not need a complete account of disablism or to know *everything* about lives in W_1. We do not even need to know the average well-being levels of disabled and non-disabled people. If we did, then it might well be impossible to make judgements about the MDV and BDV. We need to assess the comparative claim of whether the average well-being levels of the groups are on a par, or whether there is some significant difference between them. Moreover, we are looking to identify whether there is a significant difference in the average well-being of two large groups. Therefore, we don't need to concern ourselves with minor differences in the well-being of particular pairs of disabled and non-disabled individuals. We need to identify *systematic and significant differences* in the lives of disabled and non-disabled people in W_1 and, further, these need to be differences that will plausibly affect the average well-being of the two groups. And the epistemological difficulty of identifying these differences is much less than that of identifying exactly what lives will be like (or average well-being levels) in the closest non-disablist worlds.

How might we go about identifying the relevant systematic and significant differences? Well, we can focus on the sources of well-being and ask whether disabled and non-disabled people appear likely to have equal access to these sources in W_1.[102] There are at least two ways in which we might do this. First, we might look back at our list of sources and ask ourselves whether there are any reasons why disabled people would have less (or more) access to these sources in the closest worlds without disablism. On the other hand, we might start by thinking

[102] After all, to repeat my claim in chapter 3, it is plausible that, in general, a life with more access to the sources of well-being will be better than one with less.

about the things that comparatively harm disabled people *in the actual world* – that is, the things that prevent disabled people from having equal access to the sources of well-being – and consider whether these harms would still occur if we eliminated disablism. This seems like a good starting point because of the presumption that W_1 shares all its features with the actual world unless we have good reason to think that these features are disablist. So, non-disablist harms present in the actual world will also obtain in W_1.

To identify comparative harms in the actual world, we might make plausible assumptions, consider the testimony of disabled people or other empirical evidence, or we might combine both tactics. This would give us a number of salient questions to consider about the differences between disabled and non-disabled lives in W_1. That is, we could ask whether each of the things that prevents disabled people from having equal access to the sources of well-being in the actual world would also do so in W_1. And an intuitive account of disablism will often be sufficient to provide answers. Although it is likely difficult to offer a unified account of disablism, judgements on particular cases often appear far less tricky.

Suppose we think that being gainfully employed is a source of well-being. This means that those with access to gainful employment are, other things equal, likely to have higher well-being than those without. We then need to consider whether disabled and non-disabled people are similarly likely to be gainfully employed in W_1. It seems likely that the primary cause of the discrepancy in gainful employment in the actual world is disablist hiring practices. Although *some* disabled people are completely unable to work, most disabled people can perform at least some job roles if provided with the right training and accommodations. And the same goes for non-disabled people. Some are completely unable to work (perhaps because of illness) but most can perform some job roles if given the right training. So, if hiring practices were fair, it seems that disabled and non-disabled people would have similar access to gainful employment. Thus, in non-disablist worlds, it seems that there would not be a significant difference between the access of the two groups to *this* source of well-being.[103] We might reason, via a similar process, that not experiencing abuse is a source of well-being and that, in non-disablist worlds, disabled and non-disabled people are no more likely to experience abuse than each other.

For some sources of well-being (such as those above) it will be relatively clear that disabled and non-disabled people have roughly equal access in W_1, meaning that consideration of these sources speaks in favour of the MDV. For other sources, it will be entirely unclear whether

[103] This is not to say that disabled people would not have a more limited *range* of employment possibilities, even in W_1 (see chapter 5 for discussion related to this).

disabled or non-disabled people have more access in W_1. Examples of these might be friendship or desire satisfaction. I agree with Barnes that there are some sources the access to which we are not in a sufficiently good epistemic position to judge. For the sources about which we cannot plausibly gather evidence either way, we can be charitable to the MDV and assume equal access. However, for other sources of well-being, it will be reasonable to judge that there would be a difference in the access of each group. For example, it would be reasonable to reason that disabled people on average experience more pain than non-disabled people in W_1. After all, many disabilities involve or cause pain for reasons other than disablism. Avoidance of pain is a source of well-being. Thus, consideration of *this* source speaks in favour of disabled people being on average worse off than non-disabled people in W_1 and, thus, for the BDV.

To make as robust judgements as possible about probabilistic versions of the views, we would need to ask the relevant questions about each of the sources of well-being and aggregate our answers. This would be a long and difficult process but, as we do so, we would be constructing a reasonable idea of whether disabled or non-disabled people have access to a larger degree of the sources of well-being in W_1. Using this information, we could infer whether or not there is a significant positive or negative difference in the average well-being prospects of the groups in W_1 and, thus, whether the well-being prospects of disabled and non-disabled people are equal *in the actual world* minus the effects of disablism. In short, I'm arguing that we can answer many questions about access to sources of well-being in W_1 with a reliable degree of accuracy without a complete account of disablism or of the nature of W_1, and that doing so will provide a reasonable basis on which to judge whether probabilistic versions of the MDV and BDV are true.

Of course, it might be that, in performing this difficult task, we neglect to consider important differences between disabled and non-disabled lives in W_1. Plausibly, we cannot foresee all the effects of disability and non-disability on well-being in worlds without disablism. This might be the crux of Barnes' worry about the impossibility of making reasonable judgements about well-being in W_1: if we cannot make robust judgements about every element of life in W_1 (which I concede), then we cannot make reasonable judgements about the truth value of probabilistic versions of the views. However, I don't think that the putative consequent follows. As I have argued, we can make reasonable judgements about access to at least some important sources of well-being in W_1. And, for those important things that we cannot foresee, I propose that we use something akin to the *principle of indifference*.

The principle of indifference, simply stated, says that when we have equal evidence that an action *A* will produce (mutually exclusive and mutually exhaustive) outcomes *B* and *C*, we are entitled to assign equal credences to *B* and *C* (cf. Greaves, 2016: 318). In this case, an appropriately modified version of the principle implies that if we do not know whether the unforeseen effects of disability in W_1 are overall good or overall bad, we are entitled to believe that the chances that they will be overall good are equal to the chances that they will be overall bad. As such, these credences 'cancel each other out' meaning that we can legitimately ignore unforeseen goods and bads and let the foreseeable good and bad elements of disability and non-disability be the data we use to adjudicate between the theories.[104]

This method leaves it open that unforeseen aspects of life in W_1 tip the balance in favour of either view. As such, the proposed method can only provide a *defeasible* argument for either view. But this is all we are after in this context, as we can (almost) never provide completely conclusive arguments about the truth of counterfactuals, especially those as complex as the MDV and BDV. If an opponent thinks that the defeasible argument can be countered then, in my view, the burden is on them to point out what unforeseen things haven't been considered and to argue that these things plausibly have a relevant comparative effect on prospects. The mere possibility that some important differences *might* not have been considered is not enough to deem judgements formed by the described process unreasonable, unless the person performing the process was obviously ignorant of some important difference that they could have considered. As such, if someone used the process described above to form the judgement that the MDV or BDV (or GDV) is true, then it would be up to proponents of the other views to point out significant and systematic differences between the groups' access to the sources of well-being that imply that this judgement is mistaken.

The judgements formed by the described process would not be infallible. To reiterate, infallible judgements in this context are impossible. But the epistemic threshold for reasonable judgements is lower. And we are after reasonable judgements here. Barnes' fortified objection suggests that making reasonable judgements about differences in the average well-being of two groups in non-disablist worlds is either impossible or requires question-begging assumptions about disability's non-instrumental value. I have argued that both claims are false. More specifically, I have described a process by which we can form reasonable, non-question-begging judgements about the relevant issues that will allow us to provide a presumptive, defeasible

[104] The principle of indifference is not uncontroversial. In particular, it faces difficulties involving the partitioning problem (Lenman, 2000: 354; Mason, 2004: 318; Greaves, 2016: 319-20).

argument for one of the views. It is this process that I will be using for much of what remains of this thesis (in particular, chapters 5 and 7) to provide a defeasible argument for the BDV.[105]

Admittedly, determining whether probabilistic versions of the MDV or BDV are true – although not impossible – is more difficult than determining whether the Barnes-BDV or Barnes-MDV is true. And perhaps this provides one reason to prefer Barnes' versions. But the ease by which one can determine the truth value of a view is not ordinarily taken to be an important theoretical virtue, and I have offered various reasons why interpreting the views as Barnes does is problematic (see §4.1 and chapter 2).[106] No understanding is without difficulty, and each person is going to have to judge for themselves whether they find my objections to Barnes' understandings, or Barnes' objection to mine, more persuasive. I believe that I have provided convincing argument that Barnes' (fortified) objection is not especially worrying for proponents of probabilistic understandings.[107]

In sum, Barnes objects that forming reasonable beliefs about the truth of probabilistic versions of the BDV requires making question-begging assumptions about the non-instrumental value of disability. This is false. We can make reasonable (although fallible) judgements about these views by looking at averages across populations, as we do in other contexts. The fact that we must consider differences in average well-being in idealised worlds makes forming the relevant judgements trickier, but Barnes offers no conclusive reason why doing so is impossible or requires question-begging assumptions. I have argued that it is possible to do so and described a process by which one might. Therefore, Barnes' (fortified) objection fails to show that probabilistic understandings are bad interpretations of the BDV, MDV and GDV. As such, the criticism stands that, in attacking the Barnes-BDV, Barnes misses the opportunity to challenge the most plausible and relevant version of the BDV, which is that disability is typically all things considered bad for well-being.

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[105] I will not be able to consider in detail all potential differences between disabled and non-disabled access to the sources of well-being in W_1. I will discuss those I take to be particularly important. For those I do not consider in detail, I will (as mentioned) assume parity of access.

[106] In short, Barnes' version of the BDV is less plausible, less philosophically interesting, and endorsed by fewer philosophers than mine.

[107] Recall also that the typical, all things considered value of disability seems most relevant to important normative debates. So, from a practical perspective, it would be bad if we are completely unable to answer questions about it.

4.3 – Barnes' Testimony Argument

In the previous two sections, I argued that Barnes misses an important target when rejecting the Barnes-BDV. In this section, I discuss Barnes' Testimony Argument for the Barnes-MDV (and against the Barnes-BDV). You might think it odd that I am going to discuss this argument, given that Barnes did not present it as an argument for the MDV as I understand it. However, Barnes' argument is so prominent within the debate that any discussion of the connection between disability and well-being would feel incomplete without discussing it. In particular, one might be left wondering whether Barnes' Testimony Argument could be adapted to target my preferred version of the BDV. In this section, I answer that question. First, I present and note some interesting things about Barnes' Testimony Argument. Then, in §4.3.1, I consider whether an argument from testimony, or empirical evidence more generally, could show that the MDV is true and the BDV is false as I understand them, arguing that, as it stands, the empirical evidence doesn't seem robust enough to do so.

Barnes argues that disability is neutral simpliciter through appeal to significant amount of disability-positive testimony from disabled people. Potentially surprising for non-disabled people is that disabled people are often positive about disability. Some testify that they value their disability or elements of it, and others go further in saying that disability is overall a benefit to them (Barnes, 2016b: 130). Barnes offers many examples of these kinds of testimony throughout her book (2016b: esp. ch. 4). For example, Sarah Eyre – who has Multiple Sclerosis – reports really enjoying hearing music that isn't there, along with other consequences of her disability;[108] Mark Zupan – a Quadriplegic rugby player – says that '[i]n some ways, [my disability] is the best thing that ever happened to me' (quoted in Schramme, 2013: 72); and Alica Krage says that her Blindness has many benefits, including making communication with her Blind boyfriend easier.[109] Barnes understands testimony broadly, for she also counts art, film, theatre, music, culture and parades that celebrate disability as examples of disability-positive testimony.

Barnes (2016b: chs. 3 and 4) argues that the existence of large amounts of disability-positive testimony shows us that disability is neutral simpliciter. Her argument seems to rely on the plausible intuition that if many people in possession of a given trait are positive about it, even claiming that it is overall a benefit to them (Barnes, 2009a: 342), then this is good evidence that

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[108] See https://www.xojane.com/healthy/disabilitys-unexpected-silver-linings and (Barnes, 2016: 92).
[109] See https://blog.easterseals.com/7-advantages-of-being-blind/ (accessed 25/05/20). For similar, also see https://www.xojane.com/healthy/disabilitys-unexpected-silver-linings (accessed 26/02/18); http://www.cracked.com/blog/5-ways-my-disability-actually-improved-my-life/ (accessed 25/05/20); and http://kimgia3.blogspot.com/ (accessed 25/05/20).

this trait is not always overall non-instrumentally bad for well-being (cf. Brown, 2016: 193). Her argument seems to be something like the following:

1. If disability is bad simpliciter (the Barnes-BDV is true), then it is always overall non-instrumentally bad for well-being.
2. If disability were always overall non-instrumentally bad for well-being, then there would not exist large amounts of disability-positive testimony from disabled people.
3. There exist large amounts of disability-positive testimony from disabled people.
4. Therefore, disability is not always overall non-instrumentally bad for well-being (from 1, 2 and 3).
5. Therefore, disability is not bad simpliciter (the Barnes-BDV is false) (from 1 and 4).

This argument doesn't prove that disability is neutral simpliciter, as the large amount of disability-positive testimony might suggest that disability is good simpliciter. Barnes doesn't explicitly argue against the Barnes-GDV, but she makes clear throughout her work (e.g. 2016b: 88) that disability is bad for some people and good for some people. I think, then, that we can assume that the rest of her argument runs something like:

6. If disability is good simpliciter (the Barnes-GDV is true), then it is always overall non-instrumentally good for well-being.
7. Disability is not always overall non-instrumentally good for well-being.
8. Therefore, disability is not good simpliciter (from 6 and 7)
9. If disability is not good or bad simpliciter, then it is neutral simpliciter.[110]
10. Therefore, disability is neutral simpliciter (the Barnes-MDV is true) (from 5, 8 and 9).

(cf. Brown, 2016 193-4; Hawkins, 2018: 465)

Having presented Barnes' Testimony Argument, I will now briefly discuss it. I won't evaluate whether it successfully shows that disability is neutral simpliciter, as the Barnes-BDV and Barnes-MDV are not the views that I am interested in. However, I will point out a few hopefully interesting things.

First and foremost, I want to make it clear that I agree that disability is neutral simpliciter. This means that disability is not always overall non-instrumentally bad or good for well-being. As such, a single case where a disability involves no non-instrumental good or bad, or a case where disability's non-instrumental goods and bads offset one another, or a situation

[110] This is true in virtue of how Barnes defines 'neutral simpliciter'.

where at least one disability is overall non-instrumentally bad and at least one is overall non-instrumentally good, would show that the Barnes-MDV is true. Personally, I think it extremely likely that at least one of these scenarios obtains in the actual world and would also obtain in the closest non-disablist worlds.

However, it is not clear to me that appeal to testimony of disabled people is necessary to establish that disability is neutral simpliciter, or that it is the best way to do so. I think that Barnes could have established the Barnes-MDV in other, perhaps better, ways. She could, for example, have identified at least one disability that doesn't always involve any non-instrumental bad or good. Disabilities such as Deafness, Achondroplasia and Paraplegia seem like good candidates, as it is entirely unclear that these disabilities always involve (as opposed to cause) any non-instrumental bad. Perhaps Barnes did not want to venture into the debate about what has non-instrumental value. That is reasonable enough. But in relying on the testimony of disabled people to establish her view, she opens herself up to objections.

One is the familiar view that testimony from disabled people can be dismissed as unreliable instances of so-called 'adaptive preference' (cf. Elster, 1983; Barnes, 2009b; Mitchell, 2018). The idea is that the preferences of disabled people are in some way like those of people with Stockholm Syndrome – a condition in which kidnap victims identify with their captors and come to prefer captivity. The objection runs that, just as the preferences of people with Stockholm Syndrome are unreliable, so is the testimony of disabled people about their own well-being – perhaps, in each case, these preferences are formed as a kind of coping mechanism. Barnes (2016b: ch. 4) devotes most of her defence of her Testimony Argument to rebutting this objection. In my view, Barnes convincingly rejects this argument as an instance of epistemic injustice (cf. Fricker, 2007). In short, she argues that it is epistemically unjust to dismiss the testimony of a marginalised group as unreliable.

However, another objection to the Testimony Argument is not considered by Barnes. This objection relies on the plausible thought that most people find it difficult to distinguish instrumental from non-instrumental value, especially when it comes to features of themselves. Consider various features of you – perhaps you are knowledgeable, honourable and healthy – and ask yourself whether these features are instrumentally or non-instrumentally valuable for you. Now, you may well have an answer. Perhaps you are a philosopher who has spent considerable time thinking about the nature of instrumental and non-instrumental value or well-being. But even philosophers often find it difficult to discern, and disagree about, whether something is non-instrumentally or instrumentally valuable. And this is so even though

philosophers are generally well versed in the distinction. Laypersons are much less likely to have encountered the distinction. As such, I don't think it is a stretch to suppose that laypersons find it even more difficult to determine whether something (such as disability) is instrumentally or non-instrumentally valuable for them. Given this, one might think that, when disabled people testify about their disability, they are unlikely to appreciate the distinction, *especially* if they aren't asked to consider it and educated about its nature (as seems to be the case for much of the testimony Barnes considers). If the distinction between instrumental, non-instrumental and overall value is not clear to someone, then their evaluative testimony about disability is likely to consider its *overall value*, as this more comprehensive evaluation would be the default methodology for those unfamiliar with the distinction. If this is true, then much disability-positive testimony might be misleading for Barnes. She is investigating disability's non-instrumental value, but much of the testimony she appeals to is likely to also consider instrumental value.

In fact, when we look closely at the testimony Barnes cites, some of it does seem to be reports of disability's instrumental value. For example, Barnes (2016b: 92) discusses testimony from Sarah Eyre – who has MS – in which she claims that her disability causes her to have pleasant auditory hallucinations. Barnes (2016b: 95) also discusses various advantages of being Blind put forward by Kim Kilpatrick, including her inability to stereotype people based on physical appearance and lack of self-consciousness or vanity about her own. And she talks of Nadia LaSpina, who has Post-Polio Syndrome, noting that her disability has given her 'a strong sense of empowerment and a feeling of community with other disabled people' (Barnes, 2016b: 116). These advantages seem best characterised as instrumental benefits of disability. It is not a feature of Blindness itself to lack vanity about one's visual appearance, nor of Post-Polio Syndrome to feel a sense of empowerment, nor of MS to experience auditory hallucinations. These things are *caused by* disability.[111]

Barnes also mentions art, cinema, music, culture and parades as examples of disability-positive testimony. But it doesn't seem plausible that (e.g.) artists, when producing art that celebrates disability, are intending to celebrate only its non-instrumental benefits. The same point applies to playwrights, parade attendees and film directors. They do not seem likely to be confining themselves to celebrating disability's non-instrumental value, given that they are unlikely to have encountered the relevant distinction. It seems more likely that these people aim to celebrate disability's all things considered value. What this indicates, to me at least, is that

[111] Sarah reports that her auditory hallucinations are caused by a lesion on her brain stem.

much of this testimony might not be relevant to Barnes' investigation, given the way that she characterises the views. Barnes' desire to appeal to disability-positive testimony to establish the MDV might thus provide another reason why focusing on only non-instrumental value is problematic.

It is, however, important to note that none of what I have just said conclusively shows that Barnes' argument fails to establish the Barnes-MDV. It does seem likely, given that so many people are positive about disability, that disability is not always non-instrumentally bad for well-being. It also seems plausible that at least some disabled people have testified that disability is not, in itself (non-instrumentally), bad for their well-being. Perhaps Barnes is one of those people, given that she is disabled and a philosopher who is familiar with the distinction. And I agree that disability-positive testimony from disabled people should be taken at face value. The upshot of my discussion here is perhaps that it would be good for Barnes to further explain why she argues for the Barnes-MDV by appealing to testimony, and exactly how she takes the existence of disability-positive testimony to establish that disability is not always *non-instrumentally* bad for well-being, given that much of it likely also considers instrumental value.

4.3.1 – An analogous argument?

In the previous section, I presented and briefly discussed Barnes' Testimony Argument. Barnes' argument is not designed to establish my version of the MDV, but one might reasonably wonder whether an analogous argument could. In this section, I consider whether an argument based on testimony or empirical evidence more generally could provide good evidence that disability is typically all things considered bad, good or neutral for well-being.

Barnes primarily focuses on testimony from disabled people in which they report to enjoy life with disability and to value their disability, arguing that this testimony shows that disability is neutral simpliciter. It seems clear that the existence of this kind of testimony *alone* cannot establish a probabilistic, all things considered version of the MDV. This is because it makes no comparison between disabled and non-disabled lives, and it doesn't follow from the indisputable fact that many disabled people enjoy and value their lives that they are likely to have had lives of equal well-being, all things considered, were they non-disabled. Consider symmetrical testimony from non-disabled people. If we found out that many non-disabled people enjoy their lives and value the fact that they are non-disabled, this would not lead us to think that they would have been just as well off if they were disabled. We cannot reasonably infer

a comparative, all things considered, claim from this kind of non-comparative testimony. As such, the kind of testimony that Barnes focuses on cannot provide evidence in the debate, as I have conceptualised it.

Plausibly, then, to determine whether disability is typically overall neutral for well-being – that is, whether its well-being value is on a par with non-disability – we need testimony that makes a comparison between disabled and non-disabled lives. What kind of comparative testimony might this be? Obviously, comparative testimony from congenitally non-disabled people (e.g. 'I have a better life than disabled people do') doesn't provide good evidence for the BDV. Testimony has force in this debate because we generally take people to have first-person authority about what their lives are like. But we do not generally take people to have authority about what the lives *of others* are like. The congenitally non-disabled (who remain non-disabled) have no first-person experience of what it is like to be disabled, so there is no reason to think that their testimony about their well-being as compared to that of disabled people accurately reflects reality. Comparative testimony from congenitally non-disabled people, thus, has no place in this debate.[112]

Perhaps more controversially, I submit that the symmetrical point applies to the comparative testimony of congenitally disabled people (who remain disabled). Congenitally disabled people have been disabled from birth, so they have no first-person epistemic access to what it is like to be non-disabled and, as such, there is no reason to think that their comparative testimony about their well-being (e.g. 'I'm just as happy as non-disabled people are') reflects reality more accurately than that of congenitally non-disabled people. There seems to be no relevant difference between comparative testimony from congenitally disabled and congenitally non-disabled people, meaning that neither provides good evidence for the MDV or BDV.

This does not mean that no comparative testimony has a place in this debate, however. There are some people who do have first-person experience of what it is like to be disabled and non-disabled – people who have acquired disability or non-disability. Perhaps testimony from these people about the differences between disabled and non-disabled lives is well placed to tell us whether the MDV, BDV or GDV is true. After all, it would be appropriately comparative testimony from people who seem like they are going to be good sources of this kind of information.[113] However, one problem with relying on this kind of testimony is that the experiences of those who acquire disability or non-disability are likely to be importantly different

[112] See Marsh (2020) for a discussion of the limits of first-hand experience when making comparative judgements.
[113] Compare Eyal (2020) who argues that we should privilege the judgements of 'cured' patients.

to those of people who are congenitally disabled or non-disabled. As such, it is unclear that testimony from these kinds of people would provide a representative picture of the connection between disability and well-being.[114]

What about non-comparative testimony about well-being? This kind of testimony involves disabled and non-disabled people reporting their own perceived level of well-being. It would not be comparative testimony, so could not provide evidence for either view if considered in isolation. However, if we collected and collated enough of it from disabled and non-disabled people, then we could ourselves draw a comparison between disabled and non-disabled people's levels of well-being, which might provide a good idea of whether the MDV or BDV is true.[115]

This seems like a promising suggestion for how we might use testimony to provide evidence in this debate. For this kind of testimony to provide such evidence, however, it would have to be *appropriately robust*. What does this imply? Well, we are looking for evidence about the typical effect of physical disabilities on well-being. This is a large and heterogeneous group. To be robust enough to provide the evidence we are looking for, then, testimonial evidence would have to be collected from a *representative sample* of people with disabilities. Minimally, this would need to be a large sample of people with different disabilities, from different social backgrounds, of different genders and races etc. But, ideally, the sample's proportions of each disability would reflect those in wider society. And our sample of non-disabled people must also be representative.

Moreover, the testimony would need to be collected using *consistent scientific methods*. It is well documented that people's self-reports of well-being can be affected by many seemingly irrelevant factors, such as the phrasing of the questions, order of questions and current mood of the subject (Diener *et al.* 2013; Schwarz & Strack, 1999; Stutzer & Frey, 2010). And scientific methods are thought to minimise these measurement issues:

> [W]e [scientific researchers] understand how to control many errors of measurement in life satisfaction research, for example by using consistent framing of the life satisfaction question, using a consistent item order and preferably placing the life satisfaction questions at the beginning of the survey, and employing a consistent mode of presentation of the survey… using consistent [scientific] methods throughout the entire

[114] This kind of testimony might give us good information about the connection between acquired disability and well-being.
[115] There are questions concerning whether subjective perceptions of well-being accurately reflect well-being that I will not consider here.

> survey for all respondents who are to be compared with each other will substantially help in reducing measurement error (Diener *et al.*, 2013: 516).

So, for testimony to provide reliable evidence for the MDV or BDV it must be (at the very least) collected using scientific methods from representative samples of disabled and non-disabled people. These things are well within our capabilities. So far, so good for using testimony as evidence in this debate.

However, there is one problem with using testimony in this context which does not appear easily soluble. The MDV and BDV both discount the effects of disablism, but the actual world is disablist. Testimony from actual disabled and non-disabled people is thus likely to reflect this fact; evaluation of perceived well-being is likely to include disablism's effects. To avoid this does seem possible, but is certainly difficult. Researchers would need to educate the study participants on the nature of disablism and come up with some consistent and reliable process by which the participants could identify disablism's effects and discount them. I am not a scientific researcher, so I do not know what this process might be or whether it would be realistic to implement it in a way that produces scientifically robust results. All I can say is that, to my knowledge, no study in the current empirical literature attempts to discount disablism's effects on well-being.

The apparent difficulty of discounting disablism in scientific research doesn't mean, however, that research conducted in the actual world has no hope of telling us anything interesting about this debate. There are at least three other scenarios in which (appropriately robust) testimony from the actual world could provide good evidence for the MDV, BDV or GDV. First, testimony could be useful if we had a good theory of disablism, which seems achievable (I discuss the nature of disablism further in chapter 6). If we had an account of disablism, we might then be able to identify which societies in the actual world are more and less disablist.[116] If so, then we could conduct appropriately robust research into the perceived well-being of disabled and non-disabled people in several societies that are more and less disablist. Analysing this data might then allow us to see whether there is a reliable correlation between the level of disablism in a society and the well-being of disabled people as compared to non-disabled people in that society. If it turned out that there was and that, in the least disablist societies, disabled people are only slightly worse off than non-disabled people, then this would suggest that disablism is solely or primarily responsible for disabled people being on average worse off in the

[116] I acknowledge that it would be difficult to collect the relevant information on attitudes, behaviours, institutions etc. However, this seems at least possible.

actual world. This, in turn, would suggest that, in the closest non-disablist worlds, disability would not make a significant negative difference to well-being. As such, this kind of evidence would imply that the BDV is false, and it might be combined with the plausible thought that there is no apparent reason why disabled people would be better off than non-disabled people in a world without disablism to suggest that the MDV is true. But if (however unlikely this seems) this research indicated that there was little discernible relationship between the level of disablism in a society and the well-being of disabled people as compared to non-disabled people in that society, or that in only minorly disablist societies (if they exist) disabled people are still far worse off than non-disabled people, then this would suggest that disabled people are worse off in the actual world for reasons other than disablism and that the BDV is true.

It would not be necessary to possess a complete account of disablism for testimony collected in the actual world to provide evidence in this debate, though. A second way that it could do so is if our appropriately robust research showed only a small difference in the average well-being of disabled and non-disabled people. In that case, we might reason as follows: Studies show that disabled people generally rate their subjective well-being positively, and even though disabled people generally rate their well-being slightly lower than non-disabled people rate their own well-being, this discrepancy can be explained by systematic disablism. After all, it is reasonable to believe that disablism disproportionately affects the well-being of disabled people. If disabled and non-disabled people rate their own levels of well-being similarly *even in a disablist world*, then this suggests that the BDV is false and either the MDV or GDV is true. After all, it is very likely that, in a non-disablist world, disabled people would rate their well-being higher than they do in the actual world. Plausibly, then, in non-disablist worlds, disabled people would not be significantly worse off than non-disabled people. Similarly, and third, if robust testimonial evidence from the actual world showed us that disabled people generally rate their lives as better than non-disabled people rate their own lives, then this would be strong evidence for the GDV.

In sum, I do think that it is in principle possible for testimony collected in the actual (disablist) world to provide good evidence for or against the MDV, BDV or GDV. For it to do so, this testimony must i) be collected from representative samples, ii) be collected using consistent and scientific methods, and iii) account in some way for the effects of disablism. Unfortunately, though, as it stands, evidence that meets these conditions does not seem to exist.

A survey of the empirical literature suggests as much.[117] Although there are many studies that use scientific methods to measure well-being, the studies which attempt to measure the well-being of disabled people do not appear to identify representative samples. To my knowledge, there is no relevant study that identifies a large and representative sample of disabled people. Often, studies focus on particular disabilities rather than a representative sample of disabilities (e.g. Post and van Leeuwen, 2012), meaning that they cannot tell us anything significant about the connection between disability *as a whole* and well-being. This would not be such a significant problem if there were separate studies which robustly measured the well-being of people with each disability. If this were the case, we might be able to aggregate across the different studies to get a representative picture of disability's effect on well-being. But there are not existing studies for each disability, or even all the most common. The literature tends to focus on a small group of disabilities – commonly, Spinal Cord Injury (e.g. Djikers, 1998; Post *et al.*, 1998). As such, we do not seem to have a method by which we can get a representative picture of disability's effect on well-being from the current body of research.

Another problem with aggregating across various studies is that there is little consistency in how empirical studies understand disability (cf. Francescutti *et al.*, 2017) and measure well-being:

> Unfortunately, the notion of quality of life [subjective well-being][118] used in the health literature is hopelessly vague, primarily because quality of life [subjective well-being] is operationalised differently in the different instruments and questionnaires used to measure it, and dozens of these are in common use (Bickenbach, 2013: 188).

This inconsistency makes it even more difficult to aggregate across different studies to get a fuller picture than one study can provide, which we need to, given that no study identifies the representative sample we are looking for. And, as mentioned, no study I have come across attempts to identify and discount the effects of disablism.

As it stands, then, there is good reason to be sceptical that the empirical evidence we currently possess can tell us whether the MDV or BDV is true, as I have characterised them. The existing evidence does not seem to sufficiently meet conditions (i)-(iii). As such, we must look at other avenues to determine whether the MDV or BDV is true.[119]

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[117] Examples of the literature surveyed include (Brickman, Coates and Janoff-Bulman, 1978; Djikers, 1998; Post *et al.*, 1998; Albrecht and Devlieger, 1999; Hahn and Belt, 2004; Amundson, 2010; Kariuki *et al.*, 2011; Post and van Leeuwen, 2012; Bickenbach, 2013; Francescutti *et al.*, 2017).

[118] Bickenbach (2013) takes quality of life and subjective well-being to be the same thing.

[119] In particular, we can use the theoretical approach I outlined in chapters 2 and 3 and §4.2.

The forgoing should not be interpreted as general scepticism about empirical evidence. Although I am sceptical that empirical evidence – *as it stands* – can settle this debate, I have made clear that I think that it is, in principle, possible for empirical studies to provide strong evidence for or against the MDV, BDV or GDV. I also think that there are many other interesting things about disability that current empirical evidence can tell us. I will end this chapter by mentioning two that are relevant to this debate.

In a seminal paper, Bickman *et al.* (1978) surveyed lottery winners and accident 'victims' to see how well off they considered themselves to be before the event, in the period directly after, and at the time of the study. The results showed that both groups rated their well-being positively. Other studies (e.g. Albrecht and Devlieger, 1999) produce similar results. This finding is important, as it speaks against strong versions of the BDV that claim disabled people always or typically have *bad* lives. In attempting to change mistaken conceptions of disability and eliminate disablism, this kind of evidence is crucial.

A second significant empirical discovery is that non-disabled people tend to overestimate the negative impacts that being or becoming disabled has on well-being (Loewenstein and Schkade, 1999). Non-disabled people generally believe that disability inevitably has a lasting and significant negative effect on quality of life (Bagenstos and Schlanger, 2007). However, various studies (e.g. Gilbert *et al.*, 1998, 2004) indicate that disability doesn't tend to have as much of a lasting and significant impact on well-being as non-disabled people think it will. This finding is significant as it suggests that non-disabled people hold mistaken intuitions about disability's effect on well-being, which undermines brute intuitions in favour of the BDV that historically have been unthinkingly taken as evidence for the BDV. This finding is also important because it forces those who endorse the BDV to produce more sophisticated arguments than basic appeals to intuition.[120]

[120] Hedonic Adaptation might be thought to be evidence for the MDV. It is a psychological mechanism which reduces the affective intensity of positive and negative occurrences (Frederick and Loewenstein, 1999). Some studies have suggested that, when people become disabled, after a period of lower happiness, they return to levels of happiness similar to those they experienced prior to disability (Bagenstos and Schlanger, 2007: 116; Amundson, 2010: 380). One might think that this is good evidence for the MDV. After all, intuitively, becoming disabled is worse than being born with a disability because of the transition costs that often accompany acquiring disability (Barnes, 2016b: 148). If people who acquire disability often return to their previous levels of well-being, then this makes it easier to believe that people born with disability don't have lower well-being levels than congenitally non-disabled people. However, I don't take this to be good evidence for the MDV for three reasons. First, the degree to which adaptation occurs is heavily disputed. Some studies (e.g. Lucas, 2007; Headley, 2010; Anusic *et al.*, 2014) appear to show that people who acquire disabilities do experience lasting changes in life satisfaction. Second, because the period in which lower well-being is experienced counts, in my view, as part of that person's disabled life (more on this in chapter 7). So, even if people did return to exactly their previous level of well-being after some time, their average well-being as a disabled person still would be (other things equal) lower than their average as a

Conclusion

In this chapter, I discussed the arguments of Elizabeth Barnes. I argued that, in characterising the BDV as she does, Barnes attacks an uncharitable interpretation unlikely to be endorsed by many BDV proponents (§4.1). I also rejected Barnes' objection against probabilistic understandings of the views (§4.2) and, in doing so, fleshed out a method by which we can make reasonable but defeasible judgements about comparative well-being prospects in the nearest non-disablist worlds (§4.2.1). Finally, I presented Barnes' Testimony Argument and considered whether testimony from disabled people, or empirical evidence more generally, can provide good evidence for the MDV or BDV as I understand them, arguing that there are reasons to be sceptical that it is currently robust enough to do so (§4.3). As such, I think that we must look at avenues other than empirical evidence to determine whether the MDV or BDV is true, which I turn to in chapters 5, 6 and 7.

non-disabled person. Third, because these studies experience the same problems of representativeness, and inconsistency in understanding disability and measuring well-being that I mention above.

Chapter 5 – Valuable Options and Multiple Realisability

In this chapter, I evaluate an intuitive argument for the BDV.[121] A common motivation for the BDV is the thought that disability is bad for well-being to the extent that it prevents one from doing things that many people want to do. This *Options Argument* identifies reduction in valuable options as a harm of disability or, in other words, identifies the possession of valuable options as a source of well-being. Some (e.g. Wasserman & Asch, 2013: 149-52) reject this argument, arguing that disabled people's prospects for well-being aren't hindered by possessing fewer options because the non-instrumental value of the options to which disability precludes access is multiply realisable. Call this the *Multiple Realisability Reply*.

In this chapter, I defend the Options Argument and reject the Multiple Realisability Reply by arguing that, in disability cases, possessing a greater number of valuable options seems to overall improve well-being prospects, even granting that the value of the options that disabled people cannot access is multiply realisable. As such, the Options Argument appears to be sound and to support the BDV by identifying a potentially significant cost of disability. I don't argue that the soundness of the Options Argument establishes the BDV. After all, the Options Argument merely purports to identify one cost of disability, not its overall value. The purpose of my arguments here is i) to argue that the possession of valuable options in disability cases is a source of well-being, and ii) to shift the burden of proof onto those who deny that option reduction hinders disabled people's prospects and, more generally, MDV defenders. Until now, the onus seemed to be on BDV proponents to engage with MDV replies to the Options Argument. I do so in this chapter, shifting the onus back to MDV advocates either to reject my arguments or to identify a benefit of disability that counterbalances the cost of option reduction. If they cannot, then the Options Argument seems to offer good (defeasible) grounds for belief in the BDV by identifying an important difference in the access of disabled and non-disabled people to the sources of well-being in the closest non-disablist worlds.

In §5.1, I present the Options Argument and differentiate two MDV replies, arguing that the Multiple Realisability Reply is most promising but also pointing out inconsistencies between this reply and another disability-positive argument. In §5.2 and §5.3, I defend the Options Argument and reject the Multiple Realisability Reply by i) identifying benefits of possessing a greater number of options and arguing that these are relevant to disability (§5.2), and ii) arguing

[121] A version of this chapter appears in Crawley (2020).

that the costs involved in possessing additional options appear unlikely to offset the benefits in disability cases (§5.3). Finally, in §5.4, I respond to objections and note residual issues.

5.1 – Options and Disability

In this section, I explain the relevance of the connection between options and well-being to the debate between the MDV and BDV.[122] First, I present the Options Argument. Then, I discuss two MDV replies.

Intuitively, having options is good. People generally value autonomy and one way we exercise autonomy is by making choices. Choices are possible only if we have options from which to choose (Ullmann-Margalit and Morgenbesser, 1977). Accordingly, we think that it would be terrible to have no options as this would curtail our freedom. If some choice is good, perhaps more is better: possessing more options might allow me access to one that I would benefit more from exercising than I would from exercising any in my original set. If not, then perhaps I can simply ignore the additional options. This reasoning might lead one to think that possessing more options *always* improves prospects. Nozick (1969: 462) and Rawls (1971: 143) seem to have thought so (Dworkin, 1988: 64). Rawls reasons that more choice is always preferable because people 'are not compelled to accept more if they do not want to, nor does a person suffer from greater liberty' (1971: 143).

If having more options is better, this prima facie supports the BDV. On any reasonable understanding, including the one that I adopt, disabilities involve limitations: a Blind person cannot become a surgeon, pilot or proofreader; people with Spinal Muscular Atrophy sometimes cannot eat solid foods;[123] a totally Deaf person cannot listen to Mozart (in the conventional manner), and so on.[124] And many of these limitations would persist even if we eliminated disablism. Some (e.g. Singer, 2001: 56; Kahane & Savulescu, 2016: 776) think that option reduction is a harm of disability.[125] For example, Singer says:

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[122] I focus on the effects on prospects of quantity of valuable options. I won't discuss the potential effects of quantity of bad options, option quality or diversity, although all are potentially relevant to well-being prospects (Schroeder, 2018: 16). I narrow my focus, first, because the discussion about quantity of valuable options (henceforth, options) motivates the Options Argument and, second, because these other issues deserve more attention than I can provide here. I take valuable options to be those that, if exercised, are instrumentally or non-instrumentally valuable.

[123] https://catapult.co/stories/hard-to-swallow-column-on-losing-the-ability-to-eat-solid-food (accessed 25/05/20).

[124] Totally Deaf people can experience the vibrations of music.

[125] Also see Andric and Wundisch (2015: 13-15) for discussion of this.

> [T]hose with disabilities will often be unable to do things that many of us want to do. If you are deaf, you cannot listen to a thrush singing in the spring, to Mozart or to the murmur of waves on a distant beach. If you are paralyzed from the waist down, you cannot go backpacking in the wilderness or run barefoot across the beach into the sea. Maybe not everyone wants to do these things, maybe they don't add all that much to quality of life, but don't we prefer to have the option? (2001: 56)

Those who think that option reduction is a harm of disability might think, as Rawls did, that having more options is always beneficial, or they might think that *disability in particular* reduces options in a prospect hindering manner, whatever is true of other cases. That is, they might think that possessing more options is a source of well-being *in disability cases*. I'll focus on this second (more charitable) interpretation.

Here's one formulation of the Options Argument:[126]

1. If something reduces valuable options then, to the extent that it does, it can have both negative and positive effects on well-being prospects.
2. Disability reduces valuable options.
3. In disability cases, the negative effects of option reduction are greater than the positive effects.
4. Therefore, insofar as it reduces valuable options, disability hinders well-being prospects.

Of course, this argument alone doesn't establish the BDV, as it doesn't show that disability *overall* hinders prospects. What it purports to do is support the BDV by identifying a source of well-being to which, for reasons other than disablism, disabled people do not have equal access.

Before I introduce the typical MDV reply, it's worth mentioning that the heterogeneity of disabilities poses difficulties for assessing the Options Argument. Some disabilities reduce options more than others, and perhaps some do not reduce options at all.[127] And different disabilities preclude the possession of different types of options. Perhaps, then, some disabilities reduce options in a severely prospect-hindering manner, while others reduce options in a slightly disadvantageous manner and others still reduce options without hindering prospects. All of this makes it difficult to make generalisations about the impact on well-being of the option reduction involved in physical disability. And, when making general claims, we must recognise that they likely do not apply to every disability (or perhaps even to many). Assessing the Options

[126] For a formulation of a similar argument, see Stramondo and Campbell (2018: 6).
[127] See §5.1.4 for discussion of this latter point.

Argument for disability generally is, thus, likely not as illuminating as assessing a different version for each specific disability, as generalisations about disability might obscure important differences in the connection between different disabilities, options and well-being.

The difficulties of taking disability as a general category that present themselves when evaluating specific arguments about disability provide more motivation for narrowing our focus (see §7.2 for a suggestion of how we might do this). However, most who discuss the Options Argument do so for disability generally. I follow their lead here. And I do think that interesting points can be brought out by taking this practical and typical route. For example, it allows me to evaluate and engage with the arguments of other thinkers who discuss this issue (as I do below). Moreover, reasoning about disability as a whole allows me to identify patterns in the impact of option reduction across different disabilities. In doing so, it brings to light potentially useful and interesting generalisations and provides insight into the various ways that particular disabilities might hinder well-being by reducing options. However, I acknowledge that more work will be needed, if one wants to take a narrower focus, to determine whether these general points apply to particular disabilities (or particular instances in particular contexts).[128]

5.1.1 – The Multiple Realisability Reply

(1) is a modest claim that seems difficult to deny. So, those who want to reject (4) can deny either (2) or (3). Many (e.g. Stramondo and Campbell, 2018: 6-7; Campbell and Stramondo, 2017: 157-58; Wasserman and Asch, 2013: 149-52; Asch and Wasserman, 2010: 206-09; Moller, 2011: 198-99; Schroeder, 2016: 224-25) deny (3) on the following grounds. Of course, it would be bad to be *unable* to access any of life's non-instrumental goods, but disabilities typically only foreclose certain avenues by which one can access them. On any plausible interpretation, life's non-instrumental values are multiply realisable and, although disabled people cannot realise them in certain ways, they can still experience them all. For example, a Blind person can get her fill of aesthetic experience by listening to Mozart and a Paraplegic person can get his fill of play through wheelchair basketball. Therefore, although disabled people may have fewer options, they still have perfectly good option sets that allow them access to all life's non-instrumental goods – which, the reply claims, means that their prospects are not affected by option reduction and (3) is

[128] It's also worth mentioning that I try to keep my discussion of the advantages and disadvantages of additional options (below) in general terms, so that the points can be applied to a number of disabilities.

false. In other words, the reply says that, in disability cases, the possession of more options is not a source of well-being.

In defence of the MDV, then, thinkers have rejected (3) by advancing the Multiple Realisability Reply.[129] This rejection appeals to the following premise:

> Restricting goods (RG): For a subject *S* and some multiply realisable non-instrumental good *G*, restricting *S*'s options to access *G* won't affect *S*'s well-being prospects as long as *S* still possesses some/enough option(s) which enable(s) her to access *G*.

RG is ambiguous between two interpretations. *RG-some* claims that restricting *S*'s options will not affect her prospects as long as *S* still has *one option* that enables access to each good. *RG-enough* claims that restricting *S*'s options will not affect her prospects as long as *S* still has *sufficiently many options* to access each good. I'll focus on RG-enough, which is the weaker, more charitable interpretation. On RG-enough, the Multiple Realisability Reply amounts to saying that both disabled and non-disabled people have sufficiently many options, so have equal prospects insofar as these are determined by the sizes of their option sets.

5.1.2 – The DSO-argument and inconsistency

Some defend the MDV by endorsing RG. However, other arguments that purportedly support the MDV *deny* principles similar to RG. Campbell and Stramondo (2017) and Barnes (2009a, 2009b, 2016b) suggest that disability is good for prospects to the extent that it grants access to options exclusive to disabled people:[130]

> The experience of disability… isn't just one of absence... It's, rather, one of absence in particular areas that creates (*in virtue of that very absence*) opportunities in other areas—opportunities not open to the non-disabled. And some disabled people report that the resulting experiences disability creates mean that, on the whole, disability is of great benefit to them. (Barnes, 2009b: 15 original emphasis)

Examples of *disability-specific options* include things like access to the disabled community (Barnes, 2016b: 116), being able to work peacefully in loud environments (Schroeder, 2018: 15) and being permitted to avoid long queues (Campbell and Stramondo, 2017: 158).[131]

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[129] One might instead reject (2). I consider this in §5.1.4.
[130] See also (Campbell, Nyholm and Walter, forthcoming; Stramondo and Campbell, 2018: 7)
[131] See Barnes (2016b: 88–95, 2009a: 341–42) for more discussion.

This disability-positive argument – call it the Disability-Specific Options Argument or *DSO-argument* – purportedly supports the MDV by identifying a benefit of disability. However, the following is a natural extension of RG:

> Expanding goods (EG): For a subject *S* and some multiply realisable non-instrumental good *G*, adding to *S*'s options to access *G* won't affect *S*'s well-being prospects as long as *S* already possessed some/enough option(s) which enabled her to access *G*.

EG follows from RG if there is symmetry between the effects of adding and removing options. It seems clear that there is. If I benefit *S* by enlarging her option set from *O* to *O**, then I disadvantage her by reducing her options from *O** to *O*. Likewise, if going from *O* to *O** makes no difference, then going from *O** to *O* won't either.

So, RG and EG seem to have identical truth values. This is a problem for MDV defenders. RG provides them with a response to the Options Argument. However, EG undermines the disability-positive DSO-argument. According to EG, the possession of disability-specific options won't improve disabled people's prospects because i) disabled people already have access to all life's goods prior to the addition of disability-specific options, and ii) the value of disability-specific options is multiply realisable. This means that non-disabled people can realise the relevant non-instrumental goods through alternative means. For instance, the value of accessing the disabled community can presumably be realised through accessing other communities. There doesn't appear to be any non-instrumental value uniquely experienced by disabled people. Thus, EG implies that possessing disability-specific options doesn't improve disabled people's prospects. MDV proponents, therefore, must deny EG for their DSO-argument to run.

This leaves MDV proponents with a dilemma. Endorsing RG while denying EG is inconsistent. They can either reject both, which would deprive them of their reply to the Options Argument, or they can endorse both, which would deprive them of their DSO-argument about the benefits of disability. Neither option is appealing for MDV advocates.

5.1.3 – The sufficiency interpretation

Perhaps one interpretation exists on which the DSO-argument can be reconciled with the Multiple Realisability Reply: the sufficiency interpretation. To explain it, I must introduce some terminology. Call the option sets of disabled people without the addition of disability-specific

options their *basic option sets*; call their option sets with the addition of disability-specific options their *enhanced option sets*; and call the options unavailable to disabled people *non-disability-specific options*.

The DSO-argument is straightforwardly undermined by the RG-some version of the Multiple Realisability Reply, as EG-some (which is true if RG-some is true) holds that disability-specific options won't improve disabled people's prospects because disabled people have in their basic option sets *at least one* option that enables access to each good. However, EG-enough says that expanding options *will* improve prospects as long as the size of a person's option set is not already at or above the sufficiency threshold *T*. So, on the RG-enough version of the Multiple Realisability Reply, perhaps MDV proponents can consistently hold that disability-specific options do improve disabled people's prospects by enlarging their (basic) option sets closer to *T*, while believing that disabled people would *not* benefit from gaining non-disability-specific options because the size of their *enhanced* option sets is at or above *T*. That is, perhaps, on this sufficiency interpretation, MDV advocates can consistently endorse the DSO-argument and (the RG-enough interpretation of) the Multiple Realisability Reply.

I will now argue that the DSO-argument and the Multiple Realisability Reply are inconsistent, even on the sufficiency interpretation. If MDV proponents want to reject the Options Argument, as they do, it's crucial that they maintain that disabled people wouldn't benefit from possessing non-disability-specific options. For this to be so, the size of disabled people's enhanced option sets must be at *T*. If not, then possessing more options would improve disabled people's prospects. But the view that the size of disabled people's enhanced option sets is at *T* seems implausible given the significant variation in the sizes of different disabled people's basic option sets and in the amount of disability-specific options different disabled people possess. Different people with different disabilities in different locations etc. possess different numbers of options. This implies that, wherever *T* is placed, there will likely be a significant number of disabled people who don't reach it, even with the addition of disability-specific options. For these disabled people, non-disability-specific options *would* improve their prospects (on the view we are considering), meaning that the Multiple Realisability Reply – which states that the possession of non-disability-specific options wouldn't improve disabled people's prospects – would be unsound.

Seemingly, the only way to keep the Multiple Realisability Reply and make it such that the addition of non-disability-specific options wouldn't improve disabled people's prospects is to stipulate that *T* is located such that even disabled people with the smallest enhanced option sets

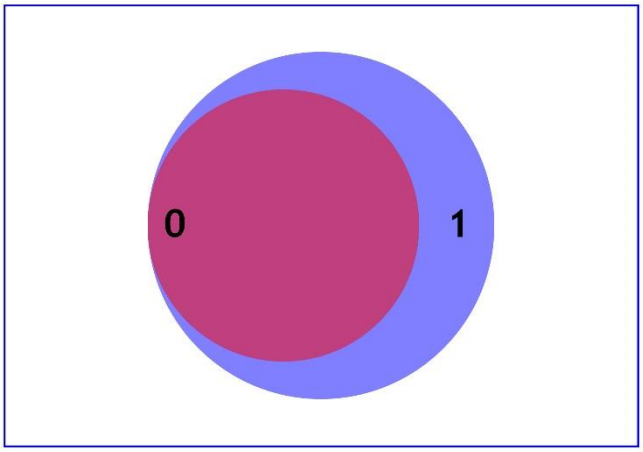
reach it. There are two problems with this move, however. First, the MDV advocate must motivate this placement of *T* to avoid seeming ad hoc. Second, and more seriously, placing *T* so low would nullify the purported benefits of disability-specific options. Placing *T* low enough to keep the Multiple Realisability Reply would imply that the majority of disability-specific options have no effect on prospects, as it would imply that most disabled people's *basic* option sets would already be at *T*, meaning that, for them, disability-specific options would have no benefit.

Now, disability-specific options are presented as general benefits of disability. This is not to say that thinkers appeal to them as evidence that disability is overall good for prospects. I mean that valuable options exclusive to disabled people are presented as benefitting the disabled people who possess them. No thinker suggests or implies that disability-specific options benefit only a subset of disabled people – namely, those with the fewest options. But the sufficiency interpretation implies exactly this, meaning that, on this interpretation, disability-specific options are not generally beneficial. In fact, this interpretation implies that they are *typically* of no benefit. As such, attempting to reconcile the Multiple Realisability Reply and the DSO-argument using the sufficiency interpretation ends up negating many of the purported benefits of possessing disability-specific options, nullifying the DSO-argument: on this interpretation, it ceases to be an argument about the benefits of disability. Therefore, the Multiple Realisability Reply and the DSO-argument about the benefits of disability are inconsistent, even on the sufficiency interpretation.

5.1.4 – Denying (2)

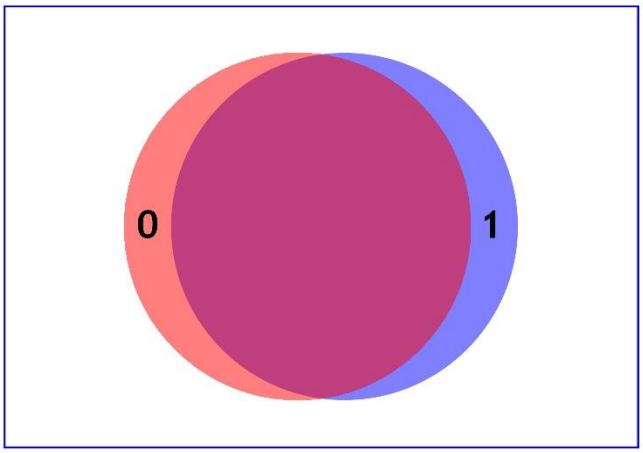
In this section, I briefly consider a different reply to the Options Argument. Some might have thought that the option set available to the disabled person is simply a subset of that available to the non-disabled person, which can be represented as the following (where 0 represents the options available to the disabled person and 1 represents those available to the non-disabled person):

Figure 2: The unequal number subset model



However, disabled people possess disability-specific options, and perhaps there are a similar number of disability-specific options as non-disability-specific ones:

Figure 3: The equal number disparity model



If this is an accurate representation, then disabled people don't possess fewer options and (2) is false.

One significant problem with this reply is that there are good reasons for thinking that, although there are some disability-specific options, the option sets of non-disabled people are (typically, other things equal) larger than those of disabled people. This is, first, because there are significant categories of options that are almost completely unavailable to all people with certain disabilities. For example, virtually all occupations and activities that require responding to environmental stimuli are unavailable to Deafblind people, and almost all options involving physical exertion are unavailable to Quadriplegic people. It might be said in reply that this point,

even if true, doesn't establish (2), as there might be similarly large numbers of disability-specific options. This is where a second point becomes relevant. An important asymmetry exists between disability-specific and non-disability-specific options: many supposedly disability-specific options are, in fact, possessed by non-disabled people. A hearing person can choose to work peacefully in noisy environments by wearing noise-cancelling headphones; a non-Paraplegic person can play wheelchair basketball, and so on (Kahane & Savulescu, 2016: 777). In general, non-disabled people can experience many allegedly disability-specific options by 'making themselves disabled' in the relevant sense for a period, but disabled people cannot do the reverse. Deaf people cannot choose to hear for a short period in order to 'try out' the benefits of hearing.[132] The claim is not that by wearing headphones the non-disabled person *knows what it is like* to be Deaf. It is merely that many purportedly disability-specific options are also open to non-disabled people.

Once this asymmetry is highlighted, it seems that there are fewer truly disability-specific options than one might have thought. I don't dispute that there might be some options truly unavailable to non-disabled people. But these two points suggest that there are more options to which disability precludes access than *truly* disability-specific options. The asymmetry may sound trivial to some, but I don't think it is. It highlights the crucial point that disability typically involves a net decrease in options and that (2) is true.

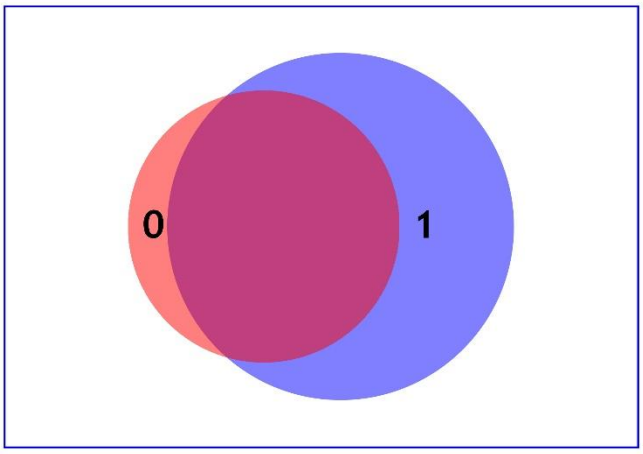
It might be objected that the substitute options available to non-disabled people are quite different to those available to disabled people, so shouldn't be classed as the same options. If so, then perhaps there is room to reject (2). I'll say two things in reply. First, even if these substitute options are classed as different options, it is undeniable that they exist and are available to non-disabled people. This means that these options would count towards non-disabled people's quantity of options, however we classify them. Thus, even if the objector's claim is true, it's entirely unclear that this would be enough to reject (2). Second, I accept that being able to work peacefully in noisy environments because one is Deaf is different in some respects to being able to do so because one wears noise-cancelling headphones. But whether we class these as separate options depends upon our chosen level of granularity. We don't want our specification to be too fine-grained, otherwise there would be no overlap between people's option sets. And defenders of RG certainly don't want too much granularity, since their reply to the Options Argument presupposes a coarse-grained account of life's goods (Asch and Wasserman, 2010: 208). However, we also don't want to be too coarse-grained, such that importantly different options

[132] A Deaf person may be able to get a cochlear implant and then have it removed. But this would require multiple surgeries.

are understood as the same. So, the question is: are these options *importantly* different? It's hard to see the important difference between working peacefully in loud environments because one is Deaf and because one wears noise-cancelling headphones. What seems relevant is the ability to work peacefully in loud environments. As such, the onus seems to be on those who want to reject (2) to argue both that disability-specific options and the substitute options often available to non-disabled people shouldn't be classed as the same options and, further, that disabled people have as many options as non-disabled people.

So, I submit that (2) is true: the option set available to the non-disabled person is (typically, other things equal) larger than that available to the disabled person, even though there exist some truly disability-specific options. We can thus think of the options available to members of the two groups in (something like) the following way:

Figure 4: The unequal number disparity model



In sum, rejecting (2) doesn't seem a plausible response to the Options Argument. As such, the Multiple Realisability Reply is the MDV's best response. But it is inconsistent with the disability-positive DSO-argument, leaving MDV advocates with a dilemma. They can advance the Multiple Realisability Reply and give up their DSO-argument, or they can keep their argument about the benefits of disability and lose their reply to the Options Argument. Either way, the MDV is weakened.

5.2 – The Benefits of More Options Applied to Disability Cases

So far, I have presented the Options Argument and discussed two MDV replies, arguing that the Multiple Realisability Reply is most promising. Here and in §5.3, I defend the Options Argument and reject the Multiple Realisability Reply, supporting the idea that possessing more valuable

options in disability cases is a source of well-being. In this section, I present three general benefits of possessing more options – even when, without these options, one can access all of life's goods – and argue that these are relevant to disability. This suggests that the Multiple Realisability Reply is unsound.

The first benefit of possessing a greater number of options is that, with more options, a person is (other things equal) more likely to possess options that suit them better, allowing them to achieve more good more easily. Of all ways of realising a particular good, some will facilitate easier access than others for certain people. This happens for various reasons. In the case of pleasure, certain options suit an individual's tastes better than others.[133] For example, both listening to music and playing sport provide me with pleasure, but I prefer music, so listening to music allows me to realise pleasure more effectively. As such, if I don't have the option of listening to music, this hinders my well-being prospects even though I can still realise pleasure through playing sport. And pleasure is not the only putative non-instrumental good to which this benefit applies. In the case of knowledge, some methods of learning might be preferable or more well suited to a person, allowing them to gain knowledge more easily. For friendship, some methods of communication might be better at making or maintaining friendships for certain people.

In general, while reducing options might not *prevent* one from realising any non-instrumental good, it might stop one from achieving as full a realisation of it as easily as one might have with more options available. This will occur when the removed options are among those that would have suited a subject better, allowing her to achieve more of a good more easily, than she could by exercising options open to her. Now, this wouldn't happen in every case of option reduction, but the fact that it is a distinct possibility suggests that, in at least some cases, restricting options will hinder prospects by preventing one from being able to achieve as much value as easily as one could have with more options, and this is so *even if* one can still access all of life's non-instrumental goods.

Is this benefit relevant to disability? It seems so. Although a Blind person might find her occupation extremely enjoyable, she might have found more pleasure or achievement in being a pilot or a surgeon; while the person with Cerebral Palsy who has speech problems might be able to make and maintain good friendships, he might have forged more or better friendships had he

[133] My examples in this section are illustrative. I mention pleasure here because many take it to be non-instrumentally valuable and because I think it illustrates the benefit clearly. I don't intend to suggest that hedonism is true, nor that pleasure is the only non-instrumental value to which my arguments apply.

no communication difficulties. While the Deafblind person might be able to achieve significant knowledge through means such as Braille, she might have gained more knowledge were she able to read text and hear people speak. In general, we cannot assume that the options a person's disability removes would not be those that suit her best, allowing her to achieve the most good most easily (cf. Andric & Wundisch 2015: 15). So, insofar as non-disabled people have more options, they appear (other things equal) more likely to possess options that suit them better, improving their access to life's goods and, thus, their prospects.[134]

The second benefit is that possessing more options makes one more likely to possess options well-suited to a variety of contexts. Certain activities are more well-suited to particular situations or moods. Suppose that pleasure is non-instrumentally good. Depending on my mood, different activities are more effective at achieving pleasure. Sometimes a discussion with friends works well. Other times, I feel like being alone so a conversation with friends is not pleasurable, but I can still access pleasure through reading. Both are ways of accessing the same non-instrumental good, but possessing various options benefits me because activity *a* is more pleasurable at certain times while activity *b* is at others.

Many cases appear analogous, where two ways of realising the same good are each more effective in different contexts. For instance, one kind of aesthetic experience might be more valuable at one time than another. Listening to Mozart might be more valuable in a given context (or mood) than appreciating a Picasso, and vice versa. In fact, there do seem to be various situations where visual aesthetic experience cannot replace auditory aesthetic experience. Whether I'm cleaning the house, commuting to work or writing philosophy, I can get value from listening to music in the background. But it does not seem that I can feasibly achieve value from visual aesthetic experience in these situations, as visual aesthetic experience typically requires explicit visual attention to be of value. The general point is that there's contextual variation in what is good for me and the extent to which things are good for me. If true, this suggests that reducing ways of realising non-instrumental goods hinders well-being prospects, even if a person still has access to a given good. If I cannot talk with my friends, sometimes this won't affect me because I can read my novel instead, but there are times when this will decrease my well-being (when a conversation would have been most effective at achieving pleasure).

This benefit appears relevant to disability. Men with Spinal Cord Injury often have difficulty getting and maintaining erections, experiencing orgasms and ejaculating (Ramos & Samso, 2004). This makes penetrative sex (with a natural penis) difficult for some and impossible

[134] I consider the objection that disabled people's tastes adapt to match their options in §5.4.1.

for others, even with treatment. Penetrative sex is one method of realising pleasure and expressing emotional intimacy – both plausibly non-instrumental values. But, while some men with Spinal Cord Injury cannot have penetrative sex, they can realise pleasure through other means, and they can express emotional intimacy through words, cuddles and other kinds of sexual activity. However, if they were not disabled, they could express emotional intimacy and achieve pleasure in all these ways *and* through penetrative sex. And it's reasonable to think that there would be contexts or moods where these substitute activities wouldn't provide as much pleasure, or express emotional intimacy as effectively, as penetrative sex would have. The key point is that one method of realising a particular non-instrumental value cannot replace another *in all contexts*. Thus, it appears better for prospects to have more options to access a given non-instrumental good, which non-disabled people do.

When considering the impact of options on prospects, we must be sensitive to the ways that options combine. The third benefit is that having more options allows for more combinations. Different ways of combining options can be prudentially significant. One consideration regarding combinations is that certain options enhance others when exercised together. Getting married is nice, but the experience is enhanced if one is surrounded by loved ones. For many, exercising these options separately doesn't equate to the value they get from exercising them together. Thus, while removing any one option would not prevent one from experiencing value, it might prevent one from achieving as much value as one could have with more combinations of options available.

This suggests a kind of value holism. Even if one has access to options *A*, *B* and *C*, it seems that exercising them separately sometimes doesn't equate to as much value as combining them. It's reasonable to think that there are many cases where options combine to realise goods more effectively than if they were exercised separately, such as when a drink enhances the enjoyment of an evening. If this is true, then increasing options to access a given good will, in some cases, allow a person to achieve value more effectively by combining options in holistically valuable ways.

This point also appears relevant to disability. Perhaps listening to certain sounds enhances certain visual experiences, or vice versa. Evidence shows that changes in lighting and music affect how food tastes.[135] So, Blindness, Deafness and Deafblindness might preclude one

[135] See https://www.theguardian.com/science/2015/apr/05/music-enhance-enjoyment-wine-food (accessed 4/08/19) and https://www.telegraph.co.uk/news/science/science-news/10760380/Why-wine-tastes-better-in-the-right-light.html (accessed 4/08/19).

from experiencing certain flavours or aesthetic experiences. More generally, disability might prevent one from experiencing holistically valuable combinations.

Moreover, certain disabilities – while not removing options – make options difficult or impossible to exercise together. For example, a Deaf person who relies on lipreading and sign language to communicate must choose between communicating and anything else that requires explicit visual attention. Thus, they cannot communicate while (e.g.) working on a computer, watching a movie or navigating a busy city, whereas non-disabled people can do these things, potentially allowing them access to a holistically valuable combination or, less strongly, to achieve two valuable things simultaneously. The point is that disability might prevent one from experiencing certain enjoyable combinations, either by removing options or by making options impossible to exercise together. This plausibly prevents disabled people from experiencing as much value as they would have with more options, hindering their prospects.

Another benefit of possessing more combinations is that this can allow one to schedule options in advantageous ways. Suppose that there are only two non-instrumental values: pleasure and knowledge. I can get knowledge by studying and pleasure by running, and both options are open to me. Merely exercising both options isn't all that matters; there might be benefits to scheduling them in different ways. Perhaps if I run first then I feel less motivated to study afterwards, resulting in less knowledge. Whereas, if I study first, I have plenty of motivation for running and gain additional pleasure at anticipating my future pleasure. So, if I have only the option of running first and studying later, then my prospects are worse than if I also have the option of studying first and running later. The point is that possessing a greater number of combinations might help resolve some of the difficulties of scheduling options in the best ways.

This third consideration about combinations also appears relevant. The effects of many disabilities are not constant. These *dynamic disabilities* can make scheduling activities in the best ways problematic. Taking the example of running and studying, suppose that I have Chronic Fatigue Syndrome which causes me to experience chronic joint pain and extreme tiredness in the evenings. As such, I must perform any physically demanding activity in the first hours of the day. In this case, the combination of studying first and running later isn't open to me. If I want to run (which I do), I must do so soon after I wake, and I rarely have the energy or inclination to study afterwards. I *can* study, but I am likely to achieve less knowledge than if I studied in the morning. To use another example, suppose that I want to care for my family which involves cooking my children dinner after school, helping them with their homework and putting them to bed. This option is theoretically open to me, but school finishes at 3pm, by which time my Chronic Fatigue

Syndrome causes me to be unable to get out of bed. In this case, my disability, in conjunction with other people's schedules, causes me to be unable to exercise the option of caring for my family in the way I want to.

Similarly, people with severe Chronic Fatigue Syndrome, or other dynamic disabilities, might not be realistically able to schedule options in any meaningful way given that they might at any time experience serious pain, discomfort, fatigue or other undesirable symptoms of their disabilities. This might not only prevent them from scheduling their own time, but also from being able to make or keep plans with friends and family. This also seems likely to hinder prospects, on the plausible assumption that it is good to be able to schedule options as one wants to and have a realistic chance of keeping to that schedule. The forgoing examples illustrate the general point that the option restriction involved in disability might prevent one from scheduling (and, more generally, combining) options in the best ways (or at all), hindering well-being prospects.

In this section, I have presented various advantages of possessing more options, even when one can already access all life's goods. I have applied these benefits to disability cases, arguing that non-disabled people benefit from having more options. Taking these benefits together, it seems that possessing more options improves non-disabled people's prospects as compared to disabled people's, even though disabled people can still access all of life's goods. If true, this shows that the Multiple Realisability Reply is unsound. The reply says that non-disabled people don't benefit from having more options than disabled people as both groups have 'enough options'. That is, they possess a number large enough such that additional options would not improve prospects. But, if my arguments are correct, then disabled people don't have 'enough options' in this sense.

Rejecting the Multiple Realisability Reply doesn't imply that disabled people must have overall bad lives. Clearly, many disabled people live excellent lives. Also note that my argument doesn't imply that no threshold exists whereby additional options make no difference to prospects. It merely implies that *if* such a threshold exists, either disabled people are typically below it whereas non-disabled people aren't, or *both* disabled and non-disabled people are typically below it. Either way, non-disabled people benefit from having more options than disabled people.

Relatedly, it seems likely that there will be diminishing marginal utility of possessing additional options. That is, (other things equal) one is going to benefit more from possessing additional options when one had fewer options originally. But this does not undermine my

argument; I presented three general benefits of possessing more options and offered realistic and generalisable examples of how disabled people would (and non-disabled people do) benefit from having more options. This indicates that, although diminishing marginal utility of options is likely, the benefit gained by non-disabled people is not negligible; the utility curve does not appear likely to sufficiently flatten out such that disabled people possess enough options to experience all the benefits of additional options. In fact, the benefits for non-disabled people seem reasonably significant. However, the fact that non-disabled people benefit from possessing more options doesn't yet show that (3) is true, that the Options Argument is sound or that possessing more options is a source of well-being in disability cases, as there may also be offsetting costs to having more options. I consider these in the next section.

5.3 – The Costs of More Options Applied to Disability Cases

I have argued that non-disabled people benefit from possessing more options than disabled people. However, there are sometimes costs involved in possessing additional options (Dworkin, 1988; Schwartz, 2004) which might outweigh the benefits. If they do, then having more options would not be *overall* good for prospects in disability cases and (3) would be false. This would mean that possessing more options in disability cases is not a source of well-being. In this section, I complete my defence of the Options Argument by arguing that the costs don't seem likely to outweigh the benefits in disability cases. I do this by arguing that non-disability cases are disanalogous to various scenarios in which having more options hinders prospects. I'll discuss three; I don't claim that this is an exhaustive taxonomy.

The first situation in which possessing more options is costly is when this increases deliberation costs. When presented with options, one must understand their natures to make an informed choice. Gaining this information and deliberating about it takes time and effort and can be stressful. In some situations, these costs are not outweighed by the marginal utility gained from the additional options. Perhaps one example is buying a car. There are so many options and combinations: which brand? Which colour? Do I want tinted windows? If so, which level of tint? etc. Plausibly, any marginal utility gained from choosing (e.g.) tint level seven as opposed to six is so slight that it doesn't compensate for the time, effort and stress involved in making the decision.

Another deliberation cost is difficulty; additional options could make deliberation so difficult that one spends too much time deliberating or is so torn with indecision that one never

makes a choice so never experiences the value of any option. Silvers (2003: 482) makes this point: '[w]e know, for instance, that the absence of limitations can also lead to suffering. People often are better off focusing on a few fulfilling options than being torn with indecision by many glittering ones'. The point is that additional options can be detrimental to prospects if they cause deliberation costs to increase too much.

The second situation in which additional options are costly is when possessing more options causes one to experience more regret. With no choice, there is no possibility for regret at options not exercised. However, if offered a choice, I may eventually regret my decision (Schwartz, 2004: ch. 7). For example, if I am at a restaurant with only salmon on the menu, then I must choose salmon and I cannot rationally regret my decision. However, if offered a selection of options, I might regret my choice of salmon when I see my wife's steak. Regret is typically unpleasant. Therefore, I might be better off with fewer options. This will be so when the disvalue of regret at options not exercised outweighs the marginal utility gained from possessing and exercising additional options.

Do the additional options possessed by non-disabled people cause them to systematically experience higher deliberation costs, or more regret, than disabled people? It's hard to see why that would be true. Neither proclivity for regret nor the deliberation costs one experiences appear closely correlated with one's quantity of options. Option quantity might be *one* relevant factor, but various others influence these things.

Much depends on the nature of the choice. Plausibly, high-stakes choices typically impose higher deliberation costs. It's also reasonable to think that one is more likely to regret certain kinds of choices – perhaps high stakes choices, or other kinds. But it's unclear that non-disabled people systematically face more high-stakes (or any other relevant kinds of) choices merely because of their increased number of options. This would need to be argued for.

Another relevant factor is the kind of person one is. Particularly relevant seems to be one's deliberative style. Schwartz (2004: 77-78) distinguishes between *maximisers* (those that aim for the best possible choice) and *satisficers* (those that aim for 'good enough' choices). He argues that maximisers have a higher proclivity for regret (2004: 86, 148) because they will always wonder whether they made the *optimal* decision, whereas satisficers are typically happy that their decisions are 'good enough'. A similar point seems to apply to deliberation costs. If one is a maximiser (or neurotic, has OCD etc.), then one seems more likely to experience costly deliberation because one wants to select the *best possible* option (cf. Ullmann-Margalit & Morgenbesser, 1977: 780). However, if one is a satisficer (or carefree, nonchalant etc.), then this

seems less likely (Schwartz, 2004: 86, 148). If this is true, then unless there is reason for thinking that disabled people are more likely to be satisficers and non-disabled people are more likely to be maximisers, we shouldn't assume that non-disabled people have a higher likelihood of experiencing regret or significant deliberation costs merely because they possess more options. We might expect this if disabled people had *no choice whatsoever*. But, crucially, the range of relevant cases does not include people with no choice. The relevant range is between non-disabled individuals with many options and disabled people with fewer, but still many, options. Disabled people typically have a large number of options – more than enough to experience regret and deliberation costs – and whether they experience as much of these things as non-disabled people will greatly depend on what kinds of choices they face and people they are.

However, if we assume – as seems reasonable given lack of evidence – that these other relevant factors are distributed evenly amongst disabled and non-disabled people, we can still ask whether non-disabled satisficers (or maximisers) are more likely to experience regret or hefty deliberation costs than disabled satisficers (or maximisers). It's not clear why they would be. Satisficers typically don't experience much regret unless it's obvious that they made a bad decision (Schwartz, 2004: 86, 148) and we're not justified in thinking that non-disabled people typically make worse decisions than disabled people. So, we turn to the question of whether non-disabled maximisers are more likely to experience regret than disabled maximisers. It seems unlikely that proclivity for regret (even for maximisers) is closely correlated with one's number of options. People (especially if they're maximisers) often feel regret even when they chose between only a few options. In fact, when we experience regret at options not exercised, we typically focus on a small number of options. We regret not choosing *that* job or *that* car. We typically don't regret not choosing dozens of options (unless we obviously made a very bad decision). We therefore need only a small number of attractive options to experience regret, which disabled people (maximisers) typically have. So, it seems unlikely that they will experience significantly less regret than non-disabled maximisers.

Similarly, we need only a small number of options to experience high deliberation costs. People rarely deliberate about every available option. Out of dozens of options, familiar considerations of taste, ease of access, cost etc. often rule out most of them without much deliberation. After this initial 'screening out' seems to be when the costliest deliberation typically takes place. We generally agonise over a small number of options, if we agonise at all. If this is true, it's unlikely that non-disabled people (maximisers) generally experience significantly more deliberation costs than disabled people (maximisers), because both groups typically have more than enough options to experience hefty deliberation costs.

To put the point another way, it's plausible that there is diminishing marginal disutility of additional options when it comes to deliberation costs and proclivity for regret. That is, supposing that possessing more options does make one more susceptible to experiencing regret or high deliberation costs, it seems that (other things equal) the difference in deliberation costs, or proclivity for regret, between having two and three options is going to be greater than that between having fifty and fifty-one. These costs don't seem likely to increase uniformly with number of options, but instead at a diminishing rate. And because disabled people have a substantial number of options, and need only a small number to experience these costs, the difference between the deliberation costs and regret that they experience and those experienced by non-disabled people doesn't seem like it is going to be significant enough to outweigh the benefits of additional options outlined in §5.2.

In sum, many factors other than number of options influence the deliberation costs one experiences and how likely one is to experience regret, including the nature of the decision and the kind of person one is. These factors will likely interact with each other – and with one's number of options – in a complex interplay, and there is no evidence that they are distributed such that either group is likely to experience significantly more costs. Moreover, if we assume that these other relevant factors are evenly distributed amongst the groups, my suggestion is that the disutility curve of these costs seems to flatten out sufficiently such that non-disabled people aren't likely to experience many more negatives than disabled people because of their additional options. Disabled people typically have enough options to experience these costs, if indeed they are the kind of people disposed to experience them, and additional options don't seem likely to make a significant negative difference *in the range of relevant cases*. This contrasts with the benefits I discussed in §5.2. I argued that disabled people would benefit from possessing the additional options they would possess if they were non-disabled, even though diminishing marginal utility of options is likely: the suggestion is that the utility curve of the benefits seems likely to be steeper for longer than the disutility curve of the costs, such that the benefits non-disabled people gain from possessing a larger number of options are more significant.

I am thus arguing that, as it stands, there is no good case to be made that non-disabled people typically experience i) more deliberation costs or regret than disabled people, or ii) enough extra deliberation costs or regret to counterbalance the benefits of having more options.

I have discussed two costs involving the mere possession of options. I will now discuss a cost involving the value gained from exercising options. I said above that a benefit of possessing more options is access to additional valuable combinations. However, valuable options might

also combine to create disvalue. If non-disabled people are likely to experience more disvalue holism in virtue of having more options, then perhaps possessing more options doesn't overall improve their prospects.

Suppose that additional options do typically grant one access to additional disvaluable combinations. One might think that, if access to additional valuable combinations improves prospects (as I argued), then access to additional disvaluable combinations hinders prospects symmetrically. However, I think this is false because of an important asymmetry: people seek out value and seek to avoid disvalue. This has two relevant implications.

First, through various mechanisms – such as education, reflection and reasoning – we often seek to learn, and come to know *prior to experience*, which combinations are disvaluable. Thus, while additional disvaluable combinations might be *accessible* to me because of additional options, I am unlikely to experience many of them as I will seek to avoid them.[136] Whereas, I am more likely to experience the valuable combinations open to me as I will seek them out.

There might be some combinations that I must experience to learn of their disvalue. This is where the second implication becomes relevant. Once I experience a combination, I typically know whether it's valuable or disvaluable, and the rational person will *continue* combining valuable combinations and *avoid* combining disvaluable combinations again. Disvaluable combinations are therefore likely to be experienced far fewer times. Thus, the net effect of having more (valuable and disvaluable) combinations is likely to be positive. A rational person will seek out and repeatedly experience valuable combinations but seek to avoid and rarely return to disvaluable ones. As such, non-disabled people seem to benefit overall from having more combinations available.

In this section, I argued that non-disability cases are disanalogous to three situations in which having more options hinders prospects. Together with my arguments in §5.2, this leads me to conclude that (3) seems true: the net effect of option reduction in disability cases seems to be negative. That is, possessing more options in disability cases appears to be a source of well-being. I have motivated this by arguing that non-disabled people benefit from having more options than disabled people (§5.2) but don't seem likely to experience offsetting costs (§5.3). I haven't established anything about the size of the difference in prospects between the groups or offered completely conclusive arguments that the negatives of option reduction must be greater than the positives. The subject matter of this debate – that is, the prospects of counterfactual

[136] There might be costs to discovering which combinations are disvaluable. However, these seem unlikely to outweigh the benefits.

individuals – makes that almost impossible. What I've argued is that the Options Argument appears to be sound and to identify one potentially weighty cost of disability. My primary aims in this chapter are i) to argue that possessing more options in disability cases is a source of well-being, and ii) to shift the burden of proof onto those (e.g. Moller, 2011; Schroeder, 2016; Wasserman & Asch, 2013) who deny that the option reduction involved in disability hinders prospects and, more broadly, MDV proponents. Until now, the onus seemed to be on BDV proponents to engage with MDV replies to the Options Argument, particularly the Multiple Realisability Reply. Given my arguments here, the onus is back on MDV proponents either to reject them or to identify something good about disability that counterbalances the negative effects of option reduction.

Now, this may be possible given the scope of my argument. I only considered the effects of valuable option quantity, but many other things might influence the prospects of each group, such as option quality and diversity, as well as other non-option-related things. I have tried to isolate the effects of one factor, insofar as this is possible. And consideration of other factors might imply that disabled people's prospects are not overall worse as they might have greater access than non-disabled people to some other source of well-being, especially given that disabilities are 'high-impact traits' that tend to have a substantial impact on how one's life unfolds (Campbell and Stramondo, 2017: 166).

It's also worth noting that if possessing fewer options were correlated with exercising more, then having fewer options (and disability) might be better for well-being prospects. I implicitly assumed that there isn't a negative correlation between the amount of options one has and the amount one exercises. This assumption is compatible with there being a positive correlation or no correlation. Either would support my conclusion. If there were a positive correlation, then non-disabled people would, in general, exercise more options than disabled people. If there were no correlation, then – because non-disabled people are more likely to possess options which optimally suit them, options suitable for a variety of contexts, and have more valuable combinations available – they are likely to have greater well-being while exercising the same amount of options as they would if they were disabled. In defence of this assumption, I responded to a few reasons for thinking that a negative correlation exists in disability cases (§5.3); however, a compelling reason for thinking that one does might undermine my argument.

Defending the Options Argument supports the BDV but doesn't establish it. To do that, one must identify all costs and benefits of disability (minus disablism). However, if MDV proponents cannot reject my arguments or identify a counterbalancing benefit of disability, then

the Options Argument gives good grounds for belief in the BDV. My argument shows that, as it stands, the Options Argument provides a defeasible argument for the BDV by identifying an important difference between the access of disabled and non-disabled people to the sources of well-being in the closest non-disablist worlds.[137][138]

5.4 – Objections, Replies and Residual Issues

In this section, I respond to two objections and note residual issues.

5.4.1 – Adaptive preference

Recall, I said that because non-disabled people have more options, they are more likely than disabled people to possess options which optimally suit their tastes. One might object by pointing out that people's preferences tend to adapt depending on their circumstances and capabilities. So-called 'adaptive preference' might mean that (e.g.) Blind people don't prefer things that require sight. Perhaps, then, the options that optimally suit a disabled person's tastes are going to be those that they possess. If so, then disabled people are just as likely as non-disabled people to have access to options that optimally suit their tastes and the first benefit discussed in §5.2 is partially undermined.

First, it's true that disabled people are among those affected by adaptive preference – almost everyone somewhat adapts their preferences to their capabilities, which is likely best explained by the human ability to respond to environmental change (Mitchell 2018).[139] But *absolute* preference adaptation isn't ubiquitous. That is, disabled people at least sometimes prefer things that their disability makes difficult or impossible. For example, people with Ocular Albinism (a visual disability causing one to 'see the world [as though] through a cloudy plastic bag') sometimes desire to create visual art, which is made more difficult by their condition.[140] We know, further, that disabled people sometimes desire to do things that their disability makes

[137] I have focused on disabled people lacking options for reasons which are not plausibly disablist.
[138] It's also worth mentioning that my arguments in §5.2 and §5.3 are in principle relevant to other debates concerning the relationship between prospects and options, such as whether it's better to have a female body capable of giving birth. However, these issues require separate discussions as they likely differ from disability cases in important respects.
[139] I don't assume that adaptive preferences are irrational or sub-optimal. It is controversial whether they are (Barnes, 2009b).
[140] See http://www.bbc.co.uk/programmes/articles/41XqVthPZMm1lJyswh5zJzN/meet-the-2018-contestants (accessed 4/08/19). Also note that I am not claiming that possessing this preference necessarily reduces the well-being of people with Ocular Albinism.

impossible – especially if they acquire disability and their preferences are, at least initially, adapted to a non-disabled body with different capabilities. We know that *some* Quadriplegic people desire to navigate the world unaided, that *some* people with Chronic Fatigue Syndrome desire to be more active than their condition allows, that *some* Blind people desire to see the faces of their children, and so on. Thus, although disabled people's preferences do adapt, adaptive preference doesn't undermine the first benefit mentioned in §5.2 as disabled people don't *only* prefer things that they can do.

Second, it could be true that absolute preference adaptation always occurs, but this would not undermine my broader argument. I presented three relevant benefits of possessing more options. Even allowing that disabled people's tastes always completely adapt, I believe that my other claims together offer a reasonable case that the option restriction involved in disability correlates with worse prospects for well-being.

5.4.2 – Other relevant factors

In §5.3, I considered whether other factors (such as the nature of the choices one faces and the kind of person one is) affect the disvalue experienced because of possessing more options, arguing that there was no good reason to think these factors are weighted in such a way as to have a systematic and disproportionate effect on the disvalue experienced by members of each group. However, I did not consider other factors in §5.2, and it's possible that other factors influence the *value* gained from possessing additional options such that non-disabled people do not benefit from this.

First, note that when I considered other factors in §5.3, I was considering the disvalue of merely possessing options. But my discussion in §5.2 concerned the value of exercising options, and it's less clear to me how, and which, other factors might influence this. However, my response is similar to my argument in §5.3: it's likely that other factors do affect the value gained from exercising options. These factors might include a person's tastes, which options their disability removes and gives access to, which options they possess for other reasons, how many options they exercise, their decision-making capabilities and more. But there appears to be no compelling reason to think that these factors are distributed amongst disabled and non-disabled people in such a way as to mitigate the benefits of possessing more options outlined in §5.2. This would need to be argued for and I leave it open to MDV proponents to do so.

I cannot make a convincing case about the effects of all possible relevant factors. My argument is not bulletproof, nor is it designed to be so. My aim was to engage with the Options Argument and the Multiple Realisability Reply and to encourage more discussion on this topic. If MDV advocates point out factors that I have not considered which mitigate the benefits I mention in §5.2, then I have succeeded.

5.4.3 – Residual difficulties

Finally, I'll briefly note three residual issues.

First, I discussed various situations in which having more options is worse for prospects and argued that non-disability cases are disanalogous; however, I didn't present an exhaustive list. This leaves the possibility open that there are situations that I didn't consider which are analogous to non-disability and imply that the option reduction involved in disability isn't correlated with worse prospects.

Second, although I think my argument is neutral between the three major theories of well-being (hedonism, desire satisfactionism and objective list theories), there may be other theories on which it doesn't run. Elster (2000) argues that working within constraints can add to the aesthetic value of creative projects. Someone might hold similar views about well-being: perhaps well-being consists in living a life as creatively as possible or with the most aesthetic value. On these accounts, having fewer options might correlate with better prospects.

Finally, it's possible that how a person thinks of themselves impacts the value they gain from possessing options or, more generally, their well-being. And disability is something that often enters into someone's self-conception; perhaps, then, conceiving of oneself as a 'disabled person' or a 'Deaf person' in some way influences how the possession of options affects prospects. This potential complication is not accounted for in my discussion.

Conclusion

In this chapter, I defended the Options Argument and rejected the Multiple Realisability Reply. First, in §5.1, I presented the Options Argument, differentiated two MDV replies and argued that the Multiple Realisability Reply is most promising but is also inconsistent with the disability-positive DSO-argument, leaving MDV proponents with a dilemma. Next, I argued that, in disability cases, possessing a larger quantity of valuable options seems to overall improve well-

being prospects. I did this by identifying three general benefits of possessing more options that are relevant to disability (§5.2) and arguing that non-disability is disanalogous to situations in which possessing more options is detrimental (§5.3). As such, the Options Argument appears to be sound and to support the BDV by identifying a potentially significant cost of disability. This shifts the burden of proof onto those who reject the Options Argument and, more generally, MDV proponents. They must reject my arguments or identify something good about disability that counterbalances the negative effects of option reduction. If they cannot, then the Options Argument offers good grounds for belief in the BDV. As it stands, the Options Argument provides a defeasible argument for the BDV by identifying a source of well-being to which disabled people seem to have less access than non-disabled people in the closest non-disablist worlds. In chapter 7, I build on my arguments here to construct a more comprehensive defeasible argument for the BDV.

Chapter 6 – Mere-Difference and Technological Development

In this chapter, I temporarily turn away from examining whether disabled and non-disabled people have similar access to the sources of well-being in the closest non-disablist worlds. Instead, I discuss the relationship between technological development and the well-being of disabled people. This topic has thus far received little philosophical attention, and I believe that discussing it reveals noteworthy and interesting features of the MDV. In particular, it brings to light a seemingly objectionable implication.

In §6.1, I argue that the MDV's truth value in a world is plausibly contingent upon the world's level of technological development. Then, I tease out two versions of the MDV that make the most plausible claims about its truth value in worlds with greater and lesser technological development than the actual world, arguing that both need additional argumentative support. In §6.2, I present a technology related objection to the MDV that I call the Frivolous Funding Objection. It holds that the MDV seems unable to account for the kind and subsequent weight of the moral reason we intuitively possess to develop and provide better assistive technologies in non-disablist worlds. It seems to follow that the MDV counterintuitively implies that, in non-disablist worlds, it is morally permissible to spend money that could be spent on developing better assistive technologies on comparatively frivolous projects merely because these projects are *slightly* more beneficial. The BDV can, however, easily block this implication, meaning that it seems to cohere better with intuition in this case. In §6.3, I begin to evaluate an MDV reply which argues that spending money that could be spent on developing better assistive technologies on seemingly frivolous things is disablist. I don't come to a definitive conclusion about whether this reply succeeds, as much will turn on how we understand disablism. I do, however, discuss reasons for pessimism that it succeeds on plausible candidate accounts.

6.1 – The MDV and Assistive Technologies

In this section, I discuss the relationship between the level of technological development in a world and the MDV's truth value in that world, teasing out two versions of the MDV which appear to make the most plausible claims about this relationship.

It seems clear that whether the MDV is true in a world turns in part on that world's level of technology.[141] In particular, the level of *assistive technology* seems likely to have a significant

[141] As such, whether the MDV is true in given societies in the actual world will depend in part on the level of technology available. This issue, although interesting, will not be my focus.

impact. Assistive technologies are devices (e.g. pieces of equipment, software programs, environmental modifications etc.) that are used to maintain or improve the functional capabilities of people with disabilities (Cook, 2009: 128). Some disabled people are unable to do some things that typical non-disabled people can. Without the use of assistive technology, *some* disabled people have difficulty independently performing everyday tasks such as (e.g.) reading, writing, going to the toilet, preparing or eating meals, communicating or mobilising.[142] The goal of assistive technologies is to allow disabled people to do all the things (conceived with appropriate granularity) that typical non-disabled people do in everyday life.[143] Paradigm examples of assistive technologies are wheelchairs, cochlear implants, prosthetic limbs, bed levers, ramps, Braille, voice synthesisers, drop kerbs, seeing eye dogs, sign languages and screen readers.

MDV proponents believe that the MDV is true in the actual world. This means that, in the closest non-disablist worlds, the well-being prospects of disabled and non-disabled people are on a par. The closest non-disablist worlds share the actual world's level of technological development and thus its level of assistive technology.[144] It follows that MDV proponents hold that the level of (assistive) technological development of the actual world is such that, if disablism were eliminated, disability would be neutral for prospects.

It seems difficult to deny, though, that the MDV has not always been true. At some point in history – perhaps in pre-industrial, feudal times – assistive technologies either did not exist or were far less sophisticated than they are today. At that time, we had made little or no progress in developing technology to aid disabled people in performing daily activities; people with mobility impairments might have had access to some kind of primitive walking stick, but not much else was available to improve the functional abilities of ordinary people with other disabilities.[145] There was certainly no Braille, cochlear implants, wheelchairs were not widely available etc. Imagine what the actual world was like at this point in history and call it the *Assistive Technology Deprived World* or *Deprived World*, for short.

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[142] There are, of course, many disabled people who can do these things independently without the use of assistive technology.

[143] In this way, assistive technologies differ from enhancement technologies which are designed to enhance functional abilities above ordinary human levels.

[144] That is, unless assistive technologies must be improved for non-disablism to obtain. I consider this in §6.3.

[145] I focus on 'ordinary' people as extremely rich disabled people might have had access to (e.g.) custom-made assistive technologies or servants to carry them in palanquins. For example, King Philip II of Spain used a custom wheelchair that needed to be pushed – see https://mobilityunlimited.org/blog/wheelchair-brief-history (accessed 25/05/20) – and historian David Starkey credits Henry VIII with first inventing the (people powered) stairlift – see http://www.yourtechstory.com/2020/02/13/david-starkey-recalls-henry-viii-as-inventor-of-stairlift/ (accessed 25/05/20).

Is the MDV true in the Deprived World? That is, if we removed disablism *from this world*, would the well-being prospects of disabled and non-disabled people be on a par? In principle, the MDV advocate might think that they would be. She might think that disablism is *all* that causes a difference between the well-being prospects of disabled and non-disabled people, such that the MDV is true in any world (similar to the actual world at any point in its history) no matter its level of technological development. But I see little reason to endorse this claim. It seems difficult to deny that disability would be worse for well-being prospects in the Deprived World *even if* everyone were entirely accepting and accommodating of disabled people. In this world, disabled people possess less functional ability than non-disabled people (and less than they do in the actual world), crucially, for reasons other than disablism. Few assistive technologies exist in the Deprived World primarily because its inhabitants do not yet have the tools or knowledge to develop sophisticated assistive technologies, and also because most cannot spare the time to do so given that they must spend most of their time performing other essential activities, such as working to earn a living and looking after their families. It's thus implausible that the closest non-disablist worlds *to this world* would have actual-world-like levels of assistive technologies. Perhaps these worlds would have somewhat more sophisticated assistive technologies than the Deprived World, but they would not have nearly the level of assistive technologies that we have in the actual world today.

In the Deprived World, those with Quadriplegia cannot mobilise or go to the toilet unaided; Blind people cannot use seeing-eye dogs to navigate the world; Deaf people find communication difficult because of lack of sign language; people with Cystic Fibrosis have no access to devices to loosen mucus from their lungs, those with MS have no access to functional electrical stimulation (which allows them to regain the use of muscles damaged due to their condition), and so on for most assistive technologies we possess today. More generally, disabled people in this world often find everyday activities (communication, mobilisation etc.) difficult or impossible and seem likely to have difficulty finding employment because of the unavoidably manual nature of most jobs. In contrast, typical non-disabled people inhabiting this world can communicate, mobilise, breathe comfortably and perform paid work. These things are all typically considered goods in life, or sources of well-being, which implies that (other things equal) those who lack these things generally have worse prospects than those who do not. And

disabled people seem to have access to fewer of these goods in the Deprived World for reasons other than disablism.[146]

It seems likely, then, that reasonable MDV proponents will admit that, in the closest non-disablist worlds to the Deprived World, disabled people's well-being prospects would be worse than non-disabled people's. That is, that the BDV is true in the Deprived World because of its lack of technological development.

In fact, the MDV seems more plausible if it says so, as this is consistent with another plausible claim: that the actual development of assistive technologies – from their level in the Deprived World to their level today – has disproportionately improved the prospects of disabled people. The development of assistive technologies has considerably improved the functional abilities of disabled people. Today, Quadriplegic people can mobilise and use a toilet unaided, Blind people can read and navigate the world, Deaf people have their own language etc. And although the development of assistive technologies probably benefitted non-disabled people to some degree, it seems extremely likely that it more so improved the prospects of the disabled people that actually use these technologies. This claim, in tandem with the view that the MDV is true now, implies that the BDV is true in the Deprived World, and was true in the past. The MDV proponent who disagrees and thinks that the MDV is true in the Deprived World and in the present world must argue for the counterintuitive view that developing assistive technologies had an equal effect on disabled and non-disabled people's prospects (minus disablism) – as this must be so for the truth value of the MDV to be the same in both worlds.

It seems, then, that the most plausible version of the MDV involves commitment to:

i. MDV: The MDV is true in the present world
ii. Past BDV: The BDV was true before assistive technologies were developed (the BDV is true in the Deprived World)
iii. Unequal Past Benefit: The actual development of assistive technologies has disproportionately benefitted disabled people's prospects (minus disablism).

Notice that (ii) and (iii) come together for those who endorse (i), as (i) and (ii) together imply (iii), and (i) and (iii) together imply (ii).

[146] The claim is not that disablism doesn't prevent disabled people from accessing any goods that they might have accessed in the Deprived World. Even in feudal times, achievable environmental, attitudinal or employment modifications might have allowed disabled people access to more (or a larger degree) of life's goods.

Versions of the MDV that accept (i)-(iii) entail (very plausibly) that the truth of the MDV is in some way contingent upon the level of assistive technological development of a world. In the next section, I'll assume that MDV proponents accept (i)-(iii) and explore what follows.[147]

6.1.1 – The Future-MDV and Sweet-Spot-MDV

Teasing out the technological (or historical) contingency of the MDV shows us that we can further specify the view with additional detail about its truth value in worlds with greater and lesser technological development than the actual world. There are various combinations of claims about this, each of which constitutes a different version of the MDV. Finding the most plausible combination of claims will thus help precisify the MDV, which is useful when adjudicating this debate. I have considered the Deprived World and argued that the MDV is more plausible if it says that the BDV is true in this world. Next, I will consider worlds with greater technological development than the actual world.

Imagine a world like the actual world in most ways. The only difference is that the goal of assistive technology has been achieved: technology has been developed that allows disabled people to function on a par with typical non-disabled people. We possess super-sophisticated assistive technologies including, for example, motorised wheelchairs capable of traversing the roughest terrains, prosthetics that function just as well as the limbs of non-disabled people and superbly advanced cochlear implants that allow even the profoundly Deaf to hear. This world is akin to what the actual world might be like in the future – call it the *Assistive Technology Enhanced World* or *Enhanced World*, for short.

Is the MDV true in the Enhanced World? That is, in the closest non-disablist worlds *to this world*, are the well-being prospects of disabled and non-disabled people on a par? I'll explore the implications of an affirmative answer first. One version of the MDV holds that the BDV was true in the past, but that the MDV is true now *and will remain true* as assistive technologies are improved to the point where disabled and non-disabled people possess equal functional capabilities. Call this the *Future-MDV*.

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[147] In this section, I have reasoned about the Deprived World, which is just like the actual world was at some point in its past. I also think that the argument would run (with a few tweaks) when considering a world just like the actual world is now, apart from a lack of assistive technologies. I have focused on a historical world because I thought it interesting to bring out the historical contingency of the MDV. But you may reframe my argument if you find the comparison cleaner between the actual world and the closest world with no assistive technologies. I think the reasonable MDV proponent will allow that disability is bad for well-being (minus disablism) in this world too.

The Future-MDV says that prospects are equal now (minus disablism) and in the hypothetical future that I've called the Enhanced World. It thus implies either that further development of assistive technologies (from their level now to their level in the Enhanced World) either makes *no difference* to the prospects of either group, or that it makes an *equal difference*.

One might defend 'no difference' by arguing that there is some threshold of sufficient development such that, past this threshold, more development of assistive technologies makes no difference to prospects and that, at present, we have passed the relevant threshold. However, there appears to be no good reason to believe this. It is difficult to believe that the development of better assistive technologies – which would seem to impact the lives of many disabled (and perhaps also non-disabled) people in profound ways – wouldn't affect *anybody's* prospects. In particular, it is difficult to believe that new assistive technologies would not benefit at least those disabled people that use them on a regular basis.

Another way to defend 'no difference' is consistent with this thought. One might argue that, although future assistive technologies will benefit some disabled people to a large extent, the *overall* impact of these technologies will be neutral, due to variability in their effects. That is, it's possible that, while a small number of disabled people will benefit greatly from each new assistive technology, many disabled people also will be harmed. For instance, the advent of bionic eyes provided exclusively for blind people *might* further marginalise those with moderate visual impairments who do not count as blind, for this might mean that less funding is (perhaps justifiably) allocated to provisions for making the built environment accommodating for people with visual impairments.[148] A situation akin to this is conceivable, but it is difficult to discern whether it is *plausible* without detailed information on the kinds of assistive technologies that exist in the Enhanced World, the impact these would have on people with different kinds of disabilities, and the distribution of disabilities in this world. We can see, then, that the heterogeneity of the conditions that count as physical disabilities complicates assessment of the impact of technology on comparative well-being. It would be easier to predict – although certainly not a simple matter – if we focused on the impact of better assistive technologies on those with a single given disability. This might provide a further reason to prefer a more narrowly focused enquiry.

Having said that, it does seem unlikely that MDV proponents would want to defend 'no difference' at all, not least because this would undermine much, perhaps all, of our reason to

[148] This example is illustrative. I am not arguing that this situation would be non-disablist.

develop assistive technologies. MDV advocates presumably think that we should continue developing assistive technologies at least in part because they benefit disabled people. Thus, they appear unlikely to defend 'no difference'.

'Equal difference' is more plausible. However, it would be striking if this is the MDV advocate's position. First, because it's doubtful that the further development of assistive technologies will equally benefit members of each group. Just like the past development of assistive technologies, further development seems more likely to disproportionately benefit disabled people. Second, because we are supposing that MDV advocates endorse Unequal Past Benefit. Thus, it would be noteworthy, and in need of explanation, that *Equal Future Benefit* is true. A satisfactory explanation would have to explain the difference between past and future development of assistive technologies that causes them to have different comparative effects on prospects. It's possible that advocates of the MDV can provide these explanations. But I can see no obvious way how.

To sum up so far, then, the Future-MDV holds that the MDV is true now and in the Enhanced World. The best defence of the Future-MDV is to argue for 'equal difference', which appears a hard task.

A different version of the MDV holds that the MDV is *false* in the Enhanced World. If so, then the GDV or BDV is true. For the MDV advocate to hold that the BDV is true in this world would be especially strange. The only difference between the present world and the Enhanced World is better assistive technologies. A version that held that the BDV is true in this technologically superior world would therefore imply that the development of better assistive technologies either disproportionately benefits non-disabled people or disproportionately harms disabled people – but both claims appear highly dubious.[149] The MDV advocate is thus more likely to hold that the GDV is true in the Enhanced World, which would fit nicely with their commitment to (i)-(iii), particularly Unequal Past Benefit. If development of assistive technologies has disproportionately benefitted disabled people so far, then it's plausible that it will continue to do so. That is, this is plausible:

iv. Unequal Future Benefit: The development of assistive technologies in future will disproportionately benefit disabled people's prospects (minus disablism).

[149] The MDV advocate might argue that new assistive technologies will benefit some disabled people but, due to their negative impact on others, will come as overall bad for disabled people, making the BDV true in the Enhanced World. But this counterintuitive claim would need defence and, as mentioned above, seems unlikely to be endorsed by MDV advocates who likely think that we should continue developing assistive technologies at least partly because they are overall beneficial to disabled people.

Versions of the MDV that endorse (i)-(iv) hold that the BDV was true in the past, that the MDV is true in the present day and that the GDV is true in the Enhanced World. Thus, according to this view, we are now occupying the particular period in which the MDV is true. Call this combination of claims the *Sweet-Spot-MDV*, called as such because it claims that we are now in a 'sweet-spot' of technological development that makes the MDV true.

The Sweet-Spot-MDV postulates a reasonably tight connection between the level of assistive technology – or the level of functioning of disabled people – and their well-being prospects. On the face of it, this seems plausible. However, postulating this tight connection leads to two related puzzles for the Sweet-Spot-MDV. First, why are prospects equal now (minus disablism) despite there being as-yet-unremoved obstacles to functioning for disabled people? Second, why would removing these obstacles and equalising functioning by developing better assistive technologies lead to disabled people having better prospects than non-disabled people? If there is a tight connection between functioning and prospects for disabled people, then one might reasonably expect there to be a similar connection for non-disabled people. That is, one might reasonably think that disabled and non-disabled people will (other things equal) gain similar well-being prospects from similar levels of functioning. However, the Sweet-Spot-MDV implies that disabled people are better at 'converting functioning into well-being' than non-disabled people, that they get the same well-being prospects from lesser functioning and will have better prospects once functioning is equalised. Maybe this is true, but it certainly needs defence.

Arguing for this claim is not the only way to defend the Sweet-Spot-MDV, however. This view could be true even if the groups are equally good at converting functioning into well-being. If so, then some other relevant factor must be unequal, such that it compensates for disabled people having lesser functional capabilities in the present world (making the MDV true) and raises the prospects of disabled people in the Enhanced World above those of non-disabled people with equal functioning (making the GDV true). However, it's not clear what this unequal factor might be. Whichever defence of the view is offered, then, the Sweet-Spot-MDV advocate must provide additional argument and explanation for why the MDV is true now and the GDV is true in the Enhanced World, and it remains to be seen whether a convincing explanation is possible.

To sum up, we can further specify the MDV with additional detail about its truth value in worlds with greater and lesser technological development. There are nine possible versions:

Figure 5: Nine further specified versions of the MDV

View	Deprived World	Present World	Enhanced World
1	GDV	MDV	GDV
2	GDV	MDV	MDV
3	GDV	MDV	BDV
4	MDV	MDV	MDV
5	MDV	MDV	GDV
6	MDV	MDV	BDV
7	BDV	MDV	BDV
8	BDV	MDV	MDV
9	BDV	MDV	GDV

Versions that endorse the MDV (or GDV) in the Deprived World appear implausible. And those that hold that the BDV is true in the Enhanced World are unlikely to be endorsed by MDV advocates. The two most plausible versions remain: the Future-MDV (8) and Sweet-Spot-MDV (9):

Figure 6: The two most plausible further specified versions of the MDV

View	Deprived World	Present World	Enhanced World
Future-MDV	BDV	MDV	MDV
Sweet-Spot MDV	BDV	MDV	GDV

These views are quite different, are vulnerable to different objections, and different additional argument needs to be provided for each. The Future-MDV advocate must explain why further development of future technologies equally affects the prospects of each group and the Sweet-Spot-MDV advocate must argue that disabled people are better at converting functioning into well-being or point to another well-being-affecting factor that is not equal between the groups.[150] As such, it is important to determine which view is endorsed by MDV proponents (or whether they endorse some other combination of claims). Doing so will provide a better understanding of the MDV and how MDV advocates understand the connection between disability, technology, functioning and well-being.

We must not forget the BDV. We can also further specify this view by determining whether its advocates think that it has always been and will always be true, or that the MDV (or GDV) will be true once we possess sufficiently sophisticated technologies. This would allow us to get a better understanding of the BDV's points of departure from the MDV and might thus help shed light on which kinds of arguments have the potential to advance this debate. In

[150] The advocate of Sweet-Spot MDV might also be charged with something similar to the status quo bias, a cognitive bias that caused a tendency to overvalue the current state of affairs, just because it is current, and to rationalise thusly. See Sparrow (2015) for a discussion of the status quo bias in a disability context.

general, asking questions about disability, technology, functioning and well-being will help precisify the views which is often helpful when evaluating or adjudicating between them.

6.2 – The Frivolous Funding Objection

So far, I have argued that the MDV's truth seems contingent upon the level of technology of a world and teased out the two versions that make the most plausible claims about the connection between technology and the comparative prospects of disabled and non-disabled people. In this section, I present a related objection which holds that the MDV seems unable to account for the kind of reason we possess to develop better assistive technologies in non-disablist worlds and thus cannot explain its intuitive moral weight. More generally, the objection holds that the MDV undermines the normative force of obligations to come to the aid of disabled people that we intuitively possess.

When discussing the objection, I'll focus on a particular (hypothetical) example of improved assistive technology: prosthetic limbs superior to those we have now in various ways. They are lighter and more durable. They don't cause skin irritation. The digits of the hands are opposable in the same way as biological fingers and thumbs. They connect directly into nerve endings so that one can control them mentally in the same way as one controls biological limbs. There is thus no need to learn new motor patterns to control these prosthetics. Once they are connected to a person's nerve endings, these prosthetics allow amputees to feel using them – just as biological limbs feel. This not only allows for more dexterity, but also prevents phantom limb pain. In short, these prosthetics allow amputees to experience little or no pain, discomfort or functional limitation because of their disability. If these improved prosthetics were developed and provided, all amputees could have occupations and hobbies that require extreme balance or dexterity (e.g. illustration, sewing, climbing, gymnastics); they could transition between different activities without needing to change their prosthesis, and they would likely feel little or no frustration because of their disability.

The objection proceeds from a claim that will be accepted by reasonable MDV and BDV proponents: we have a moral reason to spend funds on developing and providing disabled people with improved assistive technologies – in particular, these improved prosthetics – in the actual world.[151] I'll also assume that we would also possess a moral reason to do so in the closest non-disablist worlds. This is true unless the eradication of disablism *completely eliminates* this moral

[151] This is not to say that our moral reason is undefeated or decisive.

reason. But our moral reason to develop assistive technologies doesn't seem grounded *entirely* in a reason to combat or compensate for disablism. It might be somewhat grounded in this, but it's also grounded in the undeniable fact that these technologies would benefit disabled people. Even if we inhabited a non-disablist world, then, we would still possess some moral reason to develop and provide better prosthetic limbs.

The objection asks: can MDV or BDV advocates better explain the nature of the moral reason we possess to develop and provide better prosthetics in the nearest non-disablist worlds? Answering this question relies on differentiating moral reasons. There are many kinds of moral reasons postulated by different normative theories. For example, the moral reasons I possess according to deontological theories differ to those I possess according to utilitarianism, egoism or contractarianism. However, my methodology in this thesis is to remain agnostic (so far as is possible) about which normative theories are true and it would be impractical to assess this objection through the lens of every way of differentiating moral reasons. As such, I choose to differentiate moral reasons in terms of reasons of harm and benefit. I understand reasons of benefit to be reasons to bestow benefit. I understand reasons of harm to be reasons to prevent, relieve or refrain from causing harm.

I differentiate reasons in this way, first, because the distinction between reasons of harm and benefit is common both to common-sense morality and to philosophical normative theories. In fact, most plausible moral theories hold that we have moral reasons to bestow benefit, to avoid harming others and to prevent harm from coming to others (Brown, 2016: 194). As such, differentiating reasons in this way cuts across moral theories in a way that other differentiations do not. Second, our moral reason to develop better assistive technologies in non-disablist worlds intuitively doesn't seem subject to the kinds of contingencies that affect our moral reasons on some moral theories e.g. our personal relationships or preferences. So, assessing our moral reason to do so in terms of reasons of harm and benefit appropriately reflects our intuition that our reasons in this case are not contingent upon these kinds of things. Third, because the harm/benefit distinction seems most neatly aligned with the BDV/MDV distinction. For these reasons, I will proceed by differentiating reasons in this way, although I recognise that the MDV could be combined with different methods of differentiating reasons such that it has different implications in the cases discussed below. However, it would be up to MDV proponents to show this.

So, given this method of differentiating reasons, how can the MDV advocate account for the nature of our moral reason to develop better prosthetics in the closest non-disablist worlds?

Well-being prospects are equal in these worlds, by hypothesis of the MDV. Even so, let's assume that the development of assistive technologies would be beneficial for disabled people. Provided that the development of assistive technologies would benefit somebody in non-disablist worlds, the MDV advocate can explain our moral reason to develop them thusly:

1. We possess a general moral reason to benefit others.
2. Developing and providing better assistive technologies would be beneficial in non-disablist worlds.
3. Therefore, we possess a moral reason to develop and provide better assistive technologies in non-disablist worlds.

The BDV advocate can tell a different story. It's important to note that she *could* ground the relevant moral reason in our reason to bestow benefit. However, unlike the MDV advocate, she thinks that disability is a harm even in non-disablist worlds. As such, she has the resources to ground the relevant moral reason in the reason to come to the aid of people suffering harm.

4. We possess a general moral reason to alleviate harm.
5. Disability is a harm even in non-disablist worlds.
6. Better assistive technologies would alleviate (some of) this harm.
7. Therefore, we have a moral reason to develop and provide better assistive technologies in non-disablist worlds.

For obvious reasons, the MDV advocate cannot tell this story.[152]

So, we have two rival accounts. Does it matter which we endorse? I think so. More specifically, I'll argue next that the BDV account better explains the nature and subsequent weight of the relevant moral reason intuitively.

Consideration of the following cases illuminates important differences between the MDV and BDV accounts. In each case, you oversee the disbursement of funds across different projects in the nearest non-disablist worlds. You have ten thousand pounds remaining. You must choose whether to distribute the entirety to Daisy, who is an upper-limb amputee, or to Neil, who is non-disabled. Neil and Daisy's well-being prospects are equal; they are strangers to you; and you have no personal preference about to whom you distribute the funds.

[152] It should now be clear that the assumption that developing better assistive technology would be beneficial in the nearest non-disablist worlds is essential for the MDV advocate because, if they are not, then she cannot argue that we have a reason of benefit to develop them. It would seem to follow (given our way of differentiating reasons) that we would have no reason to do so, which is presumably something the MDV advocate would not endorse.

> **Benefit vs Benefit**: If given to Daisy, the funds will be used to develop and provide her with improved prosthetic arms. This will provide Daisy with 100 units of benefit. If given to Neil, the funds will be used to purchase ten years' worth of fine foods for Neil to eat. This will provide Neil with 102 units of benefit.[153]

How ought you to distribute the funds? In Benefit vs Benefit, you are choosing between funding two beneficial projects and we are supposing that the benefit produced is the only morally relevant difference between them. A fair way to distribute the funds seems to be to use *Impartiality*. Impartiality dictates that the interests of Neil and Daisy are given equal weight such that benefits to either party matter equally. Impartiality thus implies that all that is relevant is the benefit that each project provides, and not to whom the benefit is distributed. Straightforwardly, then, we ought to allocate the funds to Neil in Benefit vs Benefit, as it would be irrational (according to Impartiality) to fund the less beneficial project at the expense of the more beneficial one. But this may strike you as counterintuitive. Many will believe that we ought to distribute the funds to Daisy *even if* Neil's tastes are such that he gains slightly greater benefit from the fine foods, as they think that there is something special about our reason to develop and provide better assistive technologies that is not shared by our reason to provide Neil with fine foods.[154]

This brings to light an important feature of the MDV. MDV advocates seem compelled to understand the relevant moral reason as one to bestow benefit. But this implies that it is on a par with other reasons to bestow benefit, which leads to potentially unpalatable consequences. Resources are scarce, so we often must trade-off which benefits we bestow. The MDV understanding implies that our moral reason might come off second best in trade-off situations against others to bestow benefit. This doesn't seem problematic when considering cases where we forgo developing better prosthetics to provide a much greater benefit to many people. But it is always possible that some *seemingly trivial project* (when compared to providing better assistive technologies) will provide *slightly* more benefit than developing assistive technologies. In these

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[153] For *x* to benefit *y* is for *x* to improve *y*'s well-being. The relevant benefit might be pleasure, desire satisfaction or a more objective measure such as improved health or self-respect. As such, 'benefit' is used here as a term neutral between different theories of well-being. 'Harm' is used below in a similar fashion. Depending on one's preferred theory, one can understand harm to be any number of things, including pain, desire frustration, ill-health etc.

[154] Plausibly, potential benefits *to others* explain this belief, as other amputees would likely benefit from the development of improved prosthetics, whereas only Neil benefits from his fine foods. For cleanness of comparison, I am focusing on benefits only to Daisy and Neil. But I believe that we could alter the example such that benefits to others play no role and generate similar intuitions. For example, we might stipulate that the prosthetics have already been developed and it is *providing* them to Daisy that costs ten thousand pounds, or we might 'scale up' the case such that we compare all the future benefits of developing and providing better prosthetics with a (equally expensive, equally beneficial) project of providing a large group of non-disabled people with fine foods. In both cases, it seems that common intuition tells us to fund the prosthetics.

cases, the MDV story about the nature of our moral reason implies that morality allows or, more strongly, *requires* us to fund these seemingly frivolous projects at the expense of developing better assistive technologies. And this will be objectionable for anyone who thinks that we should not spend funds that could be used to develop better assistive technologies on comparatively frivolous, but slightly more beneficial, things – such as Neil's fine foods – because reasons to develop better assistive technologies are more weighty. To me, it seems likely that many (especially disability rights activists and MDV proponents) will think just this. But it seems that the MDV account of the relevant moral reason cannot vindicate this intuition.

Note also that it is not merely possible that the project of developing better assistive technologies might lose out to other seemingly trivial beneficial projects on the MDV account, it seems *plausible* that it would. Developing new technologies is often an extremely expensive process; there are far fewer disabled than non-disabled people; and certain assistive technologies – such as improved prosthetics – will benefit only a small number of disabled people (amputees) to any significant degree. So, it seems likely that money that could be spent on developing these technologies would often cause more benefit if funnelled to less expensive projects that slightly benefit a large number of people, such as increasing the cleanliness of a densely populated city. But I venture that it doesn't sit well with many people's sensibilities to compare the benefits of these projects, as our moral reason to develop better assistive technologies is, intuitively, of greater moral weight.

The situation is different in the next case:

> **Harm vs Benefit**: If given to Daisy, the funds will be used to develop and provide her with improved prosthetic arms. This will provide Daisy with relief from 100 units of harm. If given to Neil, the funds will be used to purchase ten years' worth of fine foods for Neil to eat. This will provide Neil with 102 units of benefit.

The value of distributing the funds to Daisy is 100 in both cases but, if we understand our situation as choosing between alleviating harm and bestowing benefit, then it is not so clear that the option with the greatest value ought to be chosen, even according to Impartiality. Impartiality says that we should consider equal benefits equally and equal harms equally. Whether we should consider equal *benefits and harm reductions* equally is a further question. When choosing between different kinds of moral reasons, the value of each project is not the only relevant difference. It thus might be rational to fund the project with lesser value (Daisy's prosthetics). This will be so if reasons of alleviating harm are weightier than those of bestowing benefit.

Now, the intuition that alleviating harm matters more morally than bestowing comparable benefit is common:

> [M]orally, the aversion, prevention, and relief of harms seem, at least presumptively, to matter more than the provision, protection, and maintenance of comparable and often greater benefits. (Shiffrin, 2012: 358)

> [Common statements about harm] suggest that there is something especially important about harm, such that we have strong, perhaps overriding reasons both to avoid harming people and to prevent harm from coming to people. (Bradley, 2012: 391)[155]

Many laypersons believe that, if offered the choice between alleviate *x* amount of harm and bestowing *x* amount of benefit, I morally ought to alleviate the harm. Think, for example, of the moral priority that most people think alleviating disease has over developing enhancement technologies. Others believe, more strongly, that I ought to choose to alleviate x amount of harm even if I have the (mutually exclusive) option of bestowing moderately greater benefit. Those who think either of these things hold that reasons of harm prevention take moral priority over those of bestowing benefit.

Because of the asymmetry in common intuitions about the moral weightiness of reasons of harm and benefit, it seems to make an important difference whether we understand our moral reason to develop and provide better assistive technologies in non-disablist worlds as one of alleviating harm or of bestowing benefit. That is, it makes an important difference whether we endorse the MDV or BDV account. Again, I take it that common intuition says that we ought to fund Daisy's prosthetics rather than Neil's fine foods even if the value gained by Neil is slightly greater. This thought is explained by a more general intuition: we ought not spend money that could be spent on developing better assistive technologies on funding comparatively frivolous projects of slightly greater benefit. The MDV account cannot adequately explain this intuition, whereas the BDV account can through appeal to the harm of disability and the greater weight of reasons of harm. The BDV thus seems to cohere better with intuitions about our moral obligations to disabled people in worlds without disablism, intuitions which I think will be held by many MDV advocates. The MDV therefore seems to have counterintuitive implications, even by its own lights. In particular, it appears to undermine obligations that we intuitively possess to come to the aid of disabled people, even after we eliminate disablism.

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[155] See also (Brown: 2016 194)

I have argued that the MDV combined with Impartiality leads to counterintuitive implications. It might seem obvious, then, that MDV proponents would reject Impartiality. Two alternatives are *Priority* and *Sufficiency*. Priority says, roughly, that we should give greater weight to benefits experienced by the worse off (Arneson, 2013: §6.2). Sufficiency says, roughly, that greater weight should be given to benefits that improve people's lives up to some threshold of sufficiency and lesser weight should be given to benefits above this threshold (Arneson, 2013: §6.1).

Neither Priority nor Sufficiency can help the MDV advocate here. We are thinking about what morality requires in the nearest non-disablist worlds. In these worlds, the MDV advocate thinks that well-being prospects are on a par. This means that disabled people are not systematically worse off than non-disabled people. So, Priority doesn't imply that we ought to give greater weight to the interests of disabled people; it implies that the same weight should be given to the interests of each group. Similarly, for Sufficiency, either *both groups* are typically above the sufficiency threshold or typically below it. So, Sufficiency also cannot help the MDV drive a wedge between reasons to benefit disabled and non-disabled people. As such, what Priority, Sufficiency and Impartiality imply about this case *for the MDV advocate* are practically indistinguishable.[156]

Notice, though, that Priority and Sufficiency provide additional BDV explanations for the relevant intuition. That is, BDV advocates needn't rely on the greater weight of reasons of harm to explain the intuition that we ought to fund Daisy's prosthetics instead of Neil's fine foods. She can instead endorse either Priority or Sufficiency, as she thinks that disabled people are typically worse off even in non-disablist worlds. For the BDV advocate, then, Priority implies, and Sufficiency might imply (depending on where the threshold is set), that greater weight should be given to benefiting disabled people. Thus, the BDV advocate has at least two plausible avenues by which she can explain why we ought to fund Daisy's prosthetics over Neil's fine foods, whereas the MDV advocate seems to have none.

In sum, intuition tells us that – even in non-disablist worlds – we should not spend funds that could be used to develop better assistive technologies on comparatively frivolous but *slightly*

[156] Other rules of distribution are Equality of (opportunity for) Welfare (e.g. Arneson, 1989) and Equality of Resources (e.g. Dworkin, 1981). If MDV advocates think that Equality of Welfare must be achieved for non-disablism to obtain, then the debate is trivialised: it amounts to saying that disabled people have equal prospects in worlds where we distribute goods to make this the case. Equality of Resources doesn't tell us much about the cases unless we stipulate many additional details: what are the resources relevant for justice? Does Daisy or Neil possess more of these resources originally? etc. Discussion of this view thus muddies the waters, as do desert-based views. Capabilities Approaches imply different things about fair distribution. I consider one of these in §6.3.4.

more beneficial things, such as Neil's fine foods. The MDV advocate cannot adequately explain this intuition. Her view counterintuitively implies that, in non-disablist worlds, morality will often require that we fund frivolous projects at the expense of developing assistive technologies. On the other hand, the BDV advocate can explain this intuition in various ways; she can appeal to the moral priority of preventing harm or of benefiting those who are worse off. The BDV story about our moral reason to develop and provide better assistive technologies thus fits better with intuitions about its nature and weight.

I have discussed the Frivolous Funding Objection with reference to our moral reasons in the nearest non-disablist worlds. This makes the discussion cleaner, as we don't have to worry about how disablism affects our distributive obligations. Undoubtedly, though, intuitions are clearer about what morality requires in the actual world. It would thus be worse for the MDV if it implied the same about the actual world. As far as I can see, there are three ways that the MDV proponent could block this implication. First, she might adopt Priority while arguing that, in the actual world, disabled people are worse off than non-disabled people. Second, she might adopt Sufficiency while arguing that disabled people are below the sufficiency threshold whereas non-disabled people are above it. In either case, benefits to disabled people would matter more morally than those to non-disabled people.

Third, she could argue that the presence of disablism adds weight to our moral reason to develop better assistive technologies because our reason to do so is at least somewhat grounded in a reason to combat or compensate for disablism. I will not spend much time evaluating this suggestion. All I will say is that to me it seems false. To combat disablism by improving the functional abilities of disabled people – in effect, making them more like non-disabled people – would be an odd, ineffective and inappropriate response. To combat disablism, we should alter social attitudes, practices and institutions, not provide better assistive technologies. And compensating for disablism by doing so doesn't appear much less strange. Perhaps we sometimes take material goods to be appropriate compensation for injustice. But it is not clear that the good must be assistive technologies. In fact, providing assistive technologies as a compensation for injustice might even have paternalistic undertones (Wolff, 2002: 214) – couldn't we simply give disabled people the money that would be spent on these technologies and allow them to choose where to spend it? Moreover, providing assistive technologies as a response to disablism appears to disrespectfully imply that the problem lies with disabled people rather than society (cf. Anderson, 1999: 336). Whether and what material goods are appropriate compensations will vary depending on the nature of the injustice and, to me, it seems inappropriate to compensate for disablism by providing better assistive technologies. A better

compensation, in my view, would be to provide disabled people with things more similar to the goods they miss out on because of disablism (e.g. more money to compensate for lesser earning power; free training courses to make up for lack of accessible education etc.).

The MDV proponent might be able to develop one of these three replies to block that the MDV's counterintuitive implication extends to the actual world. What seems clear is that the MDV suffers difficulties involving what it implies about morality in the nearest non-disablist worlds, which itself seems a troubling feature. Moreover, MDV proponents' views about non-disablist worlds *do* have implications for the actual world: they imply that, were we to eliminate disablism, then we would have no special reason *in the actual world* to develop better assistive technologies over and above the benefit that they cause. This also appears counterintuitive.

This Frivolous Funding Objection is one of a family of objections against the MDV. Each claims that the MDV undermines intuitions about our normative reasons, either in the actual world or in non-disablist worlds. I focused on our moral reason to develop better assistive technologies, but others focus on our apparent moral reason to prevent occurrences of disability (e.g. by encouraging pregnant women to supplement with folic acid (e.g. Singer 2005; Wasserman 2013)) or on our intuitive obligation to refrain from causing disability.[157]

6.3 – An MDV Reply: Non-Disablism and Justice

In this section, I discuss a potential MDV reply to the Frivolous Funding Objection. According to the objection, the MDV counterintuitively implies that, in non-disablist worlds, morality often requires that we fund seemingly frivolous projects instead of projects to develop better assistive technologies. Call this implication *Frivolity Over Technology*. One way to counter the objection is to argue that failing to develop assistive technologies is disablist so *could not possibly occur* in non-disablist worlds. If so, then the objection is misguided.

As stated, this reply is unconvincing. It's not plausible that any world in which we fail to develop better assistive technologies is therefore disablist. We cannot fund all projects and we might choose not to fund the development of assistive technologies for many legitimate reasons. Perhaps these projects are extremely expensive or don't have any realistic possibility of succeeding; perhaps other projects will benefit a larger number of people to a significantly greater degree; or perhaps there are especially important competing claims on our resources,

[157] See e.g. (Stramondo and Campbell, 2018; McMahan, 2005; Barnes, 2014; Barker and Wilson, 2019)

such as disaster relief. Choosing to fund, say, relief from a natural disaster instead of developing assistive technologies needn't be disablist. Therefore, it is at least coherent to suppose that we might fail to improve assistive technologies in a non-disablist world.

A better version of the reply accepts that we might fail to develop assistive technologies without being disablist provided that we possess strong countervailing reasons, but holds that the case I have focused on contains no such reason. That is, that Neil would benefit slightly more from his fine foods than Daisy would from her improved prosthetics doesn't count as a strong countervailing reason nor, in general, does the fact that another project is slightly more beneficial than developing assistive technologies – so says the reply.

Consider other accommodations for disabled people such as lifts that enable wheelchair users access to all floors of a multi-story building. We commonly think it disablist to build new public buildings without lifts, for including a lift in a new building typically is not extremely expensive (Barclay, 2010: 161) nor are there typically other significant costs of doing so. We also think it typically disablist to refuse to modify existing public buildings by adding a lift. We might accept that doing so would not be disablist if (e.g.) the building was historically important or if we needed to spend available funds on fighting the outbreak of a deadly disease instead. We might consider these sufficiently strong countervailing reasons for our reason to provide lifts in public buildings. But, plausibly, we would not consider it a strong countervailing reason that another seemingly frivolous project – such as organising a local parade – would bring *slightly* more benefit. We might well consider it disablist to fund this comparatively frivolous project at the expense of providing the lift. And it's plausible that the situation of assistive technological development is analogous: while it is not always disablist to refrain from developing better prosthetics, it might be always disablist to fail to fund these projects specifically in order to fund comparatively frivolous projects of slightly greater benefit. As such, perhaps Frivolity Over Technology – with emphasis on the *frivolity* – could not occur in non-disablist worlds.

This reply holds that the objection turns on a failure to properly understand the nature of non-disablism. If we did, says the reply, we would realise that it is incoherent to suppose that Frivolity Over Technology could occur. Next, I will evaluate this reply.

Whether it succeeds depends on how we understand disablism. Unfortunately, philosophical discussions of disablism are underdeveloped. No consensus exists on what 'disablism' means or on what acts qualify as disablist. Thinkers agree: 'a survey of the literature suggests that the term ['disablism'] is often referred to in a fleeting way with limited definitional or conceptual specificity' (Campbell 2012: 212-13) and '[disablism] as a concept is not well

understood' (Wolbring 2008: 252).[158] However, it is beyond my scope to defend a complete account of disablism. So, by way of evaluating the reply, I will consider whether it succeeds on various plausible accounts, offering reasons for pessimism that it does.[159]

Disablism is analogous to racism, sexism, homophobia etc. Each seems to share at least two common features. Paradigmatically, they all involve an attitudinal or doxastic element which we might call *prejudice* and a behavioural element which we might call *discrimination* (cf. Schmid, 1996; Glasgow, 2009). This suggests a framework for determining whether the MDV reply succeeds: we can consider whether Frivolity Over Technology expresses prejudice or discrimination against disabled people.

6.3.1 – Disablism as prejudice

First, I'll see what follows from understanding disablism as a prejudiced ideology that values non-disability and devalues disability. This understanding is suggested by Reynolds (2016: 60) when he says that disablism is 'the normative assumption that the "standard" or "normal" able-body is, ceteris paribus, in and of itself better than nonstandard or abnormal forms', and Campbell who says that 'at its core [disablism] characterises impairment or disability… as *inherently* negative' (2012: 213 original emphasis).

If we understand disablism as a prejudiced ideology, then eliminating disablism requires a change in beliefs and attitudes; a non-disablist world would be one where no person believes that disability is inherently inferior to non-disability. On this understanding, it is not clear that it would it be disablist to provide Neil's fine foods instead of improved prosthetics for Daisy. A non-prejudiced ideology is one that considers non-disabled and disabled people to be equal in moral worth and social status. Thus, a non-prejudiced world would be one where equal value is placed on the interests of disabled and non-disabled people (at least, when prospects are equal). One way of expressing equal respect and concern for every individual's interests when making distributive decisions is to use Impartiality. This method ignores the nature of each individual and considers only benefits as relevant. In this way, it is not prejudiced between the interests of

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[158] I also know of no precise account of disablism offered by disability rights activists. For example, disability charity Scope understand disablism to be 'discrimination or prejudice against disabled people' – see https://www.scope.org.uk/about-us/disablism/ (accessed 25/05/20). This account cannot tell us which acts qualify as disablist. In fact, no account that I have seen appreciates both the fact that not all disability disadvantages are disablist (Barclay, 2010) and elucidates which are and which are not.

[159] This discussion will be unavoidably incomplete. I don't have space for a comprehensive evaluation. I take my discussion here to be a step forward in an area that needs further exploration.

different social groups. But, as discussed above, using Impartiality to determine whether to develop assistive technologies is compatible with funding comparatively frivolous projects instead. So, it seems that Frivolity Over Technology could occur in non-prejudiced worlds.

Note, however, that this account also seems to imply that it would not be disablist to refuse to include ramps in new public buildings if the funds could be spent in slightly more beneficial ways. But, as mentioned above, many – especially MDV proponents – will consider this disablist, suggesting that those advancing this reply would not understand disablism merely to be a prejudiced ideology.[160]

6.3.2 – Disablism as discrimination

What if a necessary condition of disablism is that it involves discrimination? Again, whether this reply succeeds depends on how we understand discrimination. Lippert-Rasmussen says that *X* wrongfully discriminates against *Y* in favour of *Z* when:

> (i) *X* treats *Y* differently from *Z* in dimension *W*
>
> (ii) the differential treatment is disadvantageous to *Y*
>
> (iii) the differential treatment is suitably explained by *Y*'s and *Z*'s being (members of) different, socially salient groups.[161]

Does the case under consideration involve discrimination, on this understanding? Well, if we chose to purchase Neil's fine foods instead of funding Daisy's new prosthetics, we would be treating Neil differently than Daisy in a way that disadvantages Daisy – so conditions (i) and (ii) would be satisfied. But the differential treatment would not be suitably explained by Daisy and Neil being members of different socially salient groups. The fact that Neil benefits more from the fine foods explains the differential treatment, not the fact that Daisy is disabled and Neil is not. So, Lippert-Rasmussen's account doesn't imply that Frivolity Over Technology must be discriminatory, because (iii) needn't be satisfied (cf. Bognar, 2018: 11).

On other accounts of discrimination, it is less clear whether Frivolity Over Technology is discriminatory. For example, Segall (2012) says that two necessary conditions of wrongful discrimination are that (i) one undermines equality of opportunity, and that (ii) one treats people

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[160] Or that they would reject Impartiality as a way of being non-prejudiced. However, as argued above, it doesn't seem like other rules of distribution can help the MDV proponent.

[161] This account is a simplified version of that offered in Lippert-Rasmussen (2006: 138).

unequally *for no justifiable reason*. Clearly, this account cannot tell us whether an act is discriminatory without being supplemented with a normative theory that tells us what counts as a justifiable reason. The same problem befalls the most popular account of disability discrimination. The Americans with Disabilities Act (ADA) says that wrongful disability discrimination occurs when people fail to make 'reasonable accommodations' for people with disabilities (Silvers, 2016: 857). Again, we need a moral theory to tell us which accommodations are reasonable.

Theories of justice seem well placed to fill this role. They are often used to determine whether an allocation of funds/goods is permissible or required. So, it seems sensible to explore the implications of supplementing the ADA's account of disability discrimination with some theory of justice. To do so is to proceed on the assumptions that disability accommodations are reasonable when they promote justice in the right way and, more broadly, that treating disabled people in a non-disablist manner involves treating them justly.

6.3.3 – Disablism as injustice

To assess the MDV reply, I ultimately need to determine whether Frivolity Over Technology must be disablist. Consideration of what disablism is leads me to explore the implications of supplementing the ADA account of disability discrimination with a theory of justice. By way of evaluating the reply, then, I will now consider whether theories of justice imply that one would fail to make a reasonable accommodation for disabled people if one spent funds that could be spent on developing better assistive technologies on comparatively frivolous but slightly more beneficial projects.

There are numerous theories of justice. Many are said to face problems involving disability. For example, Rawlsian Contractualism is said to ignore the needs of disabled people by assuming that all citizens in the original position are non-disabled (Putnam *et al.,* 2019: §4.1); Luck Egalitarianism arguably disrespects disabled people by taking their bodily features to be internal deficits for which they need compensation (Anderson, 1999); and straightforward Equality of Resources views are said to fail to account for the fact that people need different amounts of resources to achieve life's goods. One example often mentioned is that disabled people sometimes need more resources to access a given good (Sen, 1992: 20; Anderson, 1999: 320; Robeyns, 2016: §2.4). For these reasons and others, disability scholars tend to gravitate towards Capabilities Theories of justice (e.g. Terzi, 2009; Wolff, 2009b).

On Capabilities Theories, *functionings* are valuable beings and doings, such as being well nourished, happy, healthy etc. *Capabilities* are real opportunities to secure functionings, given one's resources and environment (Robeyns, 2016: §2.1). Capabilities Theories hold that the proper currency of justice is capabilities. That is, to achieve justice we must distribute capabilities according to the correct rule of justice – which might be Equality, Priority, Sufficiency or something else.

6.3.4 – Justice as Democratic Equality

There are many Capabilities Theories of justice. I will focus on Anderson's Democratic Equality (Anderson, 1999, 2012a, 2012b), as it is one of the best known, most well developed and has been influential in thinking about disability justice.[162]

Democratic Equality is a version of *Relational Egalitarianism*. Relational Egalitarianism says that justice requires that people stand in relations of equality to one another (Brown, 2019: 330). On these views, distributive patterns are just instrumentally insofar as they promote equal social relations (Anderson, 1999: 313-14). More specifically, according to Democratic Equality, justice requires three things:

> **No Disrespect:** relations between individuals must not involve disrespect (e.g. paternalistic coercion, pity, condescension, demeaning judgments of people's capacities to exercise responsibility etc.)
>
> **No Ranking:** humans must not be ranked according to intrinsic worth (e.g. no ranking according to gender, race, social class, disability etc.)
>
> **Time-Relative Sufficiency:** all citizens must have, throughout the course of their lives, access to the capabilities necessary to i) avoid oppression, and ii) function as an equal citizen in democratic society.
>
> (Lippert-Rasmussen, 2018: 36-38)

Anderson thinks that the mutual satisfaction of these requirements guarantees that people stand in relations of equality to one another. No Disrespect and No Ranking together entail that all citizens are considered of equal moral worth and dignity, are treated with equal respect and concern, and stand on an equal footing in discussion and debate. That is, everyone accepts the

[162] For another Capabilities Theory, see Nussbaum (2011).

'obligation to justify their actions by principles acceptable to the other' (Anderson, 1999: 313). These requirements thus together guarantee the 'internal' (attitudinal, doxastic) elements of Democratic Equality, but they say nothing specific about what equal citizens are able to be and do.

Time-Relative Sufficiency guarantees the 'external' elements of Democratic Equality – the relevant beings and doings. It guarantees the capabilities necessary to avoid oppressive relationships. These are, for example, capabilities to earn a sufficient wage, to autonomously choose one's path in life, to report oppressive relations and to have one's reports taken seriously etc. Time-Relative Sufficiency also guarantees the capabilities necessary to act as a free and equal member of a democratic community (Anderson, 1999: 316). These are capabilities that allow one to function as a human (e.g. access to food and shelter, the ability to deliberate, psychological autonomy), as a participant in cooperative production (e.g. access to education, sufficient freedom of occupational choice, the right to make contracts with others and to organise a strike), as a political agent (e.g. being able to vote, petition government, campaign) and as a citizen (e.g. freedom of association, access to public accommodations, being able to appear in public without shame) (Anderson, 1999: 317).

Democratic Equality says that, once these three requirements are met, justice has been done and inequalities in other things are not under the purview of justice – for example, inequalities in distributions of things not needed for equal social relations (Anderson, 1999: 326). The final question I will consider in this chapter is: does Democratic Equality imply that Frivolity Over Technology is unjust and therefore disablist? To answer this question, I will consider whether we promote Democratic Equality – that is, the satisfaction of the three requirements – in the appropriate way by developing and providing better assistive technologies. To provide an absolutely definitive answer is beyond the scope of this chapter, but I will offer reasons for pessimism that Democratic Equality implies that Frivolity Over Technology must be disablist.

Let's first consider whether better assistive technologies are required to satisfy No Ranking and No Disrespect. It seems clear that they are not. Recall, assistive technologies are designed to improve the functional abilities of disabled people. However, equal ability is not needed for No Ranking and No Disrespect. People with vastly different levels of ability are perfectly capable of standing in *internal* relations of equality to one another. They needn't disrespectfully judge one another or rank each other according to their levels of ability. If they do, the appropriate response is to alter their disrespectful views through attitudinal and doxastic changes. These are likely best achieved through re-education and certainly not by developing

better assistive technologies. Seeking to eradicate disablist attitudes by developing and providing technology to improve the abilities of disabled people would be an inappropriate response to injustice. Thus, better assistive technologies are not needed to achieve these internal elements of Democratic Equality, nor are they the appropriate way to promote them.

Whether better assistive technologies are needed for Time-Relative Sufficiency is not as clear. I'll take it for granted that they aren't needed to avoid oppression. With the necessary attitudinal changes and aid from the state, physically disabled people seem capable of achieving the capabilities necessary to avoid getting entangled in oppressive social relationships.[163] But do we need better assistive technologies to furnish disabled people with the capabilities necessary to function as equal citizens in a democratic society? In our disablist world, it seems that disabled people often do not have equal access to these capabilities. To name a few examples: given the overwhelmingly visual nature of our education system, Blind people plausibly do not have equal access to education; given assumptions about what makes a good leader, disabled people are plausibly unable to campaign for office on an equal footing with non-disabled people; and given the nature of the built environment, wheelchair users often do not have access to all important public accommodations.[164]

To furnish disabled people with the necessary capabilities, we *could* provide them with better assistive technologies. We could provide the Blind person with bionic eyes to allow them equal access to education; we could provide the amputee who is considered an unfit leader with improved prosthetics that allow her to do all the things that people think leaders should be able to do (e.g. shake hands; hold a pen etc.); we could provide a wheelchair capable of climbing stairs (or bionic legs) to the Paraplegic person so that he can access all important public accommodations. But developing better assistive technologies is not *the only way* to achieve Time-Relative Sufficiency. Attitudinal and environmental changes can be equally effective. Instead of providing bionic eyes, we could alter the nature of the education system to make it equally accessible to the Blind;[165] instead of developing improved prosthetics, we could re-educate those who think that people who cannot shake hands are unsuitable leaders; instead of developing wheelchairs capable of climbing stairs, we could provide more ramps and lifts; and so on for all the relevant capabilities. In general, it doesn't seem like there are any relevant capabilities that couldn't be achieved by physically disabled people *with our current level of technology* through

[163] The same might not be true of people with severe psychological disabilities (cf. Wolff, 2009a).
[164] The truth of these claims is not important for my argument. They are illustrative.
[165] This is probably what many societies are in the process of doing.

environmental, social and attitudinal changes. So, although we *could* provide the relevant capabilities by developing better assistive technologies, we don't need to.

In fact, it seems *more appropriate* to provide the relevant capabilities by altering the environment than by developing and providing better assistive technologies – at least according to Democratic Equality. According to Wolff, we can address capabilities deficits in three ways. We can improve someone's internal resources (e.g. intelligence, strength, health), her external resources (e.g. money, property), or we can change the environment in which she lives (Wolff, 2002: 210). In this case, we are choosing between achieving justice by providing disabled people with more external resources – in particular, better assistive technologies – or by changing the environment. According to Wolff's terminology (2002: 211) we are choosing between a *targeted resource enhancement* and a *status enhancement*. Targeted resource enhancements occur when we address disadvantage by providing people with resources meant for a given purpose. Status enhancements occur when we address disadvantage by changing the environment.

Note that some assistive technologies – in particular, those that modify the environment such as lifts, ramps and textured pavements – seem more like status enhancements, as they act on the environment. But I have focused, and will continue to focus, on assistive technologies that *act on a person* rather than the environment (e.g. better prosthetics, wheelchairs etc.). These are best understood as targeted resource enhancements (Wolff, 2002: 214). My focus on targeted resource enhancement assistive technologies is noteworthy because, as will become clear, Democratic Equality implies different things about assistive technologies that count as status enhancements.[166]

Status enhancement is Democratic Equality's preferred method of achieving justice. Anderson criticises Luck Egalitarianism because it disrespects disabled people – and others who are deemed to have 'inferior natural endowments' – by offering them compensation for their 'substandard' embodiments (Anderson, 1999). She claims that this expresses pity and disrespect, so would not occur in a society of equal relations (1999: 306). When people do not possess the capabilities needed to function as an equal in society, then, Anderson thinks that changing the social environment (status enhancement) is, other things equal, preferable to changing the person as 'to change the person rather than the norm insultingly suggests that the defect lies with the person rather than society' (1999: 336; cf. Wolff, 2009b). Providing disabled people with the better assistive technologies that I've focused on seems closer to changing 'the person rather

[166] Henceforth, unless otherwise qualified, I will use 'assistive technology' to refer to assistive technologies that are targeted resource enhancements.

than the norm', as targeted resource enhancements act on a person rather than changing framework in which a person operates, as status enhancements do (Wolff, 2002: 214).

Relatedly, targeted resource enhancements often involve having to identify a person as needing compensation for a capability deficit (Wolff, 2002: 215). But singling people out as needing personal compensation because of their natural endowments is wholly rejected by Anderson. She (e.g. 1999: 306) argues that doing so is humiliating, disrespectful, stigmatising and expresses contemptuous pity. As such, providing better assistive technologies to disabled people to achieve justice may well violate No Disrespect by implying that their endowments are inferior ones for which they need compensation. On the other hand, status enhancements don't involve identifying particular people in need of compensation. They act on the environment, so are plausibly less demeaning and stigmatising for people who gain capabilities via their introduction (Wolff, 2002: 215).

It seems, then, that Democratic Equality implies that status enhancements are a more appropriate response than targeted resource enhancements to disabled people lacking capabilities necessary for justice. As such, we should address the relevant capability deficits through changing the environment where possible. And often this is possible. In particular, we needn't develop better prosthetics, better wheelchairs, superior cochlear implants, bionic eyes, or any other targeted resource enhancement assistive technology to provide disabled people with the capabilities necessary for Democratic Equality. Attitudinal and environmental changes (status enhancements) are sufficient and more respectful. So, Democratic Equality doesn't seem to imply that we promote justice for disabled people in the appropriate way by developing better assistive technologies. In fact, it appears to imply that doing so is disrespectful.

It might be objected that this argument implausibly implies that developing and providing *any* assistive technologies is disrespectful, including (e.g.) eyeglasses and wheelchairs. However, my argument does not imply this. First, because developing and providing better assistive technologies is a disrespectful compensation for capability deficits only when i) these technologies are targeted resource enhancements, and ii) alternative status enhancements can provide the same capabilities. It follows that not all assistive technologies are disrespectful compensations. Second, because my claim is not that *no* (targeted resource enhancement) assistive technologies are needed to achieve Democratic Equality; it is that we don't need to develop *more advanced* ones than we have now, as we already have sufficient assistive technologies to furnish physically disabled people with the capabilities needed for Democratic Equality. Thus,

assistive technologies that already exist might be needed for Democratic Equality; they might be, or have been, the best or only way to furnish disabled people with the relevant capabilities.

What about wheelchairs and eyeglasses? Wheelchairs furnish people with many important capabilities, and I can think of no feasible environmental change that could allow (e.g.) Paraplegic people sufficient mobility to achieve these capabilities – so, (ii) is not satisfied in the case of wheelchairs. Eyeglasses more plausibly provide capabilities that alternative status enhancements could do. The most straightforward reason why those with minor visual impairments lack the capabilities necessary for Democratic Equality is because they cannot read small text, and our society is structured such that reading small text is important for daily life, education and employment. But it seems possible to structure society such that one needn't read small text to achieve Democratic Equality.[167] Most text today is available electronically, so we can dictate its size or read it use screen-reading software. We also have mobile applications that can read non-electronic text (e.g. street signs) aloud. Thus, we don't need glasses *now* for Democratic Equality, as other status enhancements can provide the relevant capabilities. But eyeglasses date back to the thirteenth century (Ilardi, 2007: 5) and these status enhancements were not available then. Anderson (1999: 336) says that, *other things equal*, status enhancement is preferable to targeted resource enhancement. But things were not equal at the advent of eyeglasses. So, at the time of their development, (ii) was not satisfied. Developing glasses was the best appropriately respectful way of providing capabilities needed for relational equality.

In sum, I've argued that Democratic Equality implies that developing and providing better assistive technologies is often an inappropriate response to disability injustice because (i) better technologies aren't needed to achieve Democratic Equality for physically disabled people, and (ii) providing targeted resource enhancements is a disrespectful response to disadvantage when alternative status enhancements are available. Many assistive technologies are targeted resource enhancements for which alternative status enhancements are available – e.g. improved prosthetics, better cochlear implants and bionic eyes. Thus, Democratic Equality doesn't appear to imply that we promote justice in the appropriate way by developing these assistive technologies. So, it doesn't imply that one would fail to make a 'reasonable accommodation' for Daisy's disability if one allocated funding to Neil instead, nor that worlds where one does so – and, more generally, those where Frivolity Over Technology occurs – are always disablist worlds. It seems, then, that supplementing the ADA's account of disability discrimination with Anderson's theory of justice does not allow the MDV advocate to respond to the Frivolous

[167] It must be if (as I have argued) it is possible for Blind people to achieve Democratic Equality without bionic eyes!

Funding Objection. As such, the objection stands that the MDV counterintuitively implies that, in non-disablist worlds, morality will often require that we fund frivolous projects at the expense of developing and providing better assistive technologies.

That completes my discussion of this objection. However, I want to be clear that I haven't assessed all possible replies. MDV proponents might supplement their account of discrimination with a different account of justice or advance an altogether different reply. It remains to be seen whether a successful reply will be forthcoming. Whether or not it is, it seems that an important step forward in this debate is to further specify disablism. This will, amongst other things, allow for more detailed exploration of whether the MDV undermines our intuitive obligations in non-disablist worlds. One good way of properly specifying disablism might well be to draw connections between the literature on wrongful discrimination and the vast literature on justice. This is a difficult but potentially fruitful undertaking. My work in this section is merely a start.

Conclusion

In this chapter, I discussed the relationship between technological development and the well-being of disabled people. In §6.1, I argued that we can further specify the MDV if given additional information about how it understands the connection between the level of technology of a world and the MDV's truth value in that world. Then, I argued that the Future-MDV and Sweet-Spot-MDV are the most plausible further specified versions, and that each requires (different) additional defence. In §6.2, I presented the Frivolous Funding Objection which holds that the MDV counterintuitively implies that, in non-disablist worlds, morality often requires that we spend money that could be spent on developing better assistive technologies on comparatively frivolous projects of slightly greater benefit. In §6.3, I began to evaluate an MDV reply which argues that Frivolity Over Technology is disablist, and thus could not occur in non-disablist worlds. I didn't come to a definitive conclusion about whether this reply succeeds, as much turns on how we understand disablism and injustice. I did, however, discuss reasons for pessimism that it succeeds according to plausible candidate accounts, including Anderson's Democratic Equality.

Chapter 7 – A Defeasible Argument and a New Direction

In this final chapter, I bring together my work from earlier chapters. I use the methodology set out in chapters 3 and 4, my arguments in chapter 5, and some additional ones to present a defeasible defence of the understanding of the BDV that I defended in chapter 2. Afterwards, I briefly sketch a novel, more respectful direction that the debate between the BDV and MDV might take.

In §7.1, I argue that the BDV – as I have understood it – is true because at least five features common to disabilities (for reasons other than disablism) are typically bad for well-being, meaning that disabled people typically have worse prospects than non-disabled people in the nearest non-disablist worlds. In §7.2, I suggest that focusing on negative *features* of disability and the contexts in which they occur, rather than disability as a whole (or even particular disabilities) might improve the debate. Advantages of this tactic include that it seems to significantly alleviate the Problem of Averages, that it is less stigmatising for disabled people and that it properly respects the fact that whether a particular instance of disability is bad for well-being depends heavily on various contextual factors. As such, this proposal is in similar spirit to the Social Model and shares many of its advantages, without sharing its more controversial commitments.

7.1 – A Defeasible Argument for the BDV

In chapter 2, I argued that the best version of the BDV is probabilistic and considers the overall value of disability in comparison to non-disability:

> **BDV**: discounting the effects of disablism, a person is (ceteris paribus) typically (likely to be) overall worse off with a disability (in virtue of their disability) over the course of their life than they would have been without.

This view says that the well-being prospects of non-disabled people are typically better than those of disabled people in the closest non-disablist worlds. In chapters 3 and 4, I set out a methodology for making reasonable judgements about whether the BDV, MDV or GDV is true. In short, this methodology involves consideration of whether disabled and non-disabled people have equal access to the sources of well-being in the nearest non-disablist worlds. In this section, I use this methodology to present a simple and defeasible argument for the BDV, which builds on my work of earlier chapters.

I am going to suggest that at least five features common to disability in the closest non-disablist worlds are typically bad for well-being. The presence of these features pulls down the average well-being of disabled people in the nearest non-disablist worlds, meaning that they typically have worse prospects than non-disabled people and, as such, the BDV is true (cf. Campbell and Stramondo, 2017: 168).

7.1.1 - Pain

The first negative feature common to many disabilities is pain. Pain can be understood more narrowly or broadly. In the narrow sense, it refers to sensory pain which is almost universally recognised as bad for well-being. In terms of the three major philosophical theories of well-being, all forms of hedonism take sensory pain to be non-instrumentally bad; almost everyone has an (idealised, non-instrumental) preference to avoid sensory pain; and objective list theories often take pleasure to be non-instrumentally good (e.g. Ross, 1930: 135; Griffin, 1986: 67; Fletcher, 2013: 214; Rice, 2013: 210; Heathwood, 2014: 201; Hooker, 2015: 19-21) which suggests that they might also take pain to be non-instrumentally bad. Most objective list theories don't present lists of objective bads (Kagan, 2014: 272-76), so we cannot be certain that these lists would include pain. In any case, though, objective list theorists appear likely to agree that sensory pain is bad for well-being in some respect, even if only instrumentally. This is because sensory pain plausibly prevents (or makes more difficult) the realisation of other objective goods. For example, those experiencing regular pain may well have less time and energy to make and maintain personal relationships or to pursue their lifetime ambitions. After all, experiencing sensory pain is often fatiguing, debilitating and frustrating. Moreover, pain might hinder control over one's situation (Shepherd, 2018: 9). In this sense, it might hinder autonomy, which many take to be an important source of well-being (e.g. Griffin, 1986: 67; Rice, 2013: 210; Hooker, 2015: 23-24). In general, sensory pain (especially if it is chronic) is often instrumentally bad because it causes other bad things and prevents other good things. Uncontroversially, then, painful conditions are (other things equal) worse for well-being than non-painful ones because sensory pain is understood by almost everyone as either always non-instrumentally, or very often instrumentally, bad for well-being. Thus, the avoidance of pain is a source of well-being; it is something that typically makes lives go better.

Many disabilities involve sensory pain as an intrinsic feature. For example, Fibromyalgia is characterised as a condition that involves 'widespread pain' (Ngian *et al.,* 2011). And experiencing consistent pain for six weeks is part of the diagnostic criteria for Rheumatoid

Arthritis.[168] A larger number of disabilities don't *involve* pain, but do *cause* it.[169] Examples include Epidermolysis Bullosa (which causes painful blisters to occur all over the body (Felder, 2013: 183)), Limb Loss (which often causes phantom limb pain)[170] and Spina Bifida (which often causes Arthritis, headaches, back pain, visceral pain due to organ problems, and pain associated with degeneration of the spine).[171]

We can say without much controversy that disabilities are bad for prospects insofar as they involve or cause sensory pain. And many disabilities do, crucially, for reasons other than disablism. The pains that I have mentioned, and many others that disabled people experience, are direct results of their disabilities. They are either intrinsic features of disability or instrumental features that would remain even if we entirely eradicated disablism. In Thomas' (2010: 37) terminology, they are 'impairment effects'. The amount of sensory pain experienced by disabled people in virtue of their disability in W_1 would thus be similar to that which is experienced in the actual world.[172]

My discussion so far has focused on sensory pain. However, we might understand pain more broadly to include anything experienced as unpleasant. Things typically experienced as unpleasant include discomfort, fatigue, frustration, anxiety, depression and low self-esteem. Some disabilities non-instrumentally involve unpleasant experiences, such as Chronic Fatigue Syndrome which non-instrumentally involves feelings of profound fatigue.[173] Disabilities that *involve* unpleasant experiences would still do so in the nearest non-disablist worlds. Many disabilities also *cause* unpleasant experiences. Surely, many unpleasant effects of disability are due to disablism. In our disablist world, disabled people might have low self-esteem because they are pitied or infantilised by the non-disabled public (Brown, 2019: 327, 335); they might experience frustration because of lack of proper access to public accommodations; or they might experience emotional distress at being derided because of their disability. Of course, these unpleasant experiences (and many, many others) would not occur in non-disablist worlds. Disabled people would thus certainly experience far less unpleasantness because of their disabilities in W_1. However, in the nearest non-disablist worlds, disabled people would still experience *some* unpleasant effects of their disability. Examples include the discomfort often caused by wearing

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168 https://www.nchpad.org/281/1789/Primer~on~Pain (accessed 25/05/20).
169 Recall, I use '*x* involves *y*' and '*x* contains *y*' to mean that *y* is a non-instrumental feature of *x*.
170 https://www.nchpad.org/281/1786/Primer~on~Pain (accessed 25/05/20).
171 https://www.spinabifidaassociation.org/resource/pain/ (accessed 25/05/20).
172 Recall the important point that the closest non-disablist worlds share the actual world's level of technological development; so, they share the actual world's medical technologies. As such, there would not be extraordinary medical advances in these worlds that significantly reduce or eliminate the sensory pain often involved in or caused by disability.
173 https://www.nhs.uk/conditions/chronic-fatigue-syndrome-cfs/ (accessed 25/05/20).

prosthetics,[174] the frustration you might feel because of MS causing you to have difficulty controlling your bladder,[175] and the unpleasant emotions (e.g. anger, frustration, depression) caused by being unable to do things that one wants to do and perhaps could do previously. These and many other unpleasant effects of disability are not a result of unjust discrimination against disabled people. They are unpleasant consequences of disability not caused by injustice.[176]

This is all to say that disabled people seem (other things equal) likely to experience more pain (in virtue of their disability) than non-disabled people do (in virtue of non-disability) even in the nearest non-disablist worlds. As such, disabled people seem to have less access to an important source of well-being – the avoidance of pain – in these worlds.

7.1.2 – Reduced lifespan

The second negative feature common to some disabilities is reduced lifespan. Disabilities such as Cystic Fibrosis,[177] Tay-Sachs[178] and Anencephaly[179] all typically cause premature death, sometimes during childhood. Premature death is typically bad. On most interpretations, the goods in life are time sensitive. That is, we can sometimes only achieve them given sufficient time or, less strongly, are more likely (other things equal) to experience them to a larger degree if given more time. Goods of this nature include pleasure, friendship, knowledge, the development of personal abilities, pursuing one's ambitions, and achievement. For many of life's goods, it would be extremely difficult to achieve large or even moderate amounts of them if one died during childhood. Other things equal, those who die prematurely seem likely to experience a lesser degree of pleasure, knowledge, achievement and friendship than those who live to the end of a typical human life (say, eighty years) simply because living longer gives us more time to pursue and experience these goods. Moreover, the impact of shortened life seems qualitative as well as quantitative. There are some goods that seem inaccessible to those who die young, such as raising children to adulthood, being a grandparent and the special bond that comes with being married for many decades (Wasserman and Asch, 2013: 161).

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[174] https://mcopro.com/amputee-resources/common-prosthetic-issues/ (accessed 25/05/20).
[175] https://www.nhs.uk/conditions/multiple-sclerosis/ (accessed 25/05/20).
[176] Many activity restrictions of disability that occur in the actual world are caused by disablism. As such, disabled people are likely to experience less unpleasant emotion because of their disability in a non-disablist world.
[177] https://www.nhs.uk/conditions/cystic-fibrosis/ (accessed 25/05/20).
[178] Tay-Sachs is usually fatal by the age of five. See https://www.nhs.uk/conditions/tay-sachs-disease/ (accessed 25/05/20).
[179] Almost all babies with Anencephaly die shortly after birth. See https://www.cdc.gov/ncbddd/birthdefects/anencephaly.html (accessed 25/05/20).

For these reasons, disabilities that reduce lifespan are typically bad for prospects even in worlds with no disablism.[180] They, quite simply, often prevent us from attaining as much good in our lives as we likely could have if we had lived longer. And they do so for reasons other than disablism. Commonly, it is intrinsic features of disability that would remain even if we entirely eradicated disablism that cause premature death. This is certainly the case with Cystic Fibrosis, Tay-Sachs and Anencephaly.[181]

Acknowledging that premature death is typically bad for well-being doesn't commit us to the view that living *forever* is desirable. There are familiar problems with immortality that I won't engage with here (see Williams, 1973: 82-100). It is sufficient for my purposes that within the range of relevant cases – say, people aged zero to one hundred – living longer is typically, other things equal, better for well-being. That is, living to the end of a normal human life is a source of well-being to which disabled people have less access than non-disabled people in the nearest non-disablist worlds.

7.1.3 – Transition costs

The third negative feature common to multiple disabilities are transition costs. This is a general term meaning, roughly, the costs that come with experiencing and 'getting used to' something new. Transition costs might occur when changing occupation, getting divorced or moving house. In the disability context, they are most often understood as the costs involved in adapting to life with a newly acquired disability.

It is commonly said that acquiring a disability, or becoming disabled, is bad for well-being because it causes transition costs (McMahan, 2005: 95; Shakespeare, 2011: 102; Campbell and Stramondo, 2017: 168; Barnes, 2016b: 148). Becoming disabled is experienced as a hardship by most people because those who do often must change their self-conception and learn to come to terms with living a life that differs from their non-disabled life in many ways. This might include abandonment or alteration of goals that were important to them (McMahan, 2005: 95). Some negative features of their new disabled life that they must adapt to are caused by disablist attitudes and barriers. For example, in our disablist world a new wheelchair user must adapt to

[180] This argument assumes that well-being is additive, which some deny (Vellemen, 1991; Wasserman and Asch, 2013: 145). It also assumes that well-being is generally overall positive. This seems to be accepted by both sides of the debate, but some deny it (e.g. Benatar, 2006).

[181] I am not arguing that the premature death of disabled people in the actual world is always due to intrinsic features of disabilities alone. Often social factors that would not obtain in non-disablist worlds (such as unjust poverty caused by disablist hiring practices) will significantly contribute to the premature death of disabled people.

having lesser access to public accommodations and to being viewed as incompetent because of her disability. A new wheelchair user in non-disablist worlds would not have to adapt to *these changes* or many others that disabled people do in our world. However, some transition costs would occur even in non-disablist worlds, such as coming to terms with being unable to partake in certain activities that one valued before becoming disabled or changing one's self conception. No matter the level of disablism, Paraplegic people are unable to use their legs and adapting to this is often a difficult and traumatic experience. And, crucially, this needn't be because others treat you unjustly; it might just be because you previously enjoyed activities that involved use of your legs and you find it difficult to accept that those activities are no longer open to you.[182] The same goes for many other disabilities. For example, people who develop Chronic Fatigue Syndrome often must adapt to restrictions they experience because of lacking energy and experiencing chronic pain. For many, adaptation is a difficult and unpleasant process.[183]

Disabilities acquired after infancy typically cause transition costs. One might think, then, that acquired disabilities are (other things equal) typically worse for prospects than non-disability (and congenital disabilities, too). However, some thinkers appear to accept that acquired disabilities cause transition costs while suggesting that acquiring disability is not bad for well-being. They point to examples such as peak fitness (Reynolds, 2016: 158) to suggest that *becoming x* can often be bad without the state of *x itself* being bad. Barnes (2014: 96) says that 'even if being disabled is not a harm, becoming disabled is still a difficult and painful process'. Stramondo and Campbell (2018: 5) offer the following analogy: 'many people dislike moving, even if they know they will be equally happy in their new home once they settle in.'

The idea behind these arguments seems to be that transitioning from being non-disabled to being disabled can be bad for well-being even if disability is not bad for well-being after full adaptation. This seems plausible. However, I don't think it motivates the conclusion that acquired disabilities are not bad for well-being. This is, first, because it turns on a dubious distinction between 'being' and 'becoming' disabled. When does someone stop 'becoming' and start 'being' disabled? Suppose that Jack has his leg amputated and experiences a difficult period where his disability causes him mental anguish but, after some time, Jack adapts to his new condition and returns to *exactly* his level of well-being prior to amputation. Let's go further and assume that this struggle-followed-by-absolute-adaptation trajectory occurs for every person who

[182] This might be so even if there are perfectly good substitute options open to you (see chapter 5).
[183] Empirical literature supports this claim. The earlier a disability is acquired, the higher the reported quality of life (Uppal, 2006), and progressive disabilities produce lower quality of life reports than static ones (Amundson, 2010: 375).

acquires disability after infancy. This only establishes that becoming disabled is bad for well-being while being disabled is not if we interpret the point at which Jack stopped 'becoming disabled' as exactly the point at which he stopped experiencing transition costs. However, there seems to be no principled reason to set the threshold there. Doing so thus appears an ad hoc move to motivate the view that acquired disabilities are not bad for well-being.

The principled and more natural thing to say is that Jack counts as 'being disabled' the moment his leg was amputated or, more carefully, the moment he started experiencing limitations in regular activities because of his non-standard bodily feature interacting with other contextual factors. If we set the threshold there, then the transition costs Jack experiences while adapting to disability would be part of his disabled life. They would be part of him *being* disabled.[184] As such, even if Jack returns to exactly his non-disabled level of well-being after adaptation, the period of his life in which Jack is disabled is, on the whole, worse for him than the period in which he was non-disabled (assuming that other things are equal) because of the traumatic period of adaptation (cf. Shakespeare, 2011: 102).

Return to Stramondo and Campbell's moving house analogy. It is often true that the process of moving is bad but that one ends up just as happy in the new house after settling in. But it would be irrational to move house knowing that this would be the case.[185] If one is merely going to be *just as happy* in the new house as one was in the old house, then it would make little sense to put oneself through a period of hardship in order to move. And, if we interpret the start of 'living in a new house' as the moment one arrives at the new home, then living in the new house is, overall, worse for your well-being than living in the old house. You would have been better off if you stayed put, as the benefits of the new home don't compensate for the hardship of moving and settling in. The case of acquired disability is, I think, analogous. Even if you return to your previous level of well-being after adaptation (which is disputed (Lucas, 2007)), you would have more aggregate well-being – and better well-being prospects – if you remained in the non-disabled state. If we interpret the point at which one becomes disabled as the point that they acquire their disability – as seems reasonable – then acquired disabilities are overall bad for prospects because they cause transition costs without compensating gain.

Notice that not only acquired disabilities cause transition costs. Progressive disabilities – which might be acquired or congenital – do so as well. Progressive (also known as degenerative)

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[184] It is thus, I think, more useful to talk of these as *adaptation costs* that come with adapting to disability, rather than transition costs which occur when one is in some mysterious state intermediate between non-disability and disability.
[185] I assume here that the motivation behind moving house is to make oneself happy. This may be unrealistic, but the assumption makes the discussion cleaner.

disabilities develop over time. In normative terms, they 'get worse' for the person who has them. Examples of progressive disabilities include Multiple Sclerosis (where people often experience new or relapsing symptoms such as increased difficulty balancing, walking or moving their limbs (Stramondo and Campbell, 2018: 5)) and Muscular Dystrophy (where people's muscles gradually weaken).[186] Depending on the speed of the progression and a person's adaptation, these disabilities might cause constant transition costs where people are *never* able to completely adapt to their condition. Or they might cause a person to experience multiple periods of traumatic transition. People might adapt to the new nature of their disability for a period before experiencing further transition costs as their condition progresses or relapses.

It is my contention that disabilities are bad for well-being insofar as they cause or involve transition costs. And many disabilities do, for reasons other than disablism. Although it is likely to be easier to transition to being disabled in a non-disablist world, many of the transition costs that I have mentioned are not caused by unjust treatment of disabled people. They are caused by having to adapt to life with a new condition. As such, many disabled people inhabiting the nearest non-disablist worlds will experience transition costs because of their disability, including almost everyone who acquires disability after infancy.

This connects with my discussion of pain. Transition costs are bad for well-being because they are experienced as unpleasant – otherwise they would not be 'costs'. So, because many disabled people experience transition costs in virtue of their disabilities, they appear to have lesser access to avoiding unpleasant experiences than non-disabled people. Transition costs might also sometimes hinder well-being by preventing good things. For instance, if someone is preoccupied with adaptation or experiencing hardship because of it, then they might not be able to achieve something or acquire some knowledge that they would have otherwise.

7.1.4 – Significant reduction of valuable options

The fourth bad feature common to disability is reduction of valuable options. On any plausible understanding, disabilities often reduce valuable options. In chapter 5, I argued that reduction of valuable options in disability cases seems to be bad for prospects. My argument was not entirely conclusive. As such, I recognise that the reader might not agree that disabilities that involve a minor reduction of options are bad for well-being to any significant degree. But I believe that most will agree that disabilities that *significantly* reduce valuable options typically hinder well-being

[186] https://www.nhs.uk/conditions/muscular-dystrophy/ (accessed 25/05/20).

prospects. In chapter 5, I presented detailed arguments for this claim. In short, I think that disabilities that significantly reduce options will, on average, prevent those who have them from experiencing as much good as they would have done if they were non-disabled because, with more options, a person is i) more likely to have access to options that suit them better, allowing them to achieve more good more easily, ii) more likely to have options suitable for a variety of contexts, and iii) has more valuable combinations available. This is not to say that disabled people cannot experience all of life's goods. The suggestion is that, when considering large groups of disabled and non-disabled people, those disabled people with significantly fewer valuable options than typical non-disabled people are likely to, other things equal, experience less good in their lives than typical non-disabled people.

Examples of disabilities that significantly reduce options for reasons other than disablism are Deafblindness and Tetraplegia. People with these disabilities are precluded from exercising a vast range of options because of the nature of their disabilities and, moreover, are prevented from accessing large amounts of options in particular domains. Those with Tetraplegia are prevented from accessing almost all valuable options within the physical domain, and those who are Deafblind don't possess large numbers of options that require response to environmental stimuli; this might make substitute options harder to find. I don't doubt that some people with these disabilities will be able to replace the value of these options with others, experiencing just as much good (or more) than they would have if non-disabled. However, I think a large proportion will experience less of life's goods than they would have with more options. As such, significant reduction of options seems to hinder the well-being prospects of disabled people as compared to non-disabled people in the closest non-disablist worlds.

7.1.5 – Ill-health

The fifth bad feature common to disability, and the final one that I will mention, is ill-health. I said in previous chapters that I assume that disability is compatible with health. That is, ill-health is not an intrinsic feature of every disability. However, this claim is consistent with those that i) *some* disabilities do entail ill-health, and that ii) many disabilities are *associated with* ill-health (in the sense that they often cause it or are caused by it). On most plausible theories of health, these claims are true.[187] But I only need (ii) – the less strong claim – to make my point here.

[187] I won't offer a philosophical definition of health. I am relying on the common sense notion. See Boorse (1977), Nordenfelt (1995) and Kingma (2007) for discussion of this.

People with disabilities are more likely to have health conditions than non-disabled people. A UK survey found that sixty percent of non-disabled people rated their health as 'good' and nine percent rated their health as 'not good'. For disabled people, on the other hand, only eighteen percent rated their health as 'good' and forty percent said it was 'not good' (Office for Disability Issues, 2007: 212). Other surveys show similar trends.[188] Now, these surveys take place in our disablist world, so we cannot be sure that their findings would be replicated if we eradicated disablism. It certainly seems likely that the perceived health of disabled people would be greater in non-disablist worlds, as disabled people would not have lesser access to health care services, as they do in our world.[189] But it seems to me highly likely that disabled people would still experience more ill-health than non-disabled people in W_1 for the simple reason that some disabilities cause or are caused by unhealthy conditions. For example, Achondroplasia often causes difficulty breathing (Apnoea), obesity and recurrent ear infection;[190] Spinal Cord Injury is associated with developing deep vein thrombosis, urinary tract infections and pressure ulcers (bed sores);[191] and people with Cystic Fibrosis are more likely to develop brittle bones (Osteoporosis), Diabetes, sinus infections and liver problems.[192] It doesn't seem plausible to me that this widespread association between disabilities and health conditions is caused entirely by disablism. Many of these seem to be results of the disability itself rather than injustice. For example, people with Spinal Cord Injury often must use wheelchairs to mobilise, which unavoidably puts them at greater risk of pressure ulcers. More generally, I don't see how it could be that disablism alone causes widespread urinary tract infections, Osteoporosis, Apnoea etc. in disabled people.

So, disabled people seem likely to experience less health (more ill-health) than non-disabled people even in W_1. Health is a source of well-being. Some objective list theorists take health to be non-instrumentally valuable (e.g. Finnis, 1979: 86; Nussbaum, 2011: 33). Other theorists (e.g. hedonists) don't think so, but it is difficult to deny that health is valuable, even if only instrumentally. Most people desire to be healthy and experience ill-health as unpleasant. Health also facilitates the attainment of other sources of well-being, such as achievement, rewarding relationships, autonomy and living to the end of a normal human life. So, it seems that those with more health in their lives will, other things equal, have better lives than those with

[188] See for example https://www.cdc.gov/ncbddd/disabilityandhealth/relatedconditions.html (accessed 25/05/20).
[189] See https://www.who.int/news-room/fact-sheets/detail/disability-and-health (accessed 25/05/20) and https://www.cdc.gov/ncbddd/disabilityandhealth/relatedconditions.html (accessed 25/05/20).
[190] https://ghr.nlm.nih.gov/condition/achondroplasia (accessed 25/05/20).
[191] https://www.who.int/news-room/fact-sheets/detail/spinal-cord-injury (accessed 25/05/20).
[192] https://www.nhs.uk/conditions/cystic-fibrosis/ (accessed 25/05/20).

less. This is significant, as disabilities are commonly associated with health conditions for what appear to be reasons other than disablism.

7.1.6 – Bringing things together

I have identified five features common to disability for reasons other than disablism which are typically bad for well-being. I have argued that these things all tend to reduce disabled people's access to the sources of well-being in the nearest non-disablist worlds. Building on these arguments, in this section, I finish presenting my defeasible argument for the BDV.

Many disabilities involve or cause some combination of pain, reduced lifespan, transition costs, significantly reduced options and ill-health, and would also do so in the nearest non-disablist worlds. I have provided examples throughout this chapter. I think it's also worth noting that some disabilities involve or cause large amounts of a number of these features. To use one example, Duchenne Muscular Dystrophy is the most common form of Muscular Dystrophy.[193] It involves progressive muscle wastage from early infancy. Those affected will typically need to use a wheelchair by the time they reach twelve.[194] Adapting to the weakening of one's muscles and to the use of a wheelchair often comes with transition costs, which are experienced as unpleasant and might prevent the attainment of other goods. Use of a wheelchair also sometimes causes painful health conditions, such as pressure ulcers.[195] Pressure ulcers can get infected, which can lead to further health complications that are typically experienced as unpleasant, and might contribute to premature death. Moreover, people with Duchenne Muscular Dystrophy have their valuable options restricted because of their condition. As their muscles weaken, they are often unable to partake in ordinary physical activities. This might lead to frustration or diminished access to other goods. And people with this condition often do not live far into their thirties,[196] which might make them feel sad or distressed and plausibly prevents them from experiencing as much good as they could have if they lived to the end of a typical human life. Duchenne Muscular Dystrophy is thus a condition which often involves or causes all of the bad features discussed above for reasons other than disablism.

The example of Duchenne Muscular Dystrophy brings to light another important point: these bads of disability are often connected. The most obvious example is pain, which is

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[193] https://www.nhs.uk/conditions/muscular-dystrophy/ (accessed 25/05/20).
[194] https://www.mda.org/disease/duchenne-muscular-dystrophy/medical-management (accessed 25/05/20).
[195] https://www.nhs.uk/conditions/pressure-sores/ (accessed 25/05/20).
[196] https://www.nhs.uk/conditions/muscular-dystrophy/ (accessed 25/05/20).

connected to all the other bads. Transition costs are experienced as unpleasant, as are many health conditions. And one is likely to experience reduced options or the fact that one is likely to die early as unpleasant. But the other bads are also connected in various ways. Acquiring a disability that involves ill-health, a reduced lifespan or significantly reduced options will often be a psychologically costly process. Health conditions sometimes shorten lifespan and reduce options. And having a shortened lifespan often reduces options. This is why these features tend to 'congregate around' disabilities. That is, disabilities that involve or cause one of them often involve or cause others.

It's true that *some* disabilities (e.g. congenital Deafness) needn't involve or cause many, or perhaps even any, of these bad things in ideal social conditions, but many disabilities would involve or cause at least some of these five bad things even in non-disablist worlds. I have identified bads of disability which are not plausibly entirely caused by disablism. As such, even if we don't know all the details of the nearest non-disablist worlds, we can confidently say that these bads of disability will obtain in these worlds to some significant degree. Moreover, some disabilities involve or cause *all* these bads to a significant extent. The disabilities that involve or cause these features will, in general, hinder opportunities to access sources of well-being, making them worse for prospects than non-disability.[197] These bad disabilities will thus pull down the average well-being of disabled people in W_1 even if *some disabilities* are typically neutral for well-being (cf. Campbell and Stramondo, 2017: 168). Moreover, as far as I can see, non-disability doesn't tend to hinder access to the sources of well-being as compared to disability. There seems to be no source of well-being to which disabled people would have on average significantly more access than non-disabled people if we eliminated disablism (cf. Campbell and Stramondo, 2017: 168).[198] For some sources, such as adequate nourishment, it seems obvious that there won't be a significant and systematic difference between disabled and non-disabled people's access in W_1. For others, such as self respect, it seems entirely unclear whether one group will have access to

[197] Note that non-disability will cause transition costs if it is newly acquired, such as when one has a cochlear implant or has cataracts removed. However, the transition costs of becoming non-disabled are typically experienced as less of a hardship than those of becoming disabled (Stramondo and Campbell, 2018: 5). Intuitively, one reason for this is because it is psychologically easier to adapt to being able to do things one previously could not than it is to adapt to being unable to do things one previously could. After all, the newly non-disabled person can often live their life in very similar ways to how they did before they became non-disabled. The ambulatory person could (if she wanted to) mobilise with a wheelchair, but the Paraplegic person cannot choose to use their legs. Others have suggested that the best explanation for this asymmetry is that our world is more accommodating to non-disabled people (Stramondo and Campbell, 2018: 5). I think this plays a role but isn't the entire story. However, if you think it is (and that a similar proportion of people will acquire disability as non-disability in W_1) then you won't agree that disabled people typically experience more transition costs in the relevant worlds. But this won't ultimately affect my argument, as the point stands that the other four bads are more common to disability than non-disability.

[198] As such, it seems that we don't need detailed demographic information to come to a reasonable conclusion about whether the diverse group of physical disabilities does, on average, make on worse off, minus the effects of discrimination, which we do would if there were good-difference disabilities (see §2.4).

more of this source in the relevant worlds. For both of these kinds of goods, I assume parity of access.

All this comes together to form a defeasible argument for the BDV. If we average across the population of disabled and non-disabled people in the closest non-disablist worlds, then it seems that disability is going to typically hinder well-being prospects in these worlds because (i) many disabilities involve or cause some bad feature(s), (ii) some disabilities involve large amounts of a number of bad features, (iii) things that involve or cause these bad features typically hinder access to the sources of well-being, and (iv) there are few, if any, disabilities that allow one access to a larger degree of the sources of well-being than non-disabled people (cf. Campbell and Stramondo, 2017: 168; Stramondo and Campbell, 2018: 5). Once we recognise these four points, it seems that the probabilistic, all things considered version of the BDV is true. That is, members of the disabled group in W_1 will on average have worse well-being prospects than members of the non-disabled group, such that a rational individual who is fully informed of all the relevant facts about disabled and non-disabled lives in W_1 will have a significant reason to choose a non-disabled life.[199]

It might be objected that non-disabled people also experience all the bads I have mentioned. This is, of course, true. But, crucially, they do not experience these things qua non-disabled person; they experience them qua person. In contrast, disabled people do experience these bads qua disabled person *and* qua person. In the absence of evidence either way, I am assuming that disabled and non-disabled people have equal chances of experiencing these bads qua person. Disabled people and non-disabled people can both be hit by a bus, experience the loss of loved ones, the pain of a breakup, transition costs caused by new employment or moving home, the flu, cancer etc. Throughout this thesis, I have been assuming that other things are equal, meaning that consideration of these bads for disabled and non-disabled people (experienced qua person) cancel each other out; they provide no reason to endorse one view over the other.

It might also be pointed out that these bad things are sometimes instrumentally valuable. For example, pain can cause someone to develop a stronger mentality and a reduced lifespan might cause someone to enjoy the years that they have much more. In general, the (pro tanto) bads of disability have the potential to be overall good. Anything can be instrumentally valuable. However, cases in which these bads are overall valuable seem very likely to be rarer than ones

[199] Recall, I said (in chapter 2) that the prospects of *A* and *B* are *not* on a par if all the information about their well-being levels provides a rational individual with a significant reason to choose either life.

where they are overall disvaluable. Otherwise, it would in general benefit a person to cause them pain, ill-health, reduced lifespan etc. In addition, my arguments can accommodate the rare cases in which these bads are overall good. There might be unusual cases in each group where (e.g.) people are overall disadvantaged by health, but unusual cases appear likely to 'wash out' when considering the average well-being of large groups (see chapter 3).

I recognise that my argument in this chapter is not comprehensive. I haven't discussed all the sources of well-being in detail. It is not realistic for me to do so and, even if I thought I did, there always might be sources that I mistakenly neglected. The nature of this debate makes it almost impossible to provide an absolutely conclusive argument for any view. I have discussed the sources that I feel are particularly important in this context and which it seems that I can get a good grip on the comparative access of each group in the nearest non-disablist worlds. I've also assumed that other things are equal in W_1, including the assumption of parity of access to the other sources of well-being. This, of course, leaves it open for an opponent to argue that I am mistaken on various accounts. They might argue that there are benefits to being disabled that counterbalance or outweigh the negatives I have presented, that I haven't properly understood the nature of non-disablism, or that some other relevant things are not equal. For this reason, I have stressed that my argument is *defeasible*. It is not a knock-down argument against the MDV, but a presumptive argument that is open to refutation. My goal has been to add to the conversation on disability and well-being, not necessarily to have the final say.

In sum, I've offered a defeasible argument that disability is typically, overall bad for well-being minus the effects of disablism because disabled people seem to in general have less opportunity to access the sources of well-being in the closest non-disablist worlds. What this means is that, if we eradicated disablism in the actual world, disabled people would still (in general) have worse well-being prospects than non-disabled people.

I want to finish this section by clarifying my view, in particular by emphasising what it is not. It does not imply that disabled people have on average bad lives, as it makes a comparative claim. It does not imply that disability is always non-instrumentally bad, as it considers (average) overall value, so is compatible with Barnes' (2016b) view that disability is neutral simpliciter. It does not imply that no disabled person has better prospects than any non-disabled person, as it is a claim about average well-being prospects of members of large groups. It does not imply that someone's life could not go just as well (or better) with a disability than without as, again, it makes a claim about averages. It does not imply that disabled people cannot access the full array of life's goods. Nor does it straightforwardly imply that disabled people have less claim to scarce

medical resources, that we ought to select for non-disability, or that we ought not to select for disability. What the normative implications of this view are is a complex discussion that I have left for another time.

7.2 – A New Direction: The Features-First Approach

In the previous section, I presented a defeasible argument for the BDV. The argument was essentially that some typically bad disabilities pull down the average well-being of disabled people in W_1 below that of non-disabled people. However, it might be thought that averaging across the diverse physically disabled western population is not a useful tactic. After all, what is true of a group on average is often not true for particular members of said group (cf. Barnes, 2009a: 343; Stramondo and Campbell, 2018: 5). In chapter 2, I deemed this the *Problem of Averages*. If our ultimate concern is making as robust judgements as possible about the prospects of particular individuals, then coarse-grained, broadly focused, approaches (like mine and many others within the Philosophy of Disability) might not be appropriate, as there is always risk of error when making particular inferences from information about averages, and this problem is exacerbated if the group is heterogeneous.

Some might not find the Problem of Averages particularly worrisome. They might not be concerned by the likelihood of exceptions within a population to general claims inferred from averages across that population. Perhaps, for their purposes, general claims are all that are needed – this would, of course, depend on their purpose. Or perhaps they think that, on balance, coarse-grained approaches are best because of their practicality or other advantages. There are those, however (e.g. Barnes, 2009a: 343; Stramondo and Campbell, 2018: 5) who do seem to take the problem seriously. As such, in this section, I am going to briefly sketch an outline of a suggestion for a different direction that this debate might take, one that significantly alleviates the Problem of Averages, allows for more robust inferences about the prospects of individuals, and appears to have other benefits including being less stigmatising to disabled people.

For those that take the Problem of Averages seriously, course-grained enquiries into disability's effect on well-being are off the table. One intuitive suggestion is to conduct a more narrowly focused enquiry. Perhaps a disability-focused approach would be good, where we consider each disability separately and ask whether *that disability* is bad for well-being. However, even disability-focused approaches might misidentify individual prospects, as not all people with a given disability experience the same level of well-being in virtue of it. My suggested new

direction is, I believe, superior to a disability-focused approach, especially for those that want to make as robust judgements as possible about the prospects of individuals.

I have suggested that five features common to disabilities are typically bad for prospects. This was not designed to be an exhaustive list. There may well be other bad features of disability not caused by disablism.[200] And we must recognise that there might also be good features of disability, which might include (e.g.) involving unique, pleasurable sensory experiences or causing a strong sense of community with other disabled people. My suggestion is that the debate could stop focusing on disability conceived with any level of granularity. Don't ask whether disability as a whole hinders prospects; don't ask whether physical disabilities hinder prospects; and don't take the disability-focused approach of asking whether particular disabilities hinder prospects. The debate could proceed by focusing on identifying *the features* common to disabilities that make them bad or good for well-being prospects, either instrumentally or non-instrumentally, and which disabilities have these features in which contexts. For a case of disability in a given context, we could then determine its likely well-being value by looking at what features it is likely to manifest in that context.

How might this *Features-First Approach* work in practice? Suppose that we wanted to discern whether David is likely to have lower well-being because of his disability. To do so, we need to answer various questions about David and his disability. Broadly speaking, we need to know what disability David has, what the potentially bad and good features of David's disability are, which contexts he occupies, and which good and bad features his disability is likely to manifest in these contexts.

Suppose that David is Deaf and we think that common bad features of Deafness include an inability to communicate with those who do not speak sign language, the lack of pleasurable auditory experiences and the higher risk of accidents.[201] Suppose further that we think that common good features of Deafness include a strong sense of community with other Deaf people and the inability to be distracted by excessive noise. We would then need to know whether David's contexts are (e.g.) those where the majority of people speak sign language, those where he has access to a vibrant Deaf community, those that contain pleasurable auditory experiences or those with lots of disturbing noise, and so on. Careful consideration of this information would allow us to build a picture as to how *David's* Deafness will likely impact his

[200] Perhaps a poor fit with the environment is one as, recall, many think that *completely* inclusive design is impossible (Shakespeare, 2013: 37). Perhaps, then, some disabilities will have a poor fit with the environment no matter what we do.
[201] The bad features of disability might be those mentioned in §7.1, or others.

well-being, given the contexts that he occupies. If we know that David lives in community similar to 19th century Martha's Vineyard – which has a large Deaf community, is a place where the majority of people speak sign language[202], and has lots to offer in terms of pleasurable auditory experience – then our answer will be different than if (e.g.) David occupies contexts of excessive, disturbing noise, those where the sense of hearing would be needed to prevent attack by predators etc.

We would need to ask different questions depending on the nature of the disability under consideration. For disabilities that affect mobility, for example, we likely need to know the nature of the landscape to assess their impact on well-being (are there lots of steep hills, rocky terrains etc.?), whereas this seems less important for disabilities such as Deafness. For virtually all disabilities, though, we will need to know whether they are acquired or congenital, the level of medical and assistive technology available in the relevant context, how much access disabled people have to these technologies, and how much social support is available for people with given disabilities. Answers these questions will allow us to get a fuller picture of whether people with a certain disability are likely to experience pain, transition costs, ill-health, significant reduction of options, difficulty communicating or mobilising, or other bads in the relevant contexts.[203] More generally, as we answer these key questions about the relevant disability and context, we would be forming a fuller picture of that disability's impact on well-being in the relevant context, which may be very different to the impact of other disabilities in that context and the impact of that disability in other contexts.

Why prefer this approach to coarse-grained and disability-focused ones? Well, because it is obvious that i) a given disability's effect on well-being in context *C* depends on the amount and degree of bad and good features it involves or causes in *C*, and that ii) different instances of disabilities have different features in different contexts. Once we recognise (i) and (ii), it becomes clear that both course-grained and disability-focused approaches face difficulties. In averaging over, say, physically disabled people and taking this conclusion to apply to people with physical disabilities generally, course-grained accounts don't respect (ii), as contextual variation in disability's effect on well-being happens at a much more fine-grained level. And the findings of coarse-grained approaches will be significantly influenced by which contexts and disabilities they focus on. In fact, I have noted in various places in this thesis where its relatively broad focus poses difficulties for assessing arguments about disability's impact on well-being. And even

[202] https://www.britishdeafnews.co.uk/marthas-vineyard/ (accessed 23/11/20).
[203] These are some of the bad features that disability can manifest. See §7.1 for others. I of course cannot mention (and do not know) all the bad and good features that disability might involve or cause in different contexts.

disability-focused approaches don't properly respect (ii), as there is significant contextual variation in disability's relationship to well-being, even within those with the same disability. For example, Deafness' effect on well-being will likely heavily depend on how many of the population know sign language, the impact of Paraplegia on well-being will depend on the layout of the natural and built environment, and so on.

Focusing on features of disability and the contexts in which they occur, on the other hand, respects (i) and (ii). It foregrounds the fact that contexts are important. It significantly increases the likelihood of accuracy when making inferences about particular individuals in particular contexts, because of its higher level of fine-grainedness than disability-focused approaches – although of course there is still some possibility of error. It doesn't attempt to answer a question about disability *in general*, so doesn't suffer from problems of our choice of contexts and disabilities affecting conclusions about disability as a whole. And, crucially, it is a features-first rather than a disability-first approach; it takes features to be the most important things, and says that disabilities are bad (or good) in certain contexts to the extent that they involve or cause bad (good) features which are not compensated for by good (bad) ones. This tactic thus puts the focus where it should be: on features and contexts rather than disability or disabilities. This brings into sharp focus that disabilities often needn't have bad features, and might have good ones, if certain contextual factors are altered. By explicitly recognising this fact, this tactic has many of the benefits of the Social Model without inheriting its dubious implication that disability is entirely socially constructed. That is, this tactic implies that the best way to alleviate bad features of disability, and to promote good ones, is often to change the environment (or context) rather than the disabled person. This seems to express appropriate respect for people with disabilities and could create impetus for social change. Moreover, perhaps no one (parents, policy makers etc.) has a practical interest in how disability as a whole impacts well-being, but people may well be interested in how certain disabilities in certain contexts impact well-being. As such, this approach seems to provide more useful insights than broad- or disability-focused ones.

The Features-First Approach may also reduce the stigma associated with disability. It seems less stigmatising and disrespectful to disabled people to hold that certain *features* of their disability are bad for their well-being, rather than claiming that their disability *itself* – which may well form a large part of their identity or self-conception – is bad for their well-being. In addition, this tactic implies that disabilities aren't bad in a special kind of way. In the cases in which disability is bad for well-being, its badness is of the same kind as other things. Sports injuries and romantic relationships, for example, are bad insofar as they involve or cause bad

features. It is not that disability itself is objectively bad, or that non-disability is on our list of objective goods. Explicitly recognising this fact – as well as that some features of disability might be good for well-being in certain contexts – might also go a long way to lessening the stigma of disability. And, relatedly, it might be liberating for disabled people, or improve their self-esteem, to feel that it isn't their disability that is detrimental to their well-being, but certain features of it which, in many cases, it needn't have.[204]

The Features-First Approach thus seems to significantly mitigate the Problem of Averages, to be appropriately respectful to disabled people, and might have good consequences in lessening the stigma of disability. Moreover, if we could identify which disabilities involve or cause bad or good features when combined with particular contextual factors, this tactic would allow us, as far as I can see, to do all the important normative work that a more traditional version of the MDV or BDV might. As such, it seems more attractive than coarse-grained or disability-focused approaches, especially for those who want to make as robust judgements as possible about the prospects of given individuals.[205]

Focusing on features and contexts has various other potential advantages, too. First, instead of disagreeing about whether disability in general or particular disabilities are bad for well-being, the discussion could be more collaborative. If we all agree that (i) and (ii) are true (which we should), then we could instead all focus on identifying what the bad or good features common to disability are, which disabilities involve or cause them in which contexts, and how best we can prevent or promote their occurrence. This discussion might well have real-world benefit in improving the lives of disabled people. For example, it might provide a method of prioritising responses to disability; perhaps we ought to focus on altering the social environment and developing medical and assistive technologies that alleviate the bad features of disability and promote the good ones. That is, for example, perhaps we shouldn't focus on preventing Blindness, but on preventing Blindness from causing (e.g.) a significant reduction of valuable options, and on promoting a sense of community amongst the Blind.

Second, this tactic has intuitive results because it allows for more nuanced conclusions about disability. It allows us to recognise that *some* disabilities (such as Duchenne Muscular Dystrophy and Tay-Sachs) are typically bad for well-being in almost all contexts because they

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[204] Compare Shakespeare's (2006: 198-99) discussion of the strengths of the Social Model.

[205] This approach might not need to replace course-grained enquiries; they could occur alongside one another. Perhaps course-grained approaches are more relevant to certain questions (in particular, those where we cannot reliably predict the relevant context) and fine-grained, Features-First Approaches are more relevant to others. It also seems possible to conduct course-grained enquiries using a features-first methodology.

unavoidably have bad features and rarely have offsetting good ones. At the same time, we could also say that other disabilities (such as congenital Deafness and Achondroplasia) do not typically involve or cause many bad features, and might not involve or cause any if we suitably altered various contextual factors, so are likely neutral for well-being in many contexts once we discount the effects of disablism, but are also likely bad for well-being for some people in some contexts. And we could say all these things without worrying about what they imply about disability as a whole, or even particular disabilities, as we aren't looking for particular cases to generate general conclusions.

Third, and finally, focusing on features and contexts rather than disability in general would likely prevent those on both sides from discussing disabilities that suit their purposes. Often, those sympathetic to the BDV focus on disabilities which are obviously bad for well-being, while thinkers who are more disability-positive focus on disabilities which seem to involve few (if any) bad features in most contexts.[206] This doesn't seem useful. It makes it almost as though proponents of each view are talking past one another (cf. Schramme, 2013: 90). If they are reasonable, proponents of both views should be capable of recognising that *some* disabilities are often bad for well-being while others are not, and that this depends heavily on context. Focusing on features and contexts would hopefully encourage them to do so, as this tactic makes clear that we are not interested in what the badness or neutrality of particular disabilities in particular contexts implies about disability as a whole.

I hope the foregoing offers some clarity on how the Features-First Approach might work in disability cases and the potential advantages of it. However, there seems to be no reason in principle to restrict this approach to disability. Many things manifest different features for different people in different contexts. Thus, it might well be beneficial to apply the Features-First Approach to other things as well, especially if these things have heterogeneous effects on well-being. As an example, it might be useful to identify the good and bad features that (e.g.) unemployment or poverty commonly involves or cause – like lack of personal security or self-respect – and the contexts in which they involve or cause them. This would allow us to focus on the most important thing – impact on well-being – when making policy (and other) decisions. For example, instead of focusing on eliminating unemployment (which might be too difficult), we could focus on minimising the bad features unemployment involves and causes through certain kinds of social support. This approach might well also be less stigmatising for

[206] Silvers (2016: 852) suggests that, in taking these discussions to say something about disability as a whole, these authors commit the fallacy of composition, where they make a mistaken inference from what is true of a part to what is true of the whole.

unemployed people. More generally, it may well be instructive to discern the good- and bad-making features of life generally, and the contexts in which they occur. Doing so might allow us to enhance well-being in a more targeted manner by using different methods for different people/groups in different contexts.

My mention of identifying the good and bad features of life in general might leave the reader wondering how the Features-First Approach differs from standard objective list theories of well-being. After all, these theories look to identify the good features of life and there is no reason why we could not – within the scope of objective list theories – look at the bad features too and the contexts in which good and bad features occur. However, the Features-First Approach differs from standard objective-list theories in important respects. Objective list theories identify things that are *objectively and non-instrumentally* good for well-being, while the Features-First Approach identifies good- and bad-making features, which might improve or hinder well-being instrumentally *or* non-instrumentally. They might be causes or constituents of well-being or ill-being. Moreover, these features might be good (or bad) objectively *or* subjectively. That is, they might improve (or hinder) well-being because they are objectively good (or bad) or because they are the subject of pro-attitudes, experienced as enjoyable etc. As such, the Features-First Approach is not committed to the idea that anything is objectively prudentially valuable. The main difference between the approaches is, thus, that the Features-First Approach is neutral between the three major theories of well-being, whereas objective list theories are their own theory with particular theoretical commitments. Proponents of the Features-First Approach can thus identify good- and bad-making features of things without assuming a position on exactly how and why these features are good and bad.

The Features-First Approach also differs from non-comparative accounts of harm (e.g. Harman, 2009: 139). These theories identify the things that harm one in a non-comparative sense, and often include disability as a non-comparative harm (see §2.3 for discussion of this). On the other hand, though, the Features-First Approach – as I have presented it – identifies *comparative harms*. It identifies features of disability that make one worse off *than they would have been* if non-disabled. Thus, the Features-First Approach doesn't rely on the potentially dubious notion of non-comparative harm. Moreover, non-comparative accounts of harm tend to be accounts of non-instrumental harm.[207] They say that disability is non-instrumentally harmful. The Features-First Approach, on the other hand, remains neutral on whether the bad and good features of disability are instrumentally or non-instrumentally harmful; the Features-First

[207] The things that cause non-comparative harms will, of course, count as instrumentally harmful.

Approach might thus imply that disability is bad (or good) for well-being either instrumentally or non-instrumentally.

That concludes my sketch of a potential new direction for this debate. I have not provided all the details of how the Features-First Approach would work in practice, but I believe that I have offered enough detail to illustrate its potential benefits. I should note, finally, that the potential benefits of the Features-First Approach do not mean that broadly focused enquiries into disability and well-being – like the one I conduct in this thesis – are useless. Broadly focused approaches are practical, which can be a significant benefit, especially given that we must start somewhere in our enquiry into disability and well-being, and it is difficult to choose a particular condition (or context) to focus on from the start, as many seem worthy of investigation. Moreover, broadly focused enquiries allow us to identify interesting patterns across broad classes, which can be useful in itself and might inform later (more narrowly focused) enquiries. For example, broad enquiries might motivate the production of a list of relevant questions to ask about particular disabilities and contexts when conducting narrower enquiries using the Features-First Approach. Finally, broadly focused enquiries might be necessary if we cannot reasonably predict the context or disability of the relevant individual or group. If, for example, we wanted to assess the likely impact on well-being of some policy or intervention that will produce a large amount of disabilities, but we cannot tell which disabilities will be produced, or the contexts in which they will occur, then a broad focused enquiry might be the best choice.

Conclusion

In this chapter, I first (in §7.1) brought together my work from earlier chapters to present a defeasible argument for the BDV. This argument pointed out that many disabilities involve or cause some bad features for reasons other than disablism and that, while others plausibly do not, these bad disabilities pull down the average well-being of disabled people as compared to that of non-disabled people in the closest non-disablist worlds. To finish, (in §7.2) I briefly sketched a suggestion for a novel new direction for this debate. I suggested that focus could instead be on the good and bad *features* that disability involves or causes and the contexts in which these occur. I also mentioned various advantages of this strategy. I am hopeful that, by taking up this Features-First Approach, this debate can become more respectful, less stigmatising, more collaborative and more useful.

Conclusion

In this thesis, I have explored whether physical disability is bad for well-being if we discount the negative effects of disablism. I have offered a sustained and detailed examination of the debate between the MDV and BDV, ultimately concluding that physical disability does make one more likely to be worse off, even in the absence of disablism, because several bad features common to disability are not caused by disablism. As such, a rational, fully informed individual inhabiting the nearest non-disablist worlds would have significant reason to choose a non-disabled life over a disabled life, meaning that the BDV is true (as I have understood it). However, I have stressed that this does not imply that disabled people cannot have excellent lives, that they don't have access to a full array of life's goods, nor that disabled and non-disabled people have unequal moral status.

To recap my work: In chapter 1, I discussed how I understand disability, rejecting the Medical and Social Models in favour of a Hybrid Account (cf. Shakespeare, 2013: 74-75). In chapter 2, I argued that the best understandings of the views are that each makes a claim about the comparative, all things considered lifetime well-being prospects of disabled and non-disabled people inhabiting the nearest non-disablist worlds. In chapter 3, I presented a methodology for making reasonable judgements about the average well-being prospects of members of large groups in idealised worlds that is sufficiently neutral between the three major theories of well-being. This methodology involved determining whether there are significant and systematic differences in the groups' opportunities to access the sources of well-being. That completed the preliminary work needed prior to examination of the arguments for and against each view.

In chapter 4, I examined Barnes' arguments. First, I argued that she rejects an uncharitable interpretation of the BDV as she doesn't engage with its best interpretation. Next, in responding to Barnes' objection against probabilistic understandings of the views, I fleshed out my methodology for forming reasonable judgements about average well-being prospects in non-disablist worlds. To finish chapter 4, I explored Barnes' Testimony Argument for her version of the MDV and argued that an analogous argument cannot establish my preferred version of the MDV, given the state of current empirical evidence. In chapter 5, I explored the Options Argument, explicated it, defended it against the Multiple Realisability Reply and argued that it appears to be sound. As such, reduction of valuable options does seem to be a harm of disability. In chapter 6, I argued that the MDV can be further specified with additional information about its truth value in worlds with greater and lesser technological development than the actual world. I also presented the Frivolous Funding Objection and explored a potential

MDV reply, offering reasons for pessimism that it succeeds on plausible candidate accounts of disablism.

In chapter 7, I brought together my work from earlier chapters, using the methodology laid out in chapters 3 and 4, my arguments in chapter 5 and some additional ones to present a defeasible argument for the understanding of the BDV that I defended in chapter 2. This argument pointed out that at least five features common to disability (for reasons other than disablism) are typically bad for well-being and that disabilities with these features pull down the average well-being of disabled people in non-disablist worlds by hindering access to some sources of well-being. As such, disability does seem to make one likely to be overall worse off even if we discount the negative effects of disablism. That is, the BDV is true. Finally, to close the dissertation, I briefly sketched a novel, more respectful approach for the debate to take: the feature-first approach. I suggested that focusing on the good and bad features of disability and the contexts in which they occur might significantly improve the debate.

I have not, however, explored the implications of the truth of my preferred version of the BDV for any normative debates, such as those concerning public policy, what justice requires for disabled people or whether it is morally permissible to select for disability or non-disability using reproductive technologies. This work has been left for another time, but I am hopeful that my adjudication between the MDV and the BDV can helpfully inform it – perhaps even encouraging these debates to focus on the good and bad features of disability and the contexts in which they occur. In addition, my discussion has foregrounded the importance of properly specifying the nature of disablism. Debates about disability generally would benefit from a complete philosophical account of this phenomenon. As such, developing an account of disablism would be an extremely useful step forward in the Philosophy of Disability.

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Appendix: Glossary of Disabilities

Achondroplasia: Achondroplasia is a form of short-limbed Dwarfism. All people with Achondroplasia have short stature. The average height of an adult male with Achondroplasia is 131 centimetres (4 feet, 4 inches), and the average height for adult females is 124 centimetres (4 feet, 1 inch). Characteristic features of Achondroplasia include an average-size trunk, short arms and legs with particularly short upper arms and thighs, limited range of motion at the elbows, and an enlarged head (Macrocephaly) with a prominent forehead. Fingers are typically short, and the ring finger and middle finger may diverge, giving the hand a three-pronged (trident) appearance. Various health problems are associated with Achondroplasia.

- **Source:** US National Library of Medicine[208]
- **Discussed as a disability by:** (Shakespeare, 2013: 66; Barnes, 2016b: 10; Campbell and Stramondo, 2017: 152)

Amputation (Limb Loss): An amputation is the surgical removal of part of the body, such as an arm or leg.

- **Source:** UK National Health Service[209]
- **Discussed as a disability by:** (Amundson, 2000: 34; Barnes, 2016b: 34; Stramondo and Campbell, 2018: 3)

Anencephaly: Anencephaly is a condition that prevents the normal development of the brain and the bones of the skull. As a result, people with Anencephaly are missing large parts of the brain called the cerebrum and cerebellum. These brain regions are necessary for thinking, hearing, vision, emotion, and coordinating movement. The bones of the skull are also missing or incompletely formed. Because these nervous system abnormalities are so severe, almost all babies with Anencephaly die before birth or within a few hours or days after birth.

- **Source:** US National Library of Medicine[210]
- **Discussed as a disability by:** (Singer, 2005: 132; Anstey, 2008: note 5; Felder, 2013: 183)

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[208] https://ghr.nlm.nih.gov/condition/achondroplasia (accessed on 25/05/20).
[209] https://www.nhs.uk/conditions/amputation/ (accessed on 25/05/20).
[210] https://ghr.nlm.nih.gov/condition/anencephaly (accessed on 25/05/20).

Arthritis: Arthritis is a common condition that causes pain and inflammation in a joint. Osteoarthritis and Rheumatoid Arthritis are the two most common types. **Osteoarthritis** initially affects the smooth cartilage lining of the joint. This makes movement more difficult than usual, leading to pain and stiffness. Once the cartilage lining starts to roughen and thin out, the tendons and ligaments have to work harder. This can cause swelling and the formation of bony spurs called Osteophytes. Severe loss of cartilage can lead to bone rubbing on bone, altering the shape of the joint and forcing the bones out of their normal position. In **Rheumatoid Arthritis** the body's immune system targets affected joints, which leads to pain and swelling. The outer covering (synovium) of the joint is the first place affected. This can then spread across the joint, leading to further swelling and a change in the joint's shape. This may cause the bone and cartilage to break down. People with Rheumatoid Arthritis can also develop problems with other tissues and organs in their body.

- **Source:** UK National Health Service[211]
- **Discussed as a disability by:** (Shakespeare, 2013: 30; Barnes, 2014: 89; Putnam, 2018: 307)

Blindness (Visual Impairment): A kind of visual impairment, which is a decreased ability to see that is not correctable by glasses or contact lenses. To be certified as **severely sight impaired (Blind)** in the UK, your sight has to fall into one of the following categories, while wearing any glasses or contact lenses that you may need:

- Visual acuity of less than 3/60 with a full visual field.[212]
- Visual acuity between 3/60 and 6/60 with a severe reduction of field of vision, such as tunnel vision.
- Visual acuity of 6/60 or above but with a very reduced field of vision, especially if a lot of sight is missing in the lower part of the field.

To be certified as **sight impaired (partially sighted)** your sight has to fall into one of the following categories, while wearing any glasses or contact lenses that you may need:

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211 https://www.nhs.uk/conditions/arthritis/ (accessed on 25/05/20).

212 This first number refers to the distance at which a subject can see something; the second number refers to the distance at which a person with normal vision can see something. Thus, 'visual acuity of less than 3/60' means that one is unable to see at three metres what a person with normal eyesight can see at 60 metres.

- Visual acuity of 3/60 to 6/60 with a full field of vision.
- Visual acuity of up to 6/24 with a moderate reduction of field of vision or with a central part of vision that is cloudy or blurry.
- Visual acuity of 6/18 or even better if a large part of your field of vision, for example a whole half of your vision, is missing or a lot of your peripheral vision is missing.

- **Sources:** WHO International Classification of Diseases 11;[213] Royal Institute of Blind People[214]
- **Discussed as a disability by:** (Shakespeare, 2013: 59; Barnes, 2016b: 10; Stoner, 2016: 922)

Cerebral Palsy: Cerebral Palsy is the name for a group of lifelong conditions that affect movement and co-ordination. It develops before, during or soon after birth. Symptoms can include:

- delays in reaching development milestones – for example, not sitting by 8 months or not walking by 18 months
- seeming too stiff or too floppy
- weak arms or legs
- fidgety, jerky or clumsy movements
- random, uncontrolled movements
- walking on tiptoes
- a range of other problems – such as swallowing difficulties, speaking problems, vision problems and learning disabilities

The severity of symptoms can vary significantly. Some people only have minor symptoms, while others have severe ones.

- **Source:** UK National Health Service[215]

[213] https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/1103667651 (accessed on 25/05/20).
[214] https://www.rnib.org.uk/eye-health/registering-your-sight-loss/criteria-certification (accessed on 25/05/20).
[215] https://www.nhs.uk/conditions/cerebral-palsy/ (accessed on 25/05/20).

- **Discussed as a disability by:** (Shakespeare, 2013: 140; Campbell and Stramondo, 2017: 152; Putnam, 2018: 307)

Chronic Fatigue Syndrome (ME/CFS): Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) is a complex condition. People with ME/CFS are often not able to do their usual activities. At times, ME/CFS may confine them to bed. People with ME/CFS have overwhelming fatigue that is not improved by rest. ME/CFS may get worse after any activity, whether it is physical or mental. This symptom is known as post-exertional malaise. Other symptoms can include problems with sleep, thinking and concentrating, as well as pain, and dizziness.

- **Source:** Centres for Disease Control and Prevention[216]
- **Discussed as a disability by:** (Shakespeare, 2013: 40; Lim, 2018: 998)

Cystic Fibrosis: Cystic Fibrosis is an inherited condition that causes sticky mucus to build up in the lungs and digestive system. This causes lung infections and problems digesting food. This means that most people with Cystic Fibrosis don't absorb nutrients from food properly and need to eat more calories to avoid malnutrition.

Symptoms of Cystic Fibrosis include:

- recurring chest infections
- wheezing, coughing, shortness of breath and damage to the airways (Bronchiectasis)
- difficulty putting on weight and growing
- Jaundice
- Diarrhoea, constipation, or large, smelly poo
- a bowel obstruction in newborn babies (Meconium Ileus)

People with Cystic Fibrosis can also develop a number of related conditions, including Diabetes, thin, weakened bones (Osteoporosis), infertility in males, and liver problems.

- **Source:** UK National Health Service[217]

[216] https://www.cdc.gov/me-cfs/about/index.html (accessed on 25/05/20).
[217] https://www.nhs.uk/conditions/cystic-fibrosis/ (accessed on 25/05/20).

- **Discussed as a disability by:** (Asch and Wasserman, 2010: 201; Shakespeare, 2013: 32; Stoner, 2016: note 1)

Deafblindness: Deafblindness is a combination of sight and hearing loss that affects a person's ability to communicate, access information and get around. It is also sometimes called 'dual sensory loss' or 'multi-sensory impairment'. A Deafblind person won't usually be totally Deaf and totally Blind, but both senses will be reduced enough to cause significant difficulties in everyday life. These problems can occur even if hearing loss and vision loss are mild, as the senses typically work together and one would usually help compensate for loss of the other. People who are Deafblind may not use words, and it can be difficult to work out the best way to communicate with them.

- **Source:** UK National Health Service[218]
- **Discussed as a disability by:** Deafness and Blindness are discussed as disabilities by various authors (see above and below).

Deafness (Hearing Impairment): A type of hearing impairment. Hearing impairment means complete or partial loss of the ability to hear from one or both ears; that is, mild or worse hearing impairment, which is understood as 26 dB or greater hearing threshold, averaged at frequencies 0.5, 1, 2, 4 kHz. **Deafness** means complete loss of the ability to hear from one or both ears; that is, a profound hearing impairment, which is understood as 81 dB or greater hearing threshold, averaged at frequencies 0.5, 1, 2, 4 kHz. **Disabling hearing impairment** means moderate or worse hearing impairment in the better ear; that is the permanent unaided hearing threshold level for the better ear of 41 or 31 dB or greater in age over 14 or under 15 years respectively, averaged at frequencies 0.5, 1, 2, 4 kHz.[219]

- **Source:** World Health Organisation[220]
- **Discussed as a disability by:** (Shakespeare, 2013: 23; Barnes, 2016b: 10; Campbell and Stramondo, 2017: 125)

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[218] https://www.nhs.uk/conditions/deafblindness/ (accessed on 25/05/20) and https://www.nhs.uk/conditions/social-care-and-support-guide/practical-tips-if-you-care-for-someone/how-to-care-for-someone-with-communication-difficulties/ (accessed on 25/05/20).
[219] Unless qualified otherwise, when discussing Deafness, I will be discussing disabling hearing impairments.
[220] https://www.who.int/pbd/deafness/facts/en/ (accessed on 25/05/20).

Dyslexia: Dyslexia is a common learning difficulty that can cause problems with reading, writing and spelling. A person with dyslexia may:

- read and write very slowly
- confuse the order of letters in words
- put letters the wrong way round (such as writing "b" instead of "d")
- have poor or inconsistent spelling
- understand information when told verbally, but have difficulty with information that's written down
- find it hard to carry out a sequence of directions
- struggle with planning and organisation

But people with dyslexia often have good skills in other areas, such as creative thinking and problem solving.

- Source UK National Health Service[221]
- **Discussed as a disability by:** (Shakespeare, 2013: 23; Brown, 2016: 189; Stoner, 2016: 940)

Epidermolysis Bullosa: Epidermolysis Bullosa is the name for a group of rare inherited skin conditions that cause the skin to become very fragile. Any trauma or friction to the skin can cause painful blisters. The main symptoms of all types include:

- skin that blisters easily
- blisters inside the mouth
- blisters on the hands and soles of the feet
- scarred skin, sometimes with small white spots called Milia
- thickened skin and nails

[221] https://www.nhs.uk/conditions/dyslexia/ (accessed on 23/11/20).

- **Source:** UK National Health Service[222]
- **Discussed as a disability by:** (Felder, 2013: 183; Shakespeare, 2013: 80; Bognar, 2016: 46)

Fibromyalgia: Fibromyalgia is a long-term condition that involves pain all over the body. As well as widespread pain, people with Fibromyalgia may also have:

- increased sensitivity to pain
- extreme tiredness (fatigue)
- muscle stiffness
- difficulty sleeping
- problems with mental processes (known as "fibro-fog"), such as problems with memory and concentration
- headaches
- irritable bowel syndrome (IBS), a digestive condition that causes stomach pain and bloating

- **Source:** UK National Health Service[223]
- **Discussed as a disability by:** (Reynolds, 2016: 157; Stoner, 2016: note 1; Campbell and Stramondo, 2017: note 16)

Multiple Sclerosis (MS): Multiple Sclerosis is a condition that affects the brain and spinal cord. In MS, the coating that protects nerves (Myelin) is damaged, causing a wide range of potential symptoms, including problems with vision, arm or leg movement, sensation or balance. MS is a lifelong condition that can sometimes cause serious disability, although it can occasionally be mild. The main symptoms include:

- fatigue
- difficulty walking

[222] https://www.nhs.uk/conditions/epidermolysis-bullosa/ (accessed on 25/05/20).
[223] https://www.nhs.uk/conditions/fibromyalgia/ (accessed on 25/05/20).

- vision problems, such as blurred vision
- problems controlling the bladder
- numbness or tingling in different parts of the body
- muscle stiffness and spasms
- problems with balance and co-ordination
- problems with thinking, learning and planning

Depending on the type of MS, symptoms may come and go in phases (phasic) or get steadily worse over time (progressive).

- **Source:** UK National Health Service[224]; MS Society[225]
- **Discussed as a disability by:** (Shakespeare, 2013: 163; Barnes, 2016b: 10; Stoner, 2016: note 1)

Muscular Dystrophy: Muscular Dystrophies (MD) are a group of inherited genetic conditions that gradually cause the muscles to weaken, leading to an increasing level of disability. MD is a progressive condition, which means it gets worse over time. It often begins by affecting a particular group of muscles, before affecting the muscles more widely. Some types of MD eventually affect the heart or the muscles used for breathing, at which point the condition becomes life-threatening. **Duchenne Muscular Dystrophy** is one of the most common and severe forms, it usually affects boys in early childhood; people with the condition will usually only live into their 20s or 30s

- **Source:** UK National Health Service[226]
- **Discussed as a disability by:** (Shakespeare, 2013: 163; Barnes, 2014: 111; Stramondo and Campbell, 2018: 3)
- **Duchenne discussed as a disability by:** (Shakespeare, 2013: 143; Barnes, 2014: 111)

[224] https://www.nhs.uk/conditions/multiple-sclerosis/ (accessed on 25/05/20).
[225] https://www.mssociety.org.uk/about-ms/what-is-ms?gclid=EAIaIQobChMIp6THpe-I6QIVA7TtCh2VdQTiEAAYASABEgKB0fD_BwE (accessed on 25/05/20).
[226] https://www.nhs.uk/conditions/muscular-dystrophy/ (accessed on 25/05/20).

Ocular Albinism: Albinism affects the production of melanin, the pigment that colours skin, hair and eyes. It is a lifelong condition, but it doesn't get worse over time. One type is **Ocular Albinism.** The features of Ocular Albinism include: reduced visual acuity (typically from approximately 20/30 to approximately 20/400); Nystagmus (an uncontrollable, pendular, rapid movement of the eyes back and forth); Strabismus (a muscle imbalance of the eyes in which the eyes are "crossed" rather than straight and parallel); and sensitivity to bright light.

- **Source:** UK National Health Service[227]; visionofachild.org[228]
- **Discussed as a disability by:** Visual impairment is commonly discussed as a disability (see above).

Paralysis (Various types): Paralysis is the loss of the ability to move some or all of the body. Depending on the cause, it may be temporary or permanent. **Paraplegia** is a form of Paralysis in which function is substantially impeded from the waist down. **Quadriplegia,** also known as **Tetraplegia**, affects all four limbs, plus the torso. Most people with Tetraplegia have significant Paralysis below the neck, and many are completely unable to move. This form of Paralysis is inevitably the product of damage high in the spinal cord.

- **Source:** UK National Health Service[229]; Spinalcord.com[230]
- **Discussed as a disability by:** (Shakespeare, 2013: 86; Barnes, 2016b: 10; Brown, 2016: 188)

Post-Polio Syndrome: Polio is a viral infection that used to be common in the UK. Some people with Polio would have had Paralysis, muscle weakness and shrinking of the muscles. Usually, these problems would have either gone away over the following weeks or months or remained the same for years afterwards. **Post-Polio Syndrome** occurs when some of these symptoms return or get worse many years or decades after the original Polio infection. Post-Polio Syndrome can include a wide range of symptoms that develop gradually over time, including:

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[227] https://www.nhs.uk/conditions/albinism/ (accessed on 25/05/20).
[228] https://www.visionofchildren.org/what-is-ocular-albinism (accessed on 25/05/20).
[229] https://www.nhs.uk/conditions/paralysis/ (accessed on 25/05/20).
[230] https://www.spinalcord.com/paraplegia (accessed on 25/05/20).
and https://www.spinalcord.com/quadriplegia-tetraplegia (accessed on 25/05/20).

- persistent fatigue (extreme tiredness)
- muscle weakness
- shrinking muscles
- muscle and joint pain
- sleep Apnoea

The condition can have a significant impact on everyday life, making it difficult to get around and carry out certain tasks and activities. The symptoms tend to get gradually worse over many years, but this happens very slowly, and treatment may help slow it down further.

- **Source:** UK National Health Service[231]
- **Discussed as a disability by:** (Shakespeare, 2013: 142; Barnes, 2016b: 115)

Spina Bifida: Spina Bifida is a condition in which a baby's spine and spinal cord don't develop ordinarily in the womb, causing a gap in the spine. In most cases of Spina Bifida, surgery can be used to close the opening in the spine. But the nervous system will usually already have been damaged, which can lead to problems such as:

- weakness or total Paralysis of the legs
- bowel incontinence and urinary incontinence
- loss of skin sensation in the legs and around the bottom – the child is unable to feel hot or cold, which can lead to accidental injury

Many babies will have or develop Hydrocephalus (a build-up of fluid on the brain), which can further damage the brain.

- **Source:** UK National Health Service[232]
- **Discussed as a disability by:** (Shakespeare, 2013: 143; Stoner, 2016: 936; Campbell and Stramondo, 2017: 152)

[231] https://www.nhs.uk/conditions/post-polio-syndrome/ (accessed on 25/05/20).
[232] https://www.nhs.uk/conditions/spina-bifida/ (accessed on 25/05/20).

Spinal Cord Injury: 'Spinal Cord Injury' refers to damage to the spinal cord resulting from trauma. Symptoms of Spinal Cord Injury depend on the severity of injury and its location on the spinal cord. Symptoms may include partial or complete loss of sensory function or motor control of arms, legs and/or body. The most severe Spinal Cord Injury affects the systems that regulate bowel or bladder control, breathing, heart rate and blood pressure. Most people with Spinal Cord Injury experience chronic pain.

- **Source:** World Health Organisation[233]
- **Discussed as a disability by:** (Campbell, Nyholm and Walter, forthcoming; Shakespeare, 2013: 33; Barker and Wilson, 2019: 312)

Spinal Muscular Atrophy (SMA): Spinal Muscular Atrophy is a genetic condition that makes the muscles weaker and causes problems with movement. It progresses over time, but there are treatments to help manage the symptoms. Typical symptoms include:

- floppy or weak arms and legs
- movement problems – such as difficulty sitting up, crawling or walking
- twitching or shaking muscles (tremors)
- bone and joint problems – such as an unusually curved spine (Scoliosis)
- swallowing problems
- breathing difficulties

- **Source:** UK National Health Service[234]
- **Discussed as a disability by:** (Barnes, 2016b: 113; Campbell and Stramondo, 2017: 162; Barker and Wilson, 2019: 308)

Tay-Sachs: Tay-Sachs is a rare inherited condition that mainly affects babies and young children. It stops the nerves working properly and is usually fatal. The main symptoms include:

- being overly startled by noises and movement

[233] https://www.who.int/news-room/fact-sheets/detail/spinal-cord-injury (accessed on 25/05/20).
[234] https://www.nhs.uk/conditions/spinal-muscular-atrophy-sma/ (accessed on 25/05/20).

- being very slow to reach milestones like learning to crawl, and losing skills one has already learnt
- floppiness and weakness, which keeps getting worse until one is unable to move (Paralysis)
- difficulty swallowing
- loss of vision or hearing
- muscle stiffness
- seizures (fits)

The condition is usually fatal by around three to five years of age, often due to complications of a lung infection (Pneumonia). Rarer types of Tay-Sachs start later in childhood (juvenile Tay-Sachs) or early adulthood (late-onset Tay-Sachs). The late-onset type doesn't always shorten life expectancy.

- **Source:** UK National Health Service[235]
- **Discussed as a disability by:** (Brown, 2016b: 192; Stoner, 2016: note 1; Campbell and Stramondo, 2017: 165)

[235] https://www.nhs.uk/conditions/tay-sachs-disease/ (accessed on 25/05/20).