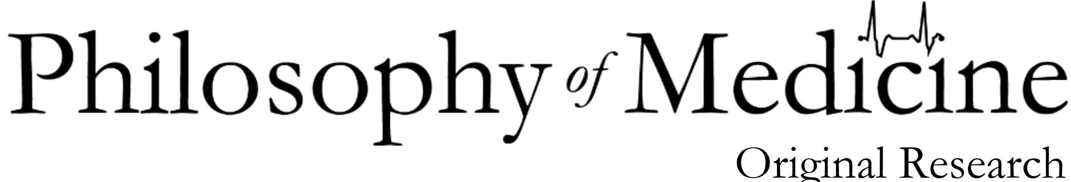
Original Research

Is the Disease Concept Enough? Redefining Health and Disease Through Conceptual Engineering

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Abstract

In the philosophy of medicine, the debate surrounding accounts of health and disease is typically centered on attempts to provide a proper conceptual analysis of a singular medicalized label, such as "disease," that is meant to represent all pathological states. Instead of engaging in conceptual analysis, I attempt to redefine our concepts of health and disease through the process of conceptual engineering. To do so, I propose a novel hybrid account of health and disease and demonstrate how, by combining aspects of naturalist and constructionist accounts and distinguishing between two different medicalized labels—"disease" and "health condition"—my account can better serve the purposes of these concepts.

1. Introduction

Philosophers, clinicians, and scientists have long sought to provide a comprehensive account of the concepts of health and disease, given their wide-ranging impacts (Duffin 2021). Traditionally, and within philosophy especially, this debate has centered around attempts to provide a proper conceptual analysis of a singular medicalized label, usually "disease," that is meant to represent all pathological states (Cooper 2020; Fagerberg 2023), with health then typically being understood as the absence of disease (or the medicalized label being analyzed).[1]

In this paper, I take a different approach. Instead of engaging in conceptual analysis, I attempt to redefine our concepts of health and disease through conceptual engineering.[2] As such, I am primarily focused on examining why we need the concepts of health and disease, and on how we can construct an understanding of these concepts that better serves those needs. Under this view, my account will succeed if it can more effectively serve our needs than our current accounts.

[1] For more on this, see Fagerberg's analysis of the "general disease concept" in the health and disease debate (Fagerberg, 2023, section 5.1).

[2] I accept a particularly permissive approach to conceptual engineering set out in Nado (2021).

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To begin, in section 2, I critically examine two major accounts of health and disease: Jerome Wakefield's harmful dysfunction analysis (HDA) and Quill Kukla's (writing as Rebecca Kukla) institutional definition of health (IDH). My examination of these accounts motivates section 3, where I develop a list of optimal desiderata an account of health and disease should satisfy.

In section 4, I propose a novel hybrid account of health and disease, the bio-institutional account, which combines aspects of naturalist and constructionist accounts and proposes the use of two distinct medicalized labels: "disease," which I take to be a biological dysfunction that is best medicalized, and "health condition," which I take to be any bodily state that is best medicalized. In this section, I demonstrate how this will enable my account to better satisfy the optimal desiderata and serve key purposes of the concepts of health and disease. In section 5, I consider two applied test cases and in section 6, I consider three objections, before concluding in section 7.

2. Evaluating Established Accounts of Health and Disease

In this section, I evaluate two robust accounts of health and disease: Wakefield's harmful dysfunction analysis (HDA) and Kukla's institutional definition of health.

2.1 The Harmful Dysfunction Account

Wakefield's HDA is a hybrid account and thus has two conditions that must be satisfied for a bodily state to be classified as a disease,[3] the first meant to account for the biological aspects of disease and the second meant to capture the evaluative nature of disease. The first condition requires diseases to be dysfunctions of naturally selected mechanisms. This means that for a bodily state to be classified as a disease, it must involve the failure of a part of the body with respect to its proper function, the function that caused it to be selected by natural selection. The second condition further requires a bodily state to be harmful, "as judged by the standards of the person's culture," to be understood as a disease (Wakefield 1992, 384). Health is subsequently understood as the absence of disease.

I begin my evaluation of the HDA by acknowledging its strengths, the ways in which it effectively serves the purposes of our concepts of health and disease. Some of the HDA's most notable strengths arise from its grounding in the objective biologically based criterion of bodily dysfunction. For example, in many instances, this understanding of disease enables clinicians to communicate both accurate and insightful information to patients. Through the disease label, the clinician can communicate to a patient that a part of their body is dysfunctional in a specific manner; that is, it is not performing the function that caused it to be selected by natural selection, which helps the patient understand something specific about the biological status of their own body.

Understanding disease as biological dysfunction often conveys additional notions about how to understand the "disease status," such as a lack of responsibility for the condition, a feeling of a lack of agency in recovery, and a focus on a particular part of the body as the

[3] While the HDA was initially devised as an account of mental disorder, it has since been taken up as an account of disease, which in the philosophical literature is the term most commonly used to refer to any pathological condition (Fagerberg 2023, 1; Griffiths and Matthewson 2018). Further, note that Wakefield himself views disorder as synonymous with disease (Wilkinson 2023, 28). Thus, I will be referring to the HDA as an account of disease for the remainder of the paper.

cause of the disease and the focus of treatment (Leader and Corfield 2008; Kukla 2014; Lewis 2017; Pickard 2017). In many paradigmatic cases of disease, such as infections, severe injuries, and organ failures, these notions are fitting, and help patients understand their bodies better, properly inform society about how to treat them, and provide clinicians with an accurate understanding of the problem at hand.

The HDA's use of biological dysfunction is also significant because it helps explain the relevance of biological states to health and disease and enables it to be compatible with the practice and understanding of scientists and clinicians. By holding that disease is tightly tied to biological dysfunction, and thus biological facts of the body, the HDA can explain why there is more to being healthy than just feeling good and why, instead, clinicians often rely on objective physiological markers to assess whether a patient has a disease (Barnes 2023). Under the HDA, it is clear why clinicians utilize tools like X-rays, MRIs, and blood tests: to assess the functional status of various aspects of the body, which will inform them about whether their patient has a disease or is healthy.

The HDA also stands out as a strong account of health and disease because of its inclusion of the evaluative condition. This is a useful inclusion because we need these concepts to explain the relevance of subjective experience and well-being to health and disease and to factor this component into the disease classification process. Consider certain bodily states, such as having a single dysfunctional kidney, or a single dead cell. Under accounts that equate disease with dysfunction of a naturally selected mechanism, there is potential for these to be correctly labeled as diseases (Wakefield 1992, 2014). The HDA, however, recognizes that there is more to disease than biological dysfunction. There is some way in which disease must be harmful to the individual (Wakefield 1992). Thus, the HDA enables us to avoid classifying these cases, and other examples of harmless dysfunctions, as diseases.

So, the HDA provides an understanding of health and disease that effectively serves a variety of purposes. However, despite its strengths, the HDA suffers from a critical weakness: It struggles to explain how we should accommodate medically relevant non-dysfunctional (MRND) conditions.

Consider depression: Depression is a condition that is clearly harmful and also greatly benefits from medical intervention (Gartlehner et al. 2017). Yet it is not clear that all instances of depression involve a biological dysfunction. Recent research suggests depression, in many cases, is the result of the activation of a naturally selected low-mood system in response to certain life circumstances, and thus not dysfunctional under the HDA (Turner 2023, 2024). Given this understanding of the condition, the HDA would fail to classify many instances of depression as a disease and thus lacks the resources to provide those with a "functional" depression any sort of medicalized label. Depression is not the only condition that causes this problem for the HDA. There are many other medically relevant conditions we wish to treat that may not involve an underlying dysfunction—for example, obesity, anxiety, and addiction may all be functional adaptations of the body to certain stimuli or environments (Hofmann 2016; Garson 2021; Lewis 2017; Miller et al. 2020).

Why exactly is this a problem? Well, the HDA faces a dilemma here that it appears unable to solve. On the one hand, it risks failing us by not providing any medicalized label for these MRND conditions. This is a significant issue because a medicalized label like "disease" is a classification that helps us distinguish between bodily states that are the

concern of medical institutions and deserve treatment, insurance coverage, societal support, and funding for further research, and those that do not (Conrad and Schneider 1992). The HDA thus risks leaving those with MRND conditions out to dry, with no medicalized label to incentivize the medical care and support they need. It even risks increasing the societal stigma those with these conditions face, as the disease label historically has decreased stigma by replacing moral accounts, which viewed those with certain conditions as morally bad or deserving of their condition (Conrad and Schneider 1992; Noble et al. 2019).

On the other hand, if proponents of the HDA attempt to still interpret some of these conditions as diseases, and thus as dysfunctional, this risks misinforming those with these conditions and society about the true nature of their conditions and how best to understand and respond to them. This is because of the conceptual baggage that comes with the disease label—discussed above—much of which does not apply to many of these non-dysfunctional conditions.

Consider addiction: There is a long-standing debate in the medical and philosophical literature about whether to classify addiction to substances as a disease (Heather 2019). Those who do not view it as a disease argue that it is a natural/functional response of the brain's reward system to highly powerful stimuli; the brain responds to certain substances similarly to the way it does to something like love (Lewis 2017). On the other hand, those who argue it is a disease hold that it is dysfunctional because these substances "hijack" natural mechanisms and impair naturally selected decision-making processes (Substance Abuse and Mental Health Services Administration [US] and Office of the Surgeon General [US] 2016; Fagerberg 2022). The issue, however, with interpreting addiction as a disease is that it ultimately misinforms the addict about their condition. The disease label often leads addicts to understand themselves as dysfunctional or broken and thus lacking individual agency and responsibility for their choices (Wiens and Walker 2015; Lewis 2017; Pickard 2017; Liu and Hogarth 2025). This is deeply problematic since the best treatments for addiction rely upon an addict's ability to exercise their own agency (Pickard and Ward 2013, 1137; Pickard 2017). Furthermore, it places the focus on the cause of addiction as a biological dysfunction in the body, even though this is controversial, and neglects the social determinants of addiction (Maté 2008; Strickland and Smith 2021). The disease label thus harms those with addiction by misinforming them and society about the nature of their condition.

Ultimately, a similar story plays out for many of the other MRND conditions or those whose functional status and disease status are controversial.[4] It is thus important to mark this dilemma as a crucial issue that the HDA lacks the tools to rectify and one that is important for my own account to solve going forward. In the next section, I examine Kukla's institutional definition of health and how it improves upon Wakefield's account.

2.2 The Institutional Definition of Health (IDH)

The primary aim of Kukla's IDH is to provide an account that can ground a normative project of health justice. Kukla contends that we need a new account because established

[4] To be clear, my claim is not that the HDA does not provide us with a story to tell about MRND conditions, but that the story is either one that leads to these conditions having no medicalized label or is inapt and misinforms patients and clinicians.

accounts of health and disease are inadequate with respect to this goal. Social constructionist accounts, which define disease as any condition we medicalize, fail because they do not enable us to call out past mistakes in our disease attributions, even when the motivation for the initial classification is derived from unjust social biases. Naturalist accounts, which base their definitions on biological dysfunction, fail because these science-oriented projects tell us nothing about why we ought to treat diseases, or how we ought to incorporate the role of health into a larger theory of social justice (Kukla 2014, 517–519).

Kukla argues that in order to achieve this goal we should avoid attempts to simply add normative principles to naturalistic accounts of health (2014, 519). This, Kukla believes, is quixotic; rather to develop an account that is "substantively useful within a normative project of deciding what just health institutions and policies would look like," we should understand health as a "special sort of institutional concept" that is "constrained by both the world and our social practices" (2014, 525). Kukla thus proposes the IDH:

> A condition or state counts as a health condition if and only if, given our resources and situation, it would be best for our collective well-being if it were medicalized—that is, if health professionals and institutions played a substantial role in understanding, identifying, managing and/or mitigating it. In turn, health is a relative absence of health conditions (and concomitantly a relative lack of dependence upon the institutions of medicine) (Kukla 2014, 526).

This account, Kukla notes, is different from the basic social constructionist account because it is concerned with what we *should* medicalize, rather than just the fact that something *is* medicalized. That something is a health condition, according to Kukla's view, is something that we can "empirically discover" and that we "can be wrong about" (2014, 526). This is because there is a fact of the matter about whether a bodily state being medicalized is best for our collective well-being.[5] We can discover whether something is a health condition by examining how the tools of medicine impact those with a particular condition. Health is thus determined by the interaction between the natural facts of biology and social facts regarding the tools and processes of medicine.

Kukla's account improves upon many previously established accounts of health and disease by providing an understanding of these concepts that can effectively be incorporated into a normative project of health justice. Kukla's account does this by building into their definition of health condition why exactly health conditions should be treated (to improve our collective well-being), which bodily states should be medicalized (those whose medicalization improves our collective well-being), why health conditions should be medicalized at all (they are just the type of thing that are best to medicalize), and how to orient health policy and institutions in actionable ways (towards improving our collective well-being by treating conditions that are best medicalized, given our resources and situation).

Kukla's account also improves upon more basic social constructionist views by enabling us to say we were wrong when we previously classified things like masturbation,

[5] It being best for a condition to be medicalized does not mean it is necessarily best treated by the institutions of medicine. It may, for example, just be best classified or diagnosed by medical institutions (Kukla 2014, 526).

drapetomania,[6] or homosexuality as diseases (Englehardt 1974; Bayer 1987; Bynum 2002), since under Kukla's account, it is clear that none of these states is best medicalized. This is an important benefit as we need our concepts of health and disease to recognize past faults and enable us to acknowledge the history of the disease label's misapplication as a means of social control grounded in problematic biases such as racism, sexism, or homophobia (Wakefield 1992, 373).

Another strength of Kukla's account is that it accommodates the subjective and evaluative aspects of health. Kukla's account does this by tying health to well-being and not making it dependent upon the presence of biological dysfunction. They explicitly recognize the fact that not all health conditions "can be understood as a single dysfunction or even a unified and stable set of dysfunctions" (Kukla 2014, 519). This leads their account to more easily accommodate MRND conditions since they can definitively be classified as health conditions (assuming it is best to medicalize them).

Kukla's treatment of these conditions also has the potential to benefit from the use of new terminology. "Health condition" does not share the same conceptual baggage as "disease," and Kukla clearly defines it in a manner that avoids implications about the functional state of the body, the cause of the condition, or the level of agency the patient has in recovery—all of which are problematic for these types of conditions. "Health condition" could thus act as a medicalized label for MRND conditions that could motivate treatment and reduce societal stigma without the misleading implications of the disease label.

Unfortunately, however, Kukla's account loses much of the benefit from utilizing new terminology because of the way they define disease. Kukla, for the normative purposes they are concerned with, does not see the importance of separating diseases from other health conditions, roughly defining disease as "a repeatable, relatively stable bodily state or process that systematically causally contributes to one or more health condition" (Kukla 2014, 527).[7] While Kukla's account can technically separate diseases from health conditions in certain cases, their understanding of disease allows for many MRND conditions to be classified as diseases, including conditions that it would be intuitively inappropriate to label as a disease.

Consider pregnancy: Pregnancy is a bodily state that fits Kukla's definition of a health condition because our collective well-being is improved by having health professionals or institutions play a significant part in understanding, identifying, and managing it. However, if pregnancy is a health condition under Kukla's account, which seems to be the case, then it is also a disease, as the bodily state underlying pregnancy is certainly repeatable, relatively stable, and systematically causally contributes to the health condition that is pregnancy.

Classifying pregnancy as a disease is an unpalatable result of Kukla's definition and points us toward the underlying problem with their definition of disease: Functional processes that underlie health conditions are no less likely than dysfunctional processes to be repeatable, relatively stable, and systematically causally contribute to those health conditions.[8] This leads Kukla's account to lump many MRND conditions under the ill-fitting

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[6] In 1851, the American physician Samuel Cartwright invented "drapetomania," a supposed disease afflicting enslaved black people in the United States, whose main symptom was attempting to escape slavery (Bynum 2002).

[7] Kukla notes this differs from the approach taken by science-oriented accounts of health, which prioritize defining what counts as a disease and then understand health as the absence of disease (Kukla 2014, 527).

[8] This is especially true if one accepts that for a bodily state to be functional it must be performing the function it was naturally selected for, since traits that are strongly selected for tend to be similarly realized across individuals.

disease label since the criteria for their account of disease are easily satisfied by both functional and dysfunctional bodily states.

To give another example: Suppose that a certain kind of non-dysfunctional depression is caused by the activation of a naturally selected-for low-mood system. The activation of a naturally selected-for system provides a very plausible candidate for the type of bodily state that would be repeatable, relatively stable, and systematically causally contribute to a health condition not just within a particular individual but across individuals with this type of depression. Thus, under Kukla's account, if we assume it is best medicalized, this type of non-dysfunctional depression would be classified as a disease. And even if this picture of depression is incorrect, the same story could be told about many MRND bodily states, such as substance use addiction and obesity, which appear to be health conditions under Kukla's view but also have underlying bodily states that fit Kukla's definition of disease.

This, as I mentioned above, is an unfortunate aspect of Kukla's account, because in many of the cases where the need for new terminology appears to be the most urgent, it misses the opportunity to break free of the conceptual baggage of the disease label and thus would continue to misinform those with non-dysfunctional health conditions. Ultimately, because of this, Kukla's account also forgoes the possibility of providing a principled way of distinguishing between those with health conditions and those with diseases that would enable patients to ascertain when their health is being impacted by an underlying dysfunction/something broken in their body and when it is impacted by a bodily state brought about by the body operating as it should. Thus, like the HDA, Kukla's account fails to fully solve the problem of MRND conditions.

Kukla's account also fails to preserve one of the major strengths of the HDA, as it is unable to explain the relevance of biological states to disease judgments and fails to craft a definition compatible with scientific and clinical practice (Barnes 2023). That a part of the body is dysfunctional has no importance in and of itself under Kukla's view. The fact that a blind person's eye cannot see, or a person with acute hepatic necrosis has a dysfunctional liver, does not explain, in any way on its own, why these conditions should be medicalized, nor that they have a negative impact on health. Even though these biological facts may ultimately play an indirect role in why a bodily state is best medicalized through their impact on well-being, Kukla's account does not sufficiently explain the importance and independence of this aspect (Barnes 2023).

In summary, Kukla has illustrated the need for our concepts of health and disease to play a role in the shaping of health institutions and policy. The IDH develops an understanding of these concepts that effectively meets this need, accommodates the subjective and evaluative aspects of health, and points the way toward a possible solution for the problem of MRND conditions through the use of new terminology. However, the IDH fails to fully solve this problem and does not successfully explain the relevance of biological states to health and disease. Consequently, there is still work to be done.

3. Purposes and Desiderata

In this section, I use the discussion in section 2 to illustrate the key purposes of health and disease. Rather than listing each use, I think it will be helpful to first outline two overarching purposes that tie them all together. The first is that our concepts of health and disease need to correctly identify the bodily states that are deserving of medicalization. We recognize that

these concepts need to be attuned to a variety of factors in order to acknowledge medically relevant conditions and avoid spuriously over- or under-medicalizing or classifying bodily states. Second, we need our concepts of health and disease to convey information that leads to the right practical outcomes by ensuring patients, clinicians, scientists, society, and policymakers have the right understandings of conditions that impact health. Thus, on the whole, we need our concepts of health and disease to properly classify and be properly informative.

So, how, during the conceptual engineering process, do we ensure that we stay on track and are able to judge whether a proposed account of health and disease effectively serves these greater purposes? Here, the discussion in section 2 is useful. Understanding the strengths, weaknesses, and intended purposes of the HDA and the IDH has enabled me to consolidate three desiderata across three different aspects of health and disease that will serve as a guide to an improved account of these concepts.[9] An account that satisfies all three desiderata will be well on its way toward correctly identifying which conditions deserve medicalization and conveying the right sort of information about these conditions.

The three desiderata and a summary of their importance are outlined below.

3.1 Bio

An account needs to explain the importance of the biological aspects of health and disease and be compatible with the practice and understanding of medical researchers, scientists, and clinicians.[10]

This desideratum reflects the takeaways from the discussion of the HDA in section 2.1. One of the main takeaways from this section was the emphasis that both clinical and scientific practices place on the biological aspects of disease and objective physiological markers. As already briefly noted, this emphasis exists because these factors can clearly tell us something about a patient's health, regardless of how they are feeling (Barnes 2023). For example, if a patient's heart rhythm is in a state of atrial flutter, it is clear they are in a pathological state, or at least a state of diminished health, because of the biological consequences of this condition. This is true (and tracks the views of clinicians and scientists), even if a patient does not notice this state or does not currently perceive its impact on their health. It is thus important that an account of health and disease acknowledge and explain this to ensure it can correctly medically classify bodily states and remain connected with clinical and scientific practice.

I have also included this desideratum since the biological aspect of disease helps explain the distinction between health and well-being. This is important because it enables the avoidance of "healthism," a societal over-medicalization that arises from conflating health and well-being (Kukla 2024). And it explains the fact that those with severe disabilities can have a high level of well-being, regardless of their level of health (Barnes 2023).

[9] In arriving at these desiderata, I drew on key lessons from my review of Wakefield and Kukla but also on ideas both implicit and explicit in the works of philosophers of medicine and clinicians such as Boorse (1977), Cooper (2002), Venkatapuram (2013), Carel (2016), Griffiths and Matthewson (2018), Ulvestad (2018), Wilkinson (2023), and Barnes (2023). I want to give special mention to Elizabeth Barnes's book *Health Problems: Philosophical Puzzles About the Nature of Health* (2023), which does an excellent job of describing the key aspects of health and disease as discussed in the philosophy of medicine and helped solidify my selection of desiderata.

[10] For more on the importance of the biological aspect of disease, see Boorse (1977); Wakefield (1992); Griffiths and Matthewson (2018); Wilkinson (2023); Barnes (2023).

Understanding the importance of the biological aspects of health and disease thus helps an account correctly classify and explain the pathological status of a variety of bodily states.

Also, as noted in section 2.1., an account that incorporates the biological aspect of health and disease enables clinicians, through medicalized labels, to communicate important information to patients about the physiological status of their body; that is, that a part of their body is not performing the function it was naturally selected for, along with other notions surrounding agency, responsibility, and so on. This information can also help guide societal treatment of those with pathological conditions. Thus, an account of health and disease should ensure it satisfies *Bio* so that it can be properly informative in the relevant spheres.

3.2 Flourish

An account should consider the subjective and evaluative nature of health and disease in order to properly accommodate MRND conditions (and medically irrelevant dysfunctions).[11]

This is a critical desideratum and one that we should pay close attention to in the conceptual engineering process since neither the HDA nor the IDH is able to provide an ideal solution to the problem of MRND conditions. There is a clear need for an account that both properly classifies these conditions and ensures that the way in which they are understood is properly informative.

As we have seen, the first step toward a solution is for an account to be able to recognize the impact that non-dysfunctional conditions can have on health. This requires considering both the subjective experience of those with these conditions, as well as the impact they have or could have on well-being, and the relevance (although not equivalence) of well-being to health. Ignoring these aspects may leave conditions like non-dysfunctional depression, addiction, obesity, and so on, without a medicalized label, since it leaves us without a clear way to recognize their impact on health.

Also, as we saw with the HDA, recognition of the subjective and evaluative aspects of health can avoid misclassifying medically irrelevant, dysfunctional conditions as diseases. And it can be helpfully informative, by encouraging patients to understand the significance of their symptoms in and of themselves. Thus, *Flourish* is an important desideratum to satisfy in order for our concepts of health and disease to be properly informative and correctly classify conditions that impact our health.

3.3 Justice

An account of health and disease should be useful in grounding a normative project of health justice. This requires an ability to call out incorrect disease attributions.

As Kukla notes, there is a clear need for an understanding of health and disease that can be used by policymakers and political philosophers to direct health policy and guide our understanding of the role health and healthcare play in a just society. Our ideas of health and disease cannot simply be inert scientistic understandings with no normative weight. They must be connected with something that has ethical and practical importance. An

[11] For more on the importance of the subjective and evaluative aspect of health, see Wakefield (1992); Cooper (2002); Carel (2008, 2016); Venkatapuram (2013); Ulvestad (2018); Barnes (2023).

account of health and disease should thus not only explain when something has gone wrong in the body, but also why this matters both to the individual and to the state and why we should medicalize it.

Further, as noted in section 2.2, we need our concepts of health and disease to be objective, in the sense that they can enable us to call out incorrect and potentially unjust disease attributions. This is important not just to recognize our past faults in obvious cases like drapetomania, but also to recognize our general fallibility and the likelihood of current and future mistakes.

Overall, this desideratum contributes towards the overarching purposes of health and disease by helping to situate the disease-attribution process within a broader context. Apt medicalization of bodily states is not solely dependent on biological facts, but also on social ones, such as the structure and function of our medical institutions. Furthermore, it encourages us to be cognizant of the role that our concepts of health and disease do and should play in informing the approach our society and political institutions take toward healthcare.

3.4 Where We Go from Here

We have now established a clear set of standards by which we can judge accounts of health and disease. Any account crafted through conceptual engineering needs to satisfy *Bio*, *Flourish*, and *Justice*. A successful account will therefore need to solve problems and serve purposes that neither the HDA nor the IDH have the tools for, while maintaining the strengths of both accounts. In the next section, I lay out the bio-institutional account of health and disease, which I have crafted to meet these three desiderata and thus improve upon previously established accounts.

4. The Bio-Institutional Account of Health and Disease

There are many accounts of health and disease I could have chosen to evaluate in section 2, including Christopher Boorse's biostatistical account (1977), Rachel Cooper's evaluativist account (2002), or a phenomenologically based approach like Havi Carel's (2008, 2016), among others. Instead, I chose to examine Wakefield's and Kukla's; this was deliberate. While neither account is perfect, both have developed effective tools that I want to preserve in my own account. From Wakefield, I want to preserve his hybrid approach and his grounding in an evolutionary conception of proper function, and from Kukla, the connection to well-being, the notion of an objective constructionist account, and the utilization of new terminology. Using these tools, I can engineer an improved account of health and disease. Thus, I propose a new account, the bio-institutional account (BIA) of health and disease, which builds upon and adds to Kukla's and Wakefield's accounts.

Consider the following two conditions:

1. The bodily state involves an underlying *dysfunction*. The/a proper function of an item or trait is the effect it yielded, which caused it to be selected by natural selection.[12]

[12] I, like Wakefield, accept the Selected Effects Theory of proper function (Neander 1991).

2. Given the *best* tools, knowledge, and resources of health professionals and institutions, *it would be best for our collective well-being* if the bodily state were *medicalized*—meaning that health professionals and institutions played a substantial role in identifying, understanding, managing and/or mitigating it.[13]

If a bodily state meets the first and second condition, it is a *disease*.[14] If a bodily state only meets the second condition, it is a *health condition*.[15] *Health* is subsequently the absence of health conditions and diseases.

The main idea behind the BIA is that there is much to gain from utilizing two medicalized labels to explain the bodily states that impact our health ("health condition" and "disease"), rather than one. This defies philosophical tradition, yet is not unprincipled, given that my approach is conceptual engineering, and as such the concern is not preserving similarity to common definitions or usage patterns but efficacy. If two labels help us solve more problems and better serve the purposes of health and disease, then there is no reason to insist on sticking with one.

This approach is helpful because it allows us to do what many, including Kukla, thought unrealistic: accommodate a scientifically based understanding of disease and a notion of health that recognizes MRND conditions, while still being normatively useful for policy and health justice projects. The BIA is able to do this because it grounds the disease label in biological dysfunction, and thus medicine and the biological sciences, *and* simultaneously enables us to recognize under the new label of "health condition" conditions that impact our health because of their impact on well-being and yet are not diseases per se—that is, they do not have an underlying biological dysfunction and do not fit the conceptual associations that come with the disease concept. Such an understanding provides us with a broad toolset we can use to effectively solve problems, address controversial cases, and serve our purposes.

4.1 Evaluation of the Bio-Institutional Account

Now that I have established my account, I evaluate it according to the three desiderata I posed in section 3: *Bio, Flourish,* and *Justice*. I begin with an overview of how it meets *Bio* and *Justice,* before exploring in-depth how it satisfies *Flourish* and solves the problem of MRND conditions, which I view as the most significant benefit of my account.

4.1.1 Bio

My account clearly meets *Bio*. To see why, let us consider how it accounts for a paradigmatic example of disease, acute hepatic necrosis (AHN), which is characterized by a toxic injury

[13] I adopt much of the language of the second condition from Kukla's institutional definition of health, discussed in section 2.2 (Kukla 2014). However, I make the change to "the best" to ensure my account is interpreted as referencing the objectively best current tools, resources, and knowledge humanity can muster.

[14] If a bodily state meets the first condition, this provides a prima facie reason to believe it will meet the second condition.

[15] Following Kukla, I construe "health professionals and institutions" to be tightly tied to medical and clinical professionals and the institutions of medicine (Kukla 2014, 526). I also want to make explicit that when determining whether a type of bodily state is best medicalized, this judgment is not made on a case-by-case basis for each patient. As Kukla notes under the IDH, having "smallish breasts" would not be considered a health condition simply because one individual may benefit from cosmetic breast augmentation. What would be a more relevant question is "whether using the tools of medicine to manage small-breastedness would be better for our collective well-being" (2014, 527).

to the liver (NIDDK 2019). The starting point when examining a bodily state under the BIA is whether it involves an underlying biological dysfunction. AHN clearly does, since this condition, as a result of damage caused by a hepatotoxin, involves an inability of the liver to perform the function that caused it to be selected by natural selection. AHN, under the BIA, is thus a candidate for the disease label. The recognition that there is an underlying biological dysfunction also gives us prima facie reason to believe that the tools of medical professionals will be helpful here. This, along with facts about the impact AHN has on well-being, leads to the conclusion that it is best for AHN to be medicalized. AHN thus satisfies conditions 1 and 2 and is correctly classified as a disease by the BIA.

Notice here that the reason the BIA classifies AHN as a disease, rather than a health condition, is because the BIA grounds the disease label in biological dysfunction. This helps the BIA account for the relevance of biological states to disease judgments and explains why clinicians focus on objective physiological markers like serum enzyme levels, which, in the case of AHN, are relevant to the disease diagnosis because these levels help assess the functional status of the liver. Thus, this connection between disease and dysfunction, just as for the HDA, allows the BIA to recognize the importance of biological factors to health and disease, and remain compatible with scientific and clinical practice.

Further, the BIA satisfies the final aspect of *Bio* by improving upon the HDA's and the IDH's ability to inform patients and society about a particular kind of bodily state using the disease label. The BIA ensures that the disease label accurately reflects a real distinction in types of phenomena, ensuring that its conceptual baggage will only be applied fittingly and informatively since diseases under this account must involve an underlying biological dysfunction, and in contrast to the HDA, there is no added pressure to associate MRND conditions with this label (since they have their own). The clinician's ability to communicate is also increased as they can contrast the disease label and its connotations with the health condition label. I expand further on this point when I address *Flourish* in section 4.1.3.

4.1.2 Justice

The BIA also satisfies *Justice*. Similarly to Kukla's account, the BIA satisfies this desideratum by connecting health to well-being and health institutions. Under the BIA, for a bodily state to be a health condition or a disease, it must be the case that it is best for our collective well-being to medicalize it. The BIA thus makes it clear why we should direct the tools and resources of medicine toward addressing health conditions and diseases, since it is built into our understanding of them that they are the bodily states that are best medicalized. It also explains which bodily states we should medicalize and connects this to something of ethical and practical importance—well-being. This enables us to explain why it is valuable to medicalize these states and shows us how to orient health policy: toward using the tools of medicine and medical institutions to improve collective well-being by treating those with health conditions and diseases.

Because of this, it is clear that the BIA's understanding of health and disease has the necessary normative impact since the definition captures why we should treat and direct funding and policy toward bodily states that impact our health.

Furthermore, the BIA is able to satisfy *Justice* by enabling us to call out incorrect attributions of disease or health condition. Under the BIA, we can discover that a bodily state is not and never was a disease by appealing to the biological facts—that is, a bodily

state does not involve a biological dysfunction—or we may discover that a particular biological dysfunction is not a disease because it is not best medicalized. As for health conditions, similar to Kukla's account, we can discover that a particular non-dysfunctional bodily state was not or is not best medicalized and thus is not a health condition. This ensures the BIA's ability to call out incorrect and potentially unjust or biased classifications.

4.1.3 Flourish

Flourish is satisfied by the BIA since it provides a medicalized label exclusively meant to accommodate MRND conditions. Under the BIA, non-dysfunctional bodily states can receive the health condition classification as long as they are best medicalized. The subjective and evaluative aspects of health are thus given their due under the BIA since it enables bodily states that take a toll on well-being to be medicalized, regardless of their functional status. The BIA also ensures that it only accommodates the relevant subjective and evaluative factors and therefore avoids overclassifying bodily states as health conditions. It does this by restricting the application of the health condition label to only those bodily states that are relevant to the tools and understanding of medicine, since it requires the medicalization of a bodily state to improve our collective well-being.

These factors enable the BIA to fully solve the problem of MRND conditions. As a reminder, consider again the HDA's dilemma, which requires us to choose between:

1. Finding a way to lump all medically relevant conditions together under the disease label by, in some manner, understanding all instances of depression, addiction, anxiety, obesity, and so on, as dysfunctional and thus involving some part of the body that is broken or not operating as it should.
2. Acknowledging that many of the aforementioned conditions in 1 are not dysfunctional, thereby ruling out their classification as diseases and forgoing the ability for them to receive a medicalized label.

As I explained in section 2.1, neither of these two options is good. Option 1 harms the self-understanding of patients and misinforms society about the nature of these MRND conditions. Option 2 decreases the chance that these conditions will receive insurance coverage, medical treatment, and proper societal understanding since they will not receive a medicalized label. A third option is provided by Kukla's account, but it is functionally similar to 1 since it still classifies many MRND conditions as diseases.

The BIA provides an alternative and better way of solving this issue since it provides a separate medicalized label for non-dysfunctional and dysfunctional conditions. The two-label approach enables the BIA to reduce stigma and motivate medical care and resources while communicating important information to the patient, no matter the functional status of a patient's condition. To understand how, consider the perspective of the clinician who, under the framework provided by the BIA, now has two medicalized labels they can utilize: health condition and disease. These two labels have distinct groundings and better reflect a real distinction in the underlying phenomena since the disease label under the BIA is exclusively reserved for conditions involving a biological dysfunction, and the health condition label is reserved for MRND conditions.

Under this framework, clinicians no longer have to worry about attaching the conceptual baggage of the disease label to conditions where it is not appropriate. Instead, they can use a separate legitimate medicalized label: health condition. This can help reduce societal

stigma for non-dysfunctional conditions and can also motivate insurance coverage, funding, and treatment. Moreover, the health condition label will be informative since it is contrasted with the disease label and thus can communicate to patients that while they have a legitimate medical condition, their body is operating as it should (given its environment) and that no part of their body is broken.[16]

Furthermore, under the BIA, the disease label can still be used to communicate important information to patients about the biological status of their body and the specific way in which their body is dysfunctional since it preserves a scientific understanding of disease. The disease label's conceptual baggage surrounding agency, responsibility, etiology, and the target of treatment will also be preserved and, under the BIA, more aptly applied only to dysfunctional conditions.

The BIA thus fully satisfies *Bio, Justice,* and *Flourish* by accounting for the subjective and evaluative aspects of health and solving the problem of MRND conditions while still preserving a science-oriented and normatively useful understanding of disease.

5. Two Test Cases

In this section, I briefly explain how the BIA handles two controversial cases, depression and addiction, before considering three objections to my account. The aim of this section is to provide an understanding of how the BIA better handles real-world cases of MRND conditions.

5.1 Depression

Approximately 332 million people in the world have depression (WHO 2025). Given the harm depression causes, there is no doubt that we have a significant public health issue on our hands. What is not as clear is whether all instances of depression should be classified in the same manner. How do we distinguish between depression that appears to be a normal response to difficult life circumstances, and depression caused by an underlying dysfunction? Currently, these are lumped under one moniker, disorder, which is used interchangeably with the disease label (Filatova et al. 2021; Bains and Abdijadid 2023).

There is growing controversy about this approach. As I mentioned in section 2.1, many philosophers, scientists, and evolutionary theorists view many instances of depression as activations of a naturally selected low-mood system in response to difficult life circumstances. The evolutionary scientist and physician Randolph Nesse (2019), for example, understands the low-mood system (LMS), and thus many instances of what we call depression, as having evolved in order to limit resource expenditure in "unpropitious situations" (Turner 2023, 3; 2024). This kind of understanding of depression has led Nesse and many others to argue against depression being understood as a disease/disorder in all cases since, in many cases of depression, the body is operating as it should (Nesse 2019; Andrews and Thomson 2009; Horwitz and Wakefield 2007; Garson 2022). The number of cases, James Turner notes, could be as high as 80% since 80% of cases occur after a severely

[16] Note that this does not mean that the body is not the subject of treatment. There may still be an incentive to influence a particular body state that is negatively affecting well-being even if that bodily state is functioning as it should (such as deactivating the low mood system by working on one's thought patterns and life circumstances, or through medication). Thank you to an anonymous reviewer for raising this concern.

negative life event that would activate the LMS (Turner 2023, 162). The remaining 20% of depression cases would be more likely to be best classified as diseases/disorders since they would be likely to involve a dysfunction, which could be caused by a variety of factors, such as a prior history of traumatic brain injury, tumors, or other brain-related issues (Litofsky and Resnick 2009; Martindale et al. 2021; Yrondi et al. 2017).

Beyond the potential for this understanding of depression to better reflect the underlying phenomena, it has many practical benefits. For example, research has demonstrated that understanding depression as a purposeful or normal signal from the body, rather than as a state brought about by an underlying dysfunction has beneficial effects on treatment outcomes (Schroder et al. 2023). Furthermore, as Turner and others point out, understanding that many cases of depression are functional can helpfully guide treatment plans, placing a focus on changing unpropitious life circumstances, which may be more effective than primarily focusing on *fixing* a dysfunction in the brain through targeted medication in cases such as these where it is working properly (Turner 2023, 177). It can also help with diagnosis, as doctors with this understanding could better recognize dysfunctional depression by recognizing that these cases are likely to present with no preceding negative life events and thus can treat them accordingly (2023, 178).

While this approach seems useful, as I have noted throughout this paper, we cannot jettison the use of a medicalized label for non-dysfunctional depression, as institutions may lose the incentive to treat, fund, or provide insurance coverage for this condition. Turner acknowledges the danger here as well but argues that we could take this risk and simply try to understand non-dysfunctional depression like pain—it is functional, and yet we treat it, even if pain itself is not a disease or disorder (Turner 2023, 177, 145).

As explained above, the BIA has a better solution to this type of problem. The BIA does not require choosing between forgoing a medicalized label for non-dysfunctional depression or lumping it together with depression caused by a dysfunction. The BIA, instead, would be able to classify the cases of depression that involve a functional LMS as health conditions and cases that involve an underlying dysfunction as diseases. This allows us to classify depression in a way that better reflects the underlying phenomena, maintains the practical benefits of a dual approach, and still incentivizes treatment and insurance coverage for all cases of depression since both would be provided with a distinct medicalized label.

Under the BIA, the starting point at the clinician's office would no longer be "You have depression; thus, you have a disease" (along with all the conceptual baggage this term carries). Rather, the clinician would have to first carefully assess their patient's life circumstances and history to determine the cause of their depression, whether functional or dysfunctional. Only then could they classify their patient's depression as a disease or, alternatively, as a health condition. Depending on their type of depression and the medicalized label they are given, the patient would be able to understand whether their depression is functional or dysfunctional, if the target of treatment should be changing their life circumstances or mindset or correcting an underlying dysfunction, and many other key ideas that may improve their understanding of themselves, their condition, and their treatment outcomes. The BIA thus offers the best approach to understanding and accommodating the existence of both dysfunctional and functional depression.

5.2 Addiction

As explained in section 2.1, there is an ongoing debate about whether to understand addiction to substances as dysfunctional and thus as a disease or functional. Neither option seems to be optimal under our current paradigms. For one, there is much harm that comes from applying the disease notion to addicts; the understanding of addiction it conveys is not helpful for treatment outcomes and is potentially inaccurate. Many in the addiction debate recognize this but are hesitant to challenge the brain-disease model or view addiction as functional. This hesitancy often stems from a fear of losing the medicalized label of disease and thereby losing access to medical resources, or backsliding into a moral account of addiction that views addicts as immoral hedonists (Foddy and Savulescu 2010; Berridge 2017). There is also the concern, even from proponents of functional views of addiction, that in severe cases, the brain changes that occur may be best characterized as pathological (Davey 2015).

Given all these factors, how should we understand addiction? While there is much that we still have to learn about this condition, it appears the BIA could be helpful here. Just as with depression, the BIA has the ability to provide us with two medicalized labels, which improves our ability to handle this issue. Under the BIA, those who think addiction does not involve an underlying dysfunction and is not a disease no longer need fear losing medical resources or backsliding into a moral account, as functional cases of addiction could be classified under the medicalized label health condition. And, if severe cases of addiction do involve a brain dysfunction, then the BIA will still be able to accommodate an apt understanding of these cases as diseases. The BIA thus provides an understanding of health and disease that more effectively accommodates addiction.

6. Objections

Before concluding, I want to address three potential objections. The first asks whether the BIA solves a real problem, since clinical and lay usage of terms referring to health conditions varies widely. The second asks whether implementing the BIA might lead to negative outcomes, and greater stigma. And the third asks whether the BIA is useful in difficult cases.

6.1 Does the BIA Solve a Real Problem?

The first objection goes as follows: While it may be true that in philosophy, one term like "disease" is typically used to represent all pathological states, [17] things are not so standardized in practice. In clinical practice and among laypeople, the terms "disease,"

[17] While some philosophers approach the debate differently, none—in my view—adequately solve the problem of MRND conditions. Fabian Hundertmark's Blueprint view, for example, focuses on demarcating health from non-health, while leaving open how the disease space is carved up (Hundertmark 2026, 20). Yet by restricting the non-health space to cases of biological dysfunction, it fails to recognize the impact of MRND conditions on health. Hundertmark accepts this, arguing that treating non-dysfunctional cases of conditions like major depressive disorder is more akin to enhancement than healing—it would "entail improving an organism's abilities beyond what they would be in their design state" since it "could not mean restoring or compensating for the functionality of a trait" (2026, 18). This, however, mischaracterizes the treatment of MRND conditions. Non-dysfunctional depression, for instance, could be "healed" without improving an individual's abilities by deactivating their LMS, shifting them back to their pre-depression functional state. This could be done by changing their life circumstances and thought patterns or through medication. Thus, we can make sense of "healing" in MRND conditions as shifts to different or prior functional states, which are not best medicalized; and we can coherently understand both the impact of these conditions on our health and their treatment.

"disorder," "condition," "illness," "sickness," and "malady" are all used, sometimes interchangeably and sometimes not. On this view, framing of the current state of things as "disease or bust" is not accurate, and thus my dual-label approach solves a nonexistent problem.

I offer two responses to this objection. First, the way I have framed this issue accurately reflects the academic debates about this subject, which are contributed to not just by philosophers, but also by clinicians and scientists. So, while it may not exactly correspond to the lay debate or practical usage entirely, it still tracks an interdisciplinary academic debate and solves an important problem within that debate.

Second, this objection points out an issue with our current usage, rather than an issue with my solution. The current usage of so many terms that among many (although not everybody) are seen as synonymous with disease only leads to further confusion. The conceptual engineering approach I offer is ideally meant to standardize an understanding of health and disease and the usage of two distinct medicalized labels. The standardization of two medicalized labels will reduce confusion and enable the types of solutions I have discussed for controversial cases like addiction and depression. Only through a standard understanding and a two-label approach like the BIA will we be able to accommodate and properly inform patients about both dysfunctional and non-dysfunctional conditions while preserving all the other important purposes of an account of health and disease.

6.2 Could Implementing the BIA Have Negative Outcomes?

The second objection I want to address concerns the practical outcomes of implementing a two-label approach. One might worry that once implemented, the practical reality will be that bodily states labeled as "health conditions" might be viewed as less legitimate than "diseases," and it might be harder to justify insurance coverage or treatment for effectively "second-class" conditions.[18]

In response, I first want to make clear that the BIA denies any hierarchical relationship between diseases and health conditions. A goal of my account is to establish two standardized legitimate medicalized labels that are equally respected by clinicians, healthcare institutions, policymakers, and the public.

I also want to note that I do not view a hierarchical relationship between "health condition" and "disease" as inevitable or as an intuitive consequence of my account. A strong benefit of the BIA, as stated previously, is that there are no established intuitions or conceptual baggage to contend with when utilizing the health condition label. Thus, how we utilize it, and our understanding of the relation between health conditions and diseases are still ours to determine.

Furthermore, I do not think the BIA naturally lends itself to the view that health conditions and diseases should have a hierarchical relation, since these labels do not carve up the world in a way that tracks severity. Consider again under the BIA that very harmful conditions (such as addiction), or conditions that involve substantial changes (such as pregnancy) may be considered health conditions, while the disease label covers not only severe diseases like AHN but also diseases like strep throat or the common cold, which are generally minimally consequential and easily managed. Thus, a nonhierarchical

[18] Thank you to two anonymous reviewers for pointing to this objection.

relationship between these two labels follows naturally, since both "health condition" and "disease" will classify issues of greatly varying severity.

There is the further question here regarding whether the BIA will or can be effectively implemented into the healthcare system—whether, for example, insurance companies would take "health conditions" seriously. It is my view that it is possible to overcome this potential difficulty. If anything, the codified and centralized structure of medical institutions lends itself more easily to the implementation of a new conceptual understanding than many other areas. For example, consider if the BIA was incorporated into DSM-6, began being backed by National Institutes of Health (US) research, or was accepted by the National Health Service (UK) or the Centers for Medicare & Medicaid Services (US)—any combination of these would go a long way toward implementing the BIA in medicine as a whole and ensuring its proper application generally and by private insurers.

One may still be concerned, however, that even if the BIA's two-label, nonhierarchical approach is successfully implemented by healthcare institutions and clinicians and accepted by insurances, patients and the general public may still interpret it in a way that could increase stigma or have other unforeseen negative effects, even if that is against the intention of my account. In response, I want to first note that this worry does not consider that our current practice of understanding everything as a disease/dysfunctional already leads to stigma and has negative effects on many conditions, such as addiction and depression. On the other hand, I have already provided some empirical evidence that suggests the BIA will have beneficial effects for the framing of these conditions (Schroder et al. 2023).[19] So, the choice is not between a non-stigmatizing account and a potentially stigmatizing account, but between an already stigmatizing account that negatively impacts those with certain conditions (our current practice) and an only potentially stigmatizing account, which is plausibly supported by some empirical evidence on the framing of health conditions.

Ultimately, though, the effect of how the BIA frames diseases and health conditions is a question for empirical study, and I hope that my work provides a fruitful avenue to explore for those engaged in empirical research on framing in medicine, and that this research will continue to strengthen my account. Unfortunately, while important, a full account of how one can successfully implement a new conceptual strategy after the conceptual engineering process is beyond the scope of this paper, but the genuine possibility of success leads me to believe that it is premature to reject my account out of fear that it could potentially go awry.

6.3 How Does the BIA Handle Difficult Cases?

One might worry about what benefit my account offers in difficult cases, where it is not obvious whether an underlying dysfunction is implicated and thus not obvious whether a person has a health condition or a disease. In these cases, might classification using the two-label approach sometimes be arbitrary? If so, why use the BIA at all?[20]

I do not think that this problem is unique to the BIA's approach; this a problem more generally for medical diagnosis. Consider that diagnosis itself is often difficult in complex cases that involve a degree of uncertainty. For example, when diagnosing a patient, it can be difficult to ascertain the underlying cause of a set of symptoms; it can be hard to know

[19] See also Wiens and Walker (2015); Liu and Hogarth (2025).
[20] Thank you to an anonymous reviewer for this objection.

where the right threshold is for the diagnosis of certain conditions and whether a specific patient has met that threshold; and diagnostic categories themselves may sometimes blend together or cover heterogeneous causes. This, however, does not make diagnosis arbitrary in the sense of being unprincipled or random, nor does it render diagnosis useless in difficult cases. Diagnosis, even in these cases, should not be discarded, for it has many invaluable pragmatic benefits, which shape the best course of treatment and help inform the patient as best as possible as to what is going on with them. Similarly, when faced with difficult cases, we need not discard the BIA's two-label approach. Clinicians should do their best to classify each particular case with the information they have access to, given the current state of research and their knowledge of the individual patient, just as they do in medical diagnosis. The pragmatic benefits of the BIA make it worthwhile even in the face of the difficulties that arise from complexity and uncertainty. And over time, just as medical diagnosis will improve for difficult cases, so will our ability to classify cases using the framework the BIA provides.

7. Conclusion

In this paper, I set out to engineer an account of health and disease that improved upon established accounts and better served the purposes of these concepts. After evaluating two current accounts, I laid out three key desiderata that are meant to reflect the need for an account to effectively explain and account for the biological, subjective and evaluative aspects of disease, solve the problem of MRND conditions, and be useful for both scientific and clinical practice and normative projects of health justice.

I contend that I have successfully demonstrated the bio-institutional account's ability to satisfy all three desiderata. The BIA provides an understanding of health and disease that incorporates both naturalist and constructionist components, which ensures compatibility with science-oriented and social justice-oriented projects, and manages to separately accommodate dysfunctional and non-dysfunctional conditions. These aspects, along with its two-label approach, enable the BIA to prove incredibly useful in addressing controversial conditions like addiction and depression.

Overall, I view the BIA as an improvement upon currently established accounts of health and disease. I do not, however, anticipate that it will be the final and best account of these concepts since conceptual engineering is a continual process of refinement and revision. Nevertheless, my account has pointed to a better path forward and ideally will have practical import on how we address MRND conditions in the future.

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