Social Rights and Economics

Claims to Health Care and Education in Developing Countries

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Abstract

The paper analyzes contemporary rights-based and economic approaches to health care and education in developing countries. It assesses the foundations and uses of social rights in development, outlines an economic approach to improving health and education service provision, and then highlights differences, similarities, and the hard questions that the economic critique poses for rights. The paper argues that the policy consequences of rights overlap considerably with a modern economic approach. Both the rights and the economic approach are skeptical that electoral politics and de facto market rules by themselves provide sufficient accountability for the effective and equitable provision of health and education services, and that further intra-sectoral reforms in governance, particularly those that strengthen the hand of service recipients, are needed. There remain differences between the two approaches. Whether procedures for service delivery are ends in themselves, the degree of disaggregation at which outcomes should be assessed, the consequences of long-term deprivation, metrics used for making tradeoffs, and the behavioral distortions that result form subsidies are all areas where the approaches diverge. Even here, however, the differences are not irreconcilable, and advocates of the approaches need not regard each other as antagonists.

I. Introduction

Human rights are increasingly important in international development discourse, particularly in the areas of health and education. The legal foundations for those rights are the Universal Declaration of Human Rights, 1948, and the International Covenant on Economic, Social and Cultural Rights, 1966. In addition, references to the right to education and health care are found in the European Social Charter, 1961, the African Charter on Human and Peoples' Rights, 1981, and the Convention of the Rights of the Child, 1989. A number of international and bilateral development agencies have endorsed a human rights orientation in the provision of health care and education in developing countries.[1] Social rights are also important at the national level. One analyst found that 110 national constitutions make reference to a right to health care (Kinney 2001). A review conducted for this paper assessed constitutional rights to education and health care in 187 countries. Of the 165 countries with available written constitutions, 116 made reference to a right to education and 73 to a right to health care. In addition, 95 stipulated free education and 29 free health care for at least some population sub-groups and services.[2]

Brazil offers a compelling example of the force of human rights language. The Brazilian Constitution of 1988 guarantees each citizen the right to free health care. Although the constitutional guarantee has not eliminated shortages and inequalities in the sector, that provision had real "bite" in 1996. That year a presidential decree initiated a program of universal access to anti-retroviral drugs for HIV patients, free of charge. The government started providing drugs to some patients living with AIDS. Partly as a result, in major Brazilian cities AIDS deaths dropped over 40 percent from 1997 to 2002. But the program is costly. Drugs alone cost the government $6,875 per patient for 74,000 patients on anti-retroviral therapy in 1998, the last year for which complete expenditure data are available (Novaes and others 2002). Meanwhile, many basic antibiotics remained too expensive for or inaccessible to millions of citizens.

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[1] See, for example, UNDP (2000), Short - DFID (1998), WHO (2002), UNESCO (2000), Human Rights Council of Australia (1995). Summary reviews are Hamm (2001) and Marks (2000).

[2] The coding system identified a right to education or health care if a constitution used the word "right," stated that the service was "guaranteed," stated that government was to provide the service to "all," or stated that the everyone was "entitled" to the service. Weaker formulations (e.g., the "state shall endeavor to provide education") were not considered constitutional rights. The analysis identified a provision for free health care if any population sub-group was to receive free services (usually the poor or indigent) and a provision for free education if any level of education was free (usually primary and/or secondary education). The analysis of the right to health care focused on the right of access to medical services, not population-based preventive measures. There were correlations between the year a constitution was first written and its declaring a right to education (0.22) and to health care (0.21). The constitutions were found at: http://www.psr.keele.ac.uk/const.htm, http://confinder.richmond.edu/, http://doc-iep.univ-lyon2.fr/Ressources/Liens/constitution-etr.html, http://www.cia.gov/cia/publications/factbook/. The review was conducted in November 2002.

Reactions to Brazil's AIDS drugs program are divided, so much so that an account of it is as an almost perfect screening instrument for distinguishing people inclined to a rights-based approach to health care from those who gravitate to an economic analysis. On the one hand, rights-based advocates contend that the Brazilian program grew out of an explicit human rights orientation and was based on the constitutional guarantee to universal and free health care. They note that while there remain other important inequalities in the country, at least some Brazilians no longer die prematurely while the country possesses the resources to save them. On the other hand, economists argue that the provision of those drugs to those who would have bought them otherwise displaces private expenditures, and to that extent is merely an income transfer. Moreover, if the decision were to set a precedent for other disease categories, government expenditures would balloon, to the detriment of other health initiatives that might save more lives at lower social cost, such as disease prevention and the provision of clean water.

Proponents of these two approaches to health care and education often regard each other as antagonists. The issue also emerges, for instance, in claims regarding the "commodification" of health care and education. Rights advocates argue that these goods should not be treated the same way that societies treat tennis shoes—by leaving distribution to private bargaining between producers and consumers, regardless of purchasing power and needs. For governments to stand by while markets leave some human beings with miserably insufficient health care and education is a violation of the modern social compact. Economists respond that health care and education have been bought and sold throughout the world for at least two thousand years. To refuse prices a role in allocation, moreover, is foolish: without rewards for good service, and without the information that the prices convey, providers would slack off, innovation and scientific progress in those fields would slow, and consumers would have a harder time distinguishing good from bad providers.

In reality, this account overemphasizes the differences. With regard to practical policy consequences, rights advocates and economists are not far apart in their approaches to health care and education. Claiming that there are rights to education and health care is consistent with the belief that the rights cannot be realized at once, that social rights are goals and not constraints, that the financing and provision of services can be public or private, and that defending social rights requires local institutions, information, organization, and advocacy. A modern economic approach to health care and education in developing countries also emphasizes the need to strengthen accountability, sectoral governance, transparency, and access to information. Both approaches would recommend greater parental participation in school management, more patient input in health care decisionmaking, more effective local and civic organizations for monitoring service delivery performance, more transparency in and clearer rules for

budget allocations, and a simplification of management and governance in the health and education sectors. In both approaches, the goal is to strengthen the position of service recipients.

There remain differences between the two approaches.[3] Whether procedures for service delivery are ends in themselves, the degree of disaggregation at which outcomes should be assessed, and the consequences of long-term deprivation are all areas where the approaches diverge. Even here, however, the differences are not irreconcilable. The harder areas involve a few pointed questions from the economic critique: given scarce resources, why allocate according to a principle other than social welfare; and why ignore the behavioral distortions that follow from subsidies?

This paper analyzes contemporary rights-based and economic approaches to health care and education in developing countries. Although other moral entitlements and immunities, such as subsistence rights and the right to physical security, have obvious relevance for health and education outcomes, and although in some sense rights might be "indivisible,"[4] the paper focuses on the direct rights to health care and education services. The first section below assesses the foundations and uses of social rights in development. The second section outlines an economic approach to improving health and education service provision. The third section highlights differences and similarities. A conclusion draws inferences for policy work in these sectors in developing countries.

2. Social Rights: Foundations, Uses, and Criticisms

Genealogically, the doctrine of human rights is related to Locke's notion of the natural right to one's labor, Rousseau's and Kant's ideas of innate liberty, and before that to Stoic and Christian conceptions of natural law, or the divinely inspired respect that is owed to human beings. But the existing human rights regime, as the term is used in contemporary moral and policy discourse, can be built on a variety of theoretical foundations. There are "plural foundations" (Guttman 2001) because human rights, while conceptually vague for reasons described below, are the product of a powerful intuition, common across many if not most cultures and religions, that human beings are especially important in the cosmos and deserve special treatment. Ideas inspired by that intuition have caught on in a variety of forms and circumstances, sometimes in conjunction with conquest, in the cases of Islam in the Middle East and liberalism in the colonial world, but frequently independent of it, such as Buddhism in India, Christianity in the Mediterranean world, and Islam in Indonesia (Taylor 1993). The foundations of human

[3] There are a variety of rights inspired and economic approaches, of course, and in some formulations the differences between them might be smaller or larger than represented in this paper. The goal here is to compare the most common or typical versions of the approaches.

[4] This somewhat opaque term refers to the means by which social and political rights reinforce each other. The use of the term is described below.

rights can be secular or religious, and religious in a variety of forms, because the notion that human beings are worthy of respect recurs throughout history.

The foundations for social rights, since they have emerged more recently than the older injunctions against unnecessary suffering and against unjustified physical confinement, are usually secular. To take one example, the right to social insurance can be established on the principle of human agency. Understood this way, the moral intuition is that in a fully realized human life a person makes important decisions—where to live, what to work on, how to worship, whom to marry—on her own, in accordance with her own understanding of the elements of a good or worthy life. The intuition is one of the reasons for the liberation of slaves and for the attack on civil practices that prevent people from imagining and creating a meaningful life, such as childhood marriage and religious persecution. The right to social insurance follows from the realization that not only slaveholders but events can so impair a person's ability to imagine and realize plans that her own human life fails, in an important sense, to be realized. Abject poverty, natural disasters, and social and economic isolation can effectively enslave people, leaving them incapable of experiencing themselves as beings whose lives are significant. The right to health care can be founded on similar arguments. Disease and disability can be so severe as to deprive a person of the opportunity to execute any significant life plan. Health care can mitigate or even eliminate their condition, to the extent that medical science allows. The right to education entails the acquisition of cognitive skills necessary for achieving economic security, a career, social and political participation, communication, and the other elements of a complete life in the modern world. These rights refer to the power of human beings to live in a way that is consistent with the widely shared, though still controversial, belief that human choice is the principal source of meaning in the world.

The rights to education and health care can also be established on a different secular foundation. This perspective emphasizes not falling victim to fate but the effects of being left in that condition by one's fellow citizens. Enjoying a healthy, vigorous life and being well educated are desirable in contemporary societies worldwide, which, at least in their urbanized centers, generally admire health and material well-being. Access to health care and education are important for participating in the modern economy, and in pursuing its related goals of physical vigor and preference satisfaction. This might appear too obvious to merit note, but a contrast with the medieval era is illuminating. As Walzer (1993) points out, centuries ago in Europe access to a spiritual advisor was considered indispensable for every soul, whether a noble or a serf, whereas access to health care and education was not a pre-requisite for meaningful participation in society. Now close to the reverse is true. Being denied education and health care not only leaves one more vulnerable to fate but also causes one to suffer possibly irreparable deprivation in the goods that society most values. Not having them is equivalent to being excluded

from modern society, with its related social and psychological consequences. The rights to health care and education, then, can be seen as elements in the "social bases of self-respect," which Rawls (1971, 2001) defines as perhaps the most important of his "primary goods." That this basis for social rights is distinct from agency, as well as from the utilitarian or economic view in which the purpose of health care and education is to achieve outcomes or functioning, is evident in the way modern societies treat incurable disabilities. Even if the treatments offered to a paralyzed or sickly person do not significantly improve her range of choices or her functioning, the treatments do support her self-respect as someone worthy and deserving of health care. There can also be, of course, religious foundations for social rights, such as commandments to love one's neighbor or engage in charity, or the conception of society as an organic whole in which the classes support each other.

Because social rights and, more broadly, human rights are established on several different foundations, there exist disagreements regarding their content and form. A foundation for social rights based on dignity, for example, might suggest a stronger principle of equality than one based on agency, which only requires that individuals enjoy the minimal social infrastructure necessary to articulate and enact a life plan. What people have a right to, whether people can hold rights without a designated person or entity bearing a duty to fulfill or protect those rights, and whether or not rights exist prior to their legal establishment are all controversial topics (Sen 2000). What people have rights to, for instance, has evolved. While earlier in the modern era, the list of rights highlighted life, liberty, the pursuit of happiness, freedom of conscience, and private property, many contemporary accounts are significantly longer. The rights to clothing, shelter, subsistence, judicial due process, non-discrimination, freedom from torture, political participation, bodily integrity, information, privacy, the experience of nature, play, movement, social security and employment have all been cited as fundamental. Critics of an expansive list argue that "rights inflation" erodes the value of the central human rights (Ignatieff 2001). They also contend that social rights are necessarily related to the welfare state, and perhaps to socialism, because ensuring that people have sufficient income, health care, and education necessarily entails large government. This controversy was acute during the Cold War, and forced the bifurcation of the international instruments meant to codify the Universal Declaration of Human Rights, which had been established after the horrors of the world wars, into separate agreements: the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights. Political concerns regarding social rights have also motivated the theoretical effort to distinguish "negative rights," which set constraints on other actors (e.g., the right to personal liberty enjoins unjustified detention and is the principle behind the common law doctrine of *habeas corpus*), from "positive rights," which entail intervention or resource support from others (e.g., the right to health care). Conceptually, the distinction does not hold because rights generally considered

"negative," such as the right to personal liberty, also require state action, in this case access to a functioning legal system and to counsel. And certain rights generally considered "positive" might entail government restraint. For example, the right to employment might in the long term require that governments limit interference in labor markets, and the right to subsistence might require that governments and other actors refrain from hoarding grains (Pogge 2002).

In addition to these theoretical difficulties with social rights, a practical objection concerns the judicial enforcement of claims to health care and education. Because education and health care services involve considerable discretion on the part of numerous independent providers at the point of delivery, and because they entail a large number of transactions between providers and recipients (Pritchett and Woolcock 2002), it is difficult for courts, the entities to which claims of rights violation are usually taken, to determine whether or not a given student or patient is being denied his right to health care or education. The example of desegregation in the United States is illustrative. When courts intervened on the grounds that separate schooling for black and white students was inherently in conflict with the equal protection clause of the national constitution, the courts discovered that guaranteeing equal protection ultimately required them to operate school systems themselves. School management, financing, and politics were so complex that remedies for segregation, such as court ordered bussing, affected the entire educational process in ways that could not be determined in advance; and in some cases there was no means short of taking over a school district to ensure equal treatment for blacks and whites. But courts were not equipped to handle the management tasks, and the involvement of the courts took educational decisionmaking out of democratic politics. That in turn created a backlash, and in some instances undermined the educational rights of the very people the courts were intervening to assist (Hochschild 1984). The case is an object lesson in the difficulty of using legal rights as a basis for social objectives. The limitations of judicial remedies for social inequalities would be even sharper in developing countries, where legal systems are often weak and less than impartial.

Do these criticisms mean that a human rights approach to health care and education in developing countries is vague, impractical, or self-defeating? If rights are understood as binding constraints on government action, it is hard to avoid those conclusions. Governments in developing countries cannot provide or assure adequate levels of health care and education. Given that those rights claims cannot be enforced and that legal systems in most developing countries are inequitable and under developed, allowing citizens to make legal claims of inadequate service provision will further politicize courts and weaken their capacity to adjudicate existing rights. Pressure to increase government financing of health care and education will rise, even where its likely result is inequitable or inefficient outcomes.

But if understood not as binding constraints but high priority goals, rights to health care and education can be useful and meaningful. (Nickel 1987, 2002) In this view, rights are not legal instruments for individuals (though they can be, if governments codify them in domestic law), but duties for governments, international agencies, and other actors to take concrete measures in pursuit of ideals on behalf of individuals. Failure to develop plans, achieve benchmarks, or establish and finance implementing agencies constitute violations of the duties associated with the rights, and invite legitimate criticism and moral pressure. Failure to pursue actions in pursuit of the goals also raises serious issues concerning the legitimacy and long-term stability of governments and international institutions because social rights are critical elements of the modern social compact and the modern personality. With rights so conceived, the problem of whether people can hold a right without a designated person or entity bearing a duty to fulfill or protect it becomes less important. Calling health care and education rights means, on this understanding, that everyone bears some responsibility for their fulfillment. If individuals in developing (or for that matter, developed) countries receive miserably inadequate health care and education, their rights impose duties on their local governments, national governments, foundations, neighbors, international agencies, and citizens of the rich countries—on all people who might be in a position to help. Kant called duties like this "imperfect obligations." The fact that no one actor bears responsibility for them means that coordinating a response might be difficult, but, as Sen notes, they remain rights nevertheless: "But is surely possible for us to distinguish between a right that person has which has not been fulfilled and a right that the person does not have" (Sen 2000). The problem of adjudicating what exactly the rights to health care and education entail and how to ensure their attainment is affected, and in this interpretation appropriately so, by political processes within countries. Again, this might mean that standards of health care and education vary from place to place; but it is possible to distinguish between governments and other actors that recognize the fundamental importance of those goods but depart from international norms of provision, and those that fail to recognize their importance altogether.[5] Similarly, on this understanding of rights, the problem of judicial enforcement is reframed and made far less damaging for the rights approach. If rights are not binding constraints, then every

[5] It might even be necessary for standards to vary. Local understandings of agency and social inclusion, arrived at through rich democratic self-government, have to be incorporated into norms of service provision because it is in principle impossible for an outsider to predict in advance what services a person will say are essential for her ability to live a good or worthy life. As a result of these varying standards, there will remain sharp disagreements across regions regarding some aspects of social policy, notably in gender roles and reproductive health, though these too can be the subject of persuasion and reasonable argument (Nussbaum 2000). Despite this, it is still possible to determine whether a government or an agency is making a good faith effort to provide adequate health care and education services according to its own understanding.

perceived shortcoming is not actionable in courts, though certain categories, such as those premised on equal protection claims, might be.

The notion of rights as high priority goals is implicit in some of the legal documents underlying the rights approach to development. The WHO Constitution, 1946, and the Declaration of Alma Ata, 1978, for instance, makes reference to the "highest attainable standard of health," which implicitly acknowledges that many developing countries cannot provide comprehensive health care for all of their citizens. The WHO interprets the principle to mean that governments should put into place "policies and action plans which will lead to available and accessible health care for all in the shortest possible time" (WHO 2002). The U.N. also describes the right to education as a mandate that is being progressively realized (UNESCO 2000).

Understanding social rights as goals brings out their self-reinforcing quality and helps clarify the somewhat opaque assertion that rights are "indivisible," as advocates sometimes contend. That rights have a self-reinforcing quality is evident from the structure of most arguments for social rights. It is usually argued that certain goods, such as health care and education, are indispensable for the exercise of one or more critical human faculties, such as self-understanding or reason, either because they provide essential physical and cognitive infrastructure or because they are necessary for social inclusion and self-respect, which are themselves pre-requisites for self-understanding or reason. But reason, self-understanding, and related capacities in turn facilitate the articulation, assertion, and defense of social and political rights. For example, a woman living in a society that supports the right to education is better able to understand a clinical diagnosis, demand appropriate treatment, and complain if her health needs are not met than a woman in a society where the right to education is not respected. She is also better positioned to argue for better monitoring so that pharmaceutical products destined to her neighborhood clinic are not stolen, and for her right to organize community members to participate in the oversight of clinics and schools. A parallel argument can be made from the perspective of dependency: educated and healthy individuals are less likely to fall into dependence on others, whether within the household or outside it, and are therefore freer to speak and organize in defense of their social rights. In both cases, some political and social rights reinforce others. If rights are understood as binding constraints on government action, rights are not necessarily self-reinforcing because the object of moral scrutiny is limited to government activity, and not what individuals are able to achieve and experience. This structure of arguments for rights brings out that they are both ends of and instruments for development. To extent that they are instruments, the policy consequences of a rights approach overlap considerably with a modern economic approach to health care and education.

3. An Economic Approach to Health Care and Education

The consumption of education and health care services is positively related to household productivity and economic growth. Although empirical work has identified a significant relationship between health and nutrition in childhood and lifetime cognitive and motor skills (Martorell 1995), it has been more difficult to establish that health mitigates poverty and enhances labor productivity. The reasons for this difficulty include measurement problems related to the fact that health is multi-dimensional, changes over time, and is unreliably reported, and conceptual problems related to the dynamic relationship between health and income, including the facts that labor can be substituted for within households, that health falls in importance as the physical intensity of labor declines, and that health is in general both a cause and effect of labor productivity (Strauss and Thomas 1998). Recent studies have demonstrated some success in identifying an effect. For instance, at the individual level there is a correlation between adult height and income even among uneducated Brazilian men and women (Thomas and Strauss 1997). At the macro level writers have argued that nutritional gains account for a large part of economic growth in Europe over the past two centuries (Fogel 1994), that malaria and endemic diseases depress economic growth in Africa (Gallup and Sachs 2000), and that declining mortality and fertility rates were associated with the unprecedented economic growth in East and Southeast Asia from the 1960s to the 1990s (Asian Development Bank 1997). Of course factors such as income, access to clean water, and education might be as or more important in promoting health than access to health care. While just how important health care is for health status remains controversial (Filmer, Hammer, and Pritchett 2000), there is enormous evidence at the micro-level that some health care interventions (skilled birth attendance, for example) have enhanced health outcomes (De Brouwere and others 1998), and compelling arguments that publicly provided and financed health care services were important in mortality declines in some countries (Johansson and Mosk 1987, McGuire 2001). In addition, partly because purchasers of health insurance can hide their actions and health status from insurers, health insurance is expensive and unavailable for many. Governments have a role in subsidizing or regulating insurance for catastrophic health events, which in developing countries often takes the form of the direct financing of hospital care. (Filmer, Hammer, and Pritchett 2002)

The evidence for the impact of education on private wages is more strongly established. Calculations of the private returns to education average about 6 percent in industrialized countries and 11 percent in developing countries. (Psacharopolous 1994) These remain rough estimates because they do not control for school quality, and there remain problems in controlling for the endogeneity of the schooling enrollment decision. But a review of studies that used compulsory schooling laws and other variables as instruments for completed education found that estimates for the returns to education

were as big or bigger than standard ordinary least squares estimates (Card 2000). At the national level, the relationship between educational attainment and growth in output per worker at the national level is weaker (Benhabib and Spiegel 1994, Pritchett 2001, Bils and Klenow 2000). But a study that measures labor force quality, based on international mathematics and science test scores, are strongly related to national growth rates (Hanushek and Kimko 2000).

Given that education and health care services are desirable, how should they be provided? An economic approach to service provision begins with an analysis of private markets. If individuals were left to finance and purchase education and health care services, particularly basic education and disease control, on their own, spending would be less than optimal because individuals would not take account of benefits to others when making consumption decisions. And pure private provision does not spontaneously lead to professional associations and provider networks, which are important for the efficient provision of some aspects of health care, such as clinical referrals. Private provision would also make it difficult for patients and students to monitor the diligence of private professionals, who necessarily have large discretion in decisionmaking and who provide services in a decentralized manner in which there are large numbers of transactions, and hard for consumers to assess quality.

For reasons such as those, governments have involved themselves in the financing and provision of health care and education. But government provision is bedeviled by the same problems that affect private provision. It is hard for clients and citizens to monitor the work of civil servants and bureaucrats; and, indeed, in government service delivery the one power clients have over service providers, the power to seek services elsewhere, by design usually has no effect on the behavior of government providers. Governments, at least democratic ones, are in theory accountable to citizens through elections rather than through market power. But because elections in modern states are relatively infrequent, are votes for candidates and parties and not single issues, and occur in relatively large districts without much voter deliberation, the existence of elections is weakly related to service quality, especially in developing countries. In other words, although elections can confer legitimacy, they do not assure accountability (Lane 2002). These problems are compounded by the fact that several different principals, the various ministries and institutions of government, share responsibility for health and education services, and thereby dilute accountability to their agents, the citizenry (Dixit 1997). In addition, the interests of civil servants are often not aligned with those of service recipients, and civil servants mobilize in pursuit of their own interests more easily than the public at large.

There exists no optimal solution to the accountability problem for the provision of health and education services. Instead, there a variety of mechanisms through which health and education service delivery can be made more accountable to clients. These

include strengthening citizens' power with respect to providers, either by granting them authority over or participation in health and education facilities or allowing them more market choices, making contracts between government and frontline providers explicit, so that provider performance is linked to rewards and sanctions, and amplifying citizens' voice in health and education by changing electoral rules, creating advocacy groups, and releasing information. Examples include service "report cards" in Bangalore, India, community control over the riverblindness reduction campaign in West Africa, participatory budget formulation in Porto Alegre, Brazil, the publication of budget allocations targeted to each school in Uganda, explicit contracting for all city services in Johannesburg, South Africa, and direct cash transfers to households that send their children to school and obtain immunizations in Mexico (World Bank 2003).

4. Similarities, Differences, and the Hard Questions

The preceding sections make clear that a rights orientation and an economic approach prescribe similar methods for service delivery in heath care and education. Participation, empowerment, transparency, and accountability are important themes for both. From the economic perspective, these are important because problems related to collective action and asymmetric information lead to inefficiencies in publicly provided services. Both private and public provision are also sub-optimal because health care and education are jointly consumed and because qualities of the services received are related to traits of the consumers, leading to problems in risk sharing, sorting, and, if the social welfare function attaches some importance to poverty, distribution. From the perspective of social rights, participation, empowerment, transparency, and accountability in service delivery are important instrumentally for ensuring health care and education quality. But those characteristics of service delivery also have a more intrinsic relationship to social rights. If social rights are elements in the social basis for self-esteem, and if the latter is considered a critical or "primary" good, then health care and education services are important not only for the clinical care and cognitive skills they impart but for the way in which they include individuals in modern societies. Then, not only what services are delivered, but how they are delivered becomes important. From this perspective, for example, informed consent so that patients can make fully informed treatment decisions, and parental participation so that local understandings of respect for elders and holidays are included in classroom practices, are both constitutive of the kind of social respect that is critical for self-esteem.

It is not surprising that a rights orientation shares certain principles with an economic approach because both are genealogically related to the renewed emphasis on reason and individualism that emerged in the Enlightenment. Both recognize individuals, not societies, tribes, or other entities, as the principal locus of moral value and meaning in the world. One way to see this is to note that both are skeptical of political systems,

including electoral democracies. Both are compatible with democracy, of course, and a commitment to human rights probably requires universal suffrage and contested elections. But in both cases, empowerment, participation, and information become critical because regular elections do not as a matter of routine lead to universal access to minimally decent health care and education. From the human rights perspective, the reason for this is that explicit legal discrimination, prolonged social exclusion, patterns of prejudice, and/or the internalization of low expectations lead to inadequate service utilization for some groups and individuals. Problems like these are acute in developing countries, where former colonial powers bequeathed varying group-based civil law for different ethnicities and religions, and where liberal constitutions are contemporaneous with feudal, clientilist, and patriarchal practices (Mamdani 1996). The remedy requires correcting legal defects, as well as empowering citizens and the civil society organizations that act on their behalf to campaign against the informal cultural, social, and economic practices that sustain unfairness in access and utilization. The economic approach is skeptical that electoral democracy by itself creates accountability in the health and education sectors for two reasons. Drawing on public choice theory, some economic analysts argue that interest groups, such as teachers unions, "capture" the institutions of service delivery for their own purposes (Birdsall and James 1990). Using the principal findings of social choice theory, others contend that the preferences of service recipients are so heterogeneous that efforts to aggregate them, whether through democratic procedures or through market provision of jointly provided services like health care and education, are invariably bedeviled by impossibility, arbitrariness, and instability (Arrow 1970). Economic solutions to interest group capture entail strengthening the market and political position of recipients by giving consumers choices, exposing providers to competitive pressures, and, where services remain publicly provided, allowing service recipients more direct participation in decisionmaking and monitoring. One solution to the aggregation problem involves group deliberation and the development of enough trust to relax some of the assumptions underlying social choice theory (Dryzek and List 2003).

In spite of these similarities, the economic and the human rights approaches result in at least three important, though not irreconcilable, differences in policy. First, the mechanisms and processes for the delivery of health and education services are, in the rights approach, themselves morally compelling. This follows from understanding the rights to health care and education as critical elements of social inclusion. If protecting and fostering the social basis of self-esteem partly motivates the provision of health care and education services, either because the denial of those services is a marker of low status or is related to a pervasive sense of personal ineffectiveness, then service delivery should be structured to support self-esteem. That means that consent to treatment, norms for due process in delivery and allocation, participation and consultation, and transparency regarding professional and bureaucratic decisionmaking not only facilitate

good service delivery but are constitutive of it. On the other hand, the economic approach views those processes instrumentally: they could in principle be reconciled with authoritarian styles in medicine and school governance if those lowered mortality and raised literacy. But the entire thrust of normative micro-economic theory is to expand choices available to consumers, both because choices raise utility directly and because competition among providers increases social welfare. In addition, benchmark theories of competitive equilibrium require full information on prices, quantities, quality, and preferences; and contemporary accounts of service delivery endorse reducing information asymmetries among principals and agents. In other words, although their affinity with utilitarianism and their commitment to maximizing behavior typically leads economic theories to place little emphasis on collective goods for which it is hard to estimate a price, such as the processes of service delivery, most contemporary microeconomic accounts of health and education services assume that client participation and rules on disclosure and transparency are essential for service delivery. Direct accountability to clients through participation or quasi-markets substitutes for market consequences in the absence of competitive markets. The processes of service delivery are critical in the economic approach, though they do not have intrinsic value.

Second, in the rights approach, evaluations of health and education programs emphasize distributions in outcomes, not only averages. The entire distribution is of concern because rights theories take seriously the idea that every human being is worthy of respect. Evaluations are used to assess the extent to which each individual has real opportunities in education and health care. If systematic discrepancies appear among large populations, rights advocates take this as evidence that services are unavailable or inadequate for some groups. The rights approach views these discrepancies as direct evidence of inequity, whereas the economic approach would first examine whether they are the result of household choices. Rights advocates pay particular attention to disaggregated data among ethnic and religious minorities, women, and the poor because they are particularly liable to practices and prejudices that that weaken their agency and the social basis of their self-esteem. Economists, of course, are also concerned with the distribution of outcomes. But typically, economists disaggregate data by income level because standard assumptions regarding the poor and the rich, such as the degree of risk aversion and the marginal utility of consumption, are available to build positive accounts of individual and household behavior. But there is nothing inherent in economic theory that conflicts with a special concern for excluded groups, or with the development of new behavioral assumptions regarding women or ethnic groups.

Third, rights approaches accommodate adaptive preferences. If rights are understood in the framework of human agency, in which there is a set of universal activities human beings should be able to perform—if rights are viewed, in other words, as capabilities (Nussbaum 1997)—then policy interventions should address the factors

that inhibit people from exercising the central human capabilities. Some constraints are external. Many cannot afford the direct or opportunity costs of schooling, for example, do not receive information about how to receive medical care, or live in communities where collective action is costly or impossible. Economic analyses highlight the important role of these factors—resources, information, and coordination—in the quality of service delivery. Rights approaches emphasize, in addition to these, constraints internal to individuals, particularly adaptive preferences—the habit of individuals subject to deprivation to lower their standards regarding what they need, want, and deserve. Rights advocates call for consciousness raising, political education, and other measures to expand the imagination and demands of excluded groups. The discipline of economics does not easily accommodate individuals who do not maximize their welfare. But many of the mechanisms through which economists propose second best solutions involve changes in available information, participation, and incentives that, in practice, also change people's awareness of what they have and what they deserve. In practice, then, the policy consequences that follow from this aspect of rights approaches overlap, at least in part, with the economic solutions.

There are two additional and less easily reconciled challenges that economic analysis poses for rights approaches. First, rights based approaches have no distributional metric. The question arises: in the rights framework, just how high is the high priority status of educational and health care goods and services, and how should governments and other actors make allocative decisions, both within and across sectors? Economics offers alternative approaches. Allocations can be based on consumer preferences and existing endowments, or on an objective social welfare function, such as cost per life saved or real social returns to human capital investments. Both of these approaches are problematic. The former simply assumes that market allocations are just and offers no ground for moral criticism, and the latter places no value on deliberative procedures and on actual preferences, which might or might not prioritize welfare and material well-being. But they have the virtue of being clear and calculable. Rights based approaches do not offer an explicit metric for making tradeoffs, and are in fact premised on the incommensurabilty of human dignity. That is why some argue that rights claims should be used sparingly; otherwise, it becomes necessary to compare the relative importance of rights, which is a logically thorny, and perhaps fallacious, exercise. It is true that some aspects of health care and education, such as skilled attendance at birth and literacy, can be identified as more fundamental to agency, social inclusion, and life chances than others, say contact lenses and earth science. But there are also countless close calls, both within and across sectors. As a result, from a rights perspective, there are always ambiguous tradeoffs, and recommended allocations are not robust to small changes in

circumstances.[6] Sorting out the various claims and counterclaims in a large population is, from the rights perspective, inevitably an activity without a formula, and one that relies on judgment guided by principle, a faculty that theorists have variously called practical wisdom, casuistry, pragmatism, or reflective equilibrium. But precisely because no formula is available for making tradeoffs, and because ambiguities in tradeoffs stem both from inevitable disagreements about priorities and lack of information about the priorities that people actually have, fair procedures that adjudicate claims according to principles of representative self-government are critical. Those procedures might in turn entail a collective decision to employ DALYs, net present value of human capital investments, or some other welfare function; but the justification for the use of any welfare function would not be independent of the adequacy of the political procedures and principles of the society. As a result of complexities like these, when making policy proposals, rights advocates tend for the sake of simplicity to fall back on modest versions of social rights—the right to subsistence, basic education, and minimal health—and argue that even these are not available in developing countries, and that, globally, resources are available to provide them without being forced to make vexing tradeoffs.

The second tough problem that economic analysis poses for rights involves the behavioral distortions associated with subsidies. If a rights approach leads to subsidies or otherwise more easily accessible services for at least some individuals or groups, those who receive the (implicit or explicit) subsidies will spend less of their own money on the services, with the result that the government or the actor supporting the services buys them at a higher social cost than it anticipates. In health care, providing anti-retrovirals for HIV patients will, to some extent, encourage risky behavior and reduce the effectiveness of prevention efforts. To take a different example, the more strictly a state regulates the adoption process, on the understanding that it is protecting the well being of potential adoptees, the larger the numbers of prospective parents who will be deterred by the regulatory costs, leading to larger numbers of children who are not adopted. The general problem is that subsidies change relative prices, which in turn changes the decisions that individuals make. Economists charge that rights advocates ignore these reactive behaviors, which might in some cases be large enough to undermine the right that the policies are deigned to promote. It is a fair criticism. On the other hand, rights advocates note that unanticipated behavioral changes that lower social costs can also follow from subsidies. For example, after Brazil, India, other countries, NGOs, and others

[6] Allocations are also ambiguous because they not only favor some services over others but some people over others. The claims of any person to health or education services are always broader than her membership in any group, including the poor, the socially excluded, those afflicted with a particular disease or condition. His or her moral claims might also involve how the person came to have the need. For instance, deprivation as the direct result of negligence or malfeasance, as a result of military or other national service, or as a consequence of oppressive family or political circumstances, all affect the claims independently of being poor or socially excluded.

started to argue for the right to right to anti-retrovirals, surprising pressure to lower prices worldwide resulted. When Uganda abolished user charges in schools, enrollment increases exceeded expectations because the move established a new norm that everyone deserves to go to school. Responses associated with subsidies can have perverse effects, but in other instances making something a right can affect norms and customs, resulting in large and positive changes in household behavior.

5. Conclusions

Rights are an increasingly important component of international development discourse. At the same time, are also subject to a number of criticisms. In reality, the criticisms both over- and underestimates the claims that right advocates make. They overestimate the claims because most accounts of social rights interpret them as goals and moral ideals, not as legally binding constraints on the policies and programs of governments and international agencies. Most also hold that rights cannot be realized at once, and that the provision of services can take several forms. The criticisms underestimate the claims because they fail to recognize the enormous rhetorical importance of rights, both at the international level and within developing countries, and the role they have played in the mobilization of social movements, professionals, and others in the expansion of education and health care services. Whether founded on secular or religious principles, the doctrine of rights underscores that every human being is worthy of respect, deserves to live with freedom and dignity, and that both political institutions, such as slavery, and external circumstances, such as abject poverty, and can deprive people of freedom. A rights orientation strengthens the position of individuals to obtain information, avail themselves of service delivery options, organize local institutions and civil organizations, and to pursue judicial redress in domestic courts where necessary. Interestingly, the policy consequences of rights overlap considerably with a modern economic approach to the provision of health care and education, which emphasizes the importance of mechanisms of accountability and empowerment, such as participation in decisionmaking and access to information, for the achievement of welfare outcomes. Both the rights and the economic approach are skeptical that electoral politics and de facto market rules by themselves provide sufficient accountability for the effective and equitable provision of health and education services, and that further intra-sectoral reforms in governance, particularly those that strengthen the hand of service recipients, are needed.

There remain differences between economic and rights-based approaches. An economic approach highlights the need to make tradeoffs and offers a metric for doing so. A rights based approach emphasizes the need to look at welfare outcomes for all individuals and groups, especially among those legally and culturally disadvantaged. A rights based approach, particularly one that focuses on the capabilities that people

actually have, takes seriously a consideration that economics internalizes with difficulty: that long-term deprivation robs individuals of the ability to avail themselves of health care and education services even when they are available. In the rights approach being treated with respect, which might entail a strong notion of equality of opportunity, is itself a development outcome as significant as material well-being. Finally, both the economic and rights approaches recognize unanticipated responses to government support, though typically in different directions. But there is still a large degree of overlap in many of their practical policy consequences, and advocates of the approaches need not regard each other as antagonists.

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