Social Rights and Economics: Claims to Health Care and Education in Developing Countries

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Summary. — The paper analyzes rights-based and economic approaches to the provision of health care and education in developing countries. It assesses the foundations and uses of social rights in development, outlines the economic approach to health care and education, highlights differences and similarities, and assesses the hard questions that the economic critique poses for rights. The paper argues that the policy consequences of the approaches overlap considerably. Differences include the consequences of long-term deprivation, metrics for tradeoffs, and the behavioral distortions of subsidies. But the differences are not irreconcilable, and advocates of the approaches need not regard each other as antagonists.

1. 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. 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. Ninety-five, moreover, stipulated free education and 29 free health care for at least some population subgroups and services.

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, when a national law initiated a program of universal access to highly active anti-retroviral therapy (HAART) for AIDS patients, free of charge. Partly as a result, in major Brazilian cities AIDS deaths have dropped sharply, falling over 40% during 1997–02. The program is costly: even after prices declined 48% from 1997–01 as a result of generic production and government pressure, drugs alone still cost the government $2,530 per patient for 113,000 patients on HAART in 2001 (Ministry of Health of Brazil, 2002). Meanwhile, many basic antibiotics remained too expensive for or inaccessible to millions of citizens.

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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 advocates contend that the Brazilian program is based on a constitutional guarantee and an explicit human rights orientation, prevents at least some Brazilians from dying prematurely while the country possesses the resources to save them, and more generally illustrates why health care is not a mere "commodity." On the other, economists argue that to the degree that providing those drugs displaces private expenditures, it is merely an income transfer; that AIDS treatment might be a lower priority than other health initiatives that could save more lives at lower social cost, such as disease prevention and the provision of clean water; and that, more generally, without the information that prices convey health care 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.

This paper will argue that the disagreements between the approaches are not as large as they appear, and that with regard to practical policy consequences for health care and education, rights advocates and economists are not far apart. Both approaches recommend wider access to information, more local organizations for clients, stronger advocacy, and changes in sectoral governance. The goal of both approaches is to strengthen the position of service recipients. Still, there remain differences. 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. This paper argues, however, that even in these areas the differences are not irreconcilable. More difficult to reconcile are issues that emerge from two 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?

Although other moral entitlements and immunities, such as subsistence rights and the right to physical security, have obvious relevance for health and education outcomes, this paper focuses on the direct rights to health care and education services. Moreover, it addresses only some of the most common approaches: it is impossible to do justice to the vast literature on these topics in a short space. Section 2 assesses the foundations and uses of social rights in development. Section 3 outlines an economic approach to improving health and education service provision. Section 4 highlights differences and similarities. A Section 5 draws inferences for policy work in these sectors in developing countries.

2. SOCIAL RIGHTS: FOUNDATIONS, USES, AND CRITICISMS

Genealogically, the concept 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. 3 There is a lively debate about whether this historical relationship necessarily makes the existing human rights regime parochial; but one can argue that the regime can in fact be built on a variety of philosophical foundations. 4 There are "plural foundations" (Guttmann, 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 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. It is arguable, moreover, that human rights do not have, and do not need, any particular philosophical foundation: they might be a "freestanding moral idea" (Nussbaum, 2000a, 2000b) or a "common agreement" that constrains institutions, describes goals, and furnishes the grounds of political criticism (Beitz, 2001).

As the preceding paragraph indicates, the theoretical issues surrounding human rights are complex, and this paper can only illustrate a
few of the principal concerns. One key issue is what counts as a right. The list of possibilities is long but can be distilled into five types: personal rights (life, liberty, security, property, conscience); legal rights (due process, equal protection under the law); political rights (participation, suffrage, assembly); social and economic rights (standard of living, employment, health care, education, nutrition); and collective rights (ethnic self-determination, minority rights).

Secular justifications for social rights, such as health care and education, are the concern of this paper, usually depend on the selection and defense of a set of basic needs, primary goods, or essential human capabilities. The key difference between an approach based on human needs or primary goods and one based on capabilities is that the latter recognizes that different people need different levels of resources: a disabled person, for instance, needs more resources to function in society than someone who is not disabled.) There are at least two general approaches to establishing social rights. In the first, which emphasizes human agency, it is argued that in a fully human life a person makes important decisions, such as 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, and that abject poverty, disease and disability, and illiteracy and ignorance can so impair a person’s ability to imagine and realize plans that her own human life fails, in an important way, to be realized.

Disease and ignorance are akin to enslavement in the sense that those afflicted cannot experience themselves as beings whose lives as significant.

The second approach, which emphasizes human dignity, emphasizes not falling victim to fate but being left in that condition by one’s fellow citizens. It points out that 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. Being denied education and health care, then, is tantamount to being excluded from modern society, with its attendant social and psychological consequences. The rights to health care and education become elements in the “social bases of self-respect,” which Rawls (1971, 2001) defines as perhaps the most important of his “primary goods.” Closely related are Sen’s notion (drawing on Adam Smith) of “the ability to appear in public without shame” (Sen, 1999) and Feinberg’s idea that “having rights enables us to ‘stand up like men,’ to look others in the eye, and to feel in some fundamental way the equal of anyone” (Feinberg, 1997). There can also be, of course, religious foundations for broad access to health care and education, such as commandments to love one’s neighbor or engage in charity, as well as communitarian approaches (De Bary, 2000; Rouner, 1988).

Some critics of social rights fear that an expansive list causes “rights inflation” and cheapens “genuine” human rights, particularly the rights of the person (Ignatieff, 2001). Others contend that guaranteeing minimal income, health care, and education necessarily entails large government, or even socialism. Political and philosophical concerns such as these have partly 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). Again, the arguments are complex; but one can show that for their fulfillment all rights require restraint, protection, and aid from the entity from whom rights are claimed, and that a reasonably effective and well funded state is a sine qua non for all rights (Holmes & Sunstein, 1999; Shue, 1996).

In addition to these theoretical difficulties with social rights, a practical objection concerns judicial enforcement. Because education and health care services involve considerable discretion at the point of delivery on the part of numerous independent providers, and because they entail a large number of transactions (Pritchett & Woolcock, 2002), it is difficult for courts, the entities to which claims of rights violation are typically taken, to determine whether a given student or patient is being denied his right to education or health care. 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 school management, financing, and politics were so intertwined that remedies, such as court ordered bussing, affected the entire educational system in ways that could not be determined in
advance. As a result, in some cases courts had to operate school systems themselves, which in turn created a backlash that weakened the educational rights of black students (Hochschild, 1984). Judicial remedies for social inequalities would be even more difficult 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 legal systems in most developing countries are inequitable and underdeveloped and that enforcement mechanisms are weak, allowing citizens to make legal claims of inadequate service provision will further politicize courts, weaken their capacity to adjudicate existing rights, and possibly increase government spending even where it is inequitable or inefficient.

If understood not as binding constraints but high priority goals, rights to health care and education can be meaningful and useful (Feinberg, 1973; 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 on behalf of individuals, or to restructure institutions so that the rights can be fulfilled more effectively (Pogge, 2002). 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, moral pressure, and, in egregious cases, justifiable external intervention (Beitz, 2001). Failure to pursue actions in pursuit of the goals might also raise serious issues concerning the legitimacy and long-term stability of governments and international institutions because social rights have become 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. The fact that no one actor bears responsibility for them means that coordinating a response might be difficult, but, as Sen (1999, pp. 230–231) notes, they remain rights nevertheless: “But is surely possible for us to distinguish between a right that a person has which has not been fulfilled and a right that the person does not have.”

On this view, the problems of adjudicating what exactly the rights to health care and education entail and how to ensure their attainment is affected, and appropriately so, by political processes within countries. This might mean that standards of health care and education, as well as the means of delivery, vary from place to place. It is possible, however, 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. 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 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, make 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 UN 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” (Declaration on the
Right to Development, 1986, cited in Marks, 2001). From the perspective of human agency, certain social 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, because they provide essential physical and cognitive infrastructure; but reason and self-understanding in turn facilitate the articulation, assertion, and defense of social and political rights. Where a society supports education, for example, a woman is more likely to understand a clinical diagnosis, demand appropriate treatment, and complain if her health needs are not met; but reasoning ability and rhetorical skills also help position her to organize and participate in community oversight of clinics and schools. There is a parallel argument from the perspective of dignity: individuals for whom social rights are fulfilled are more likely to consider themselves fully equal participants in decision making, both within the household and outside it, and are therefore emboldened to speak and organize in defense of their social rights. 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 multidimensional, changes over time, and is unreliably reported. In addition, there are 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 & 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, a measure of long-term nutrition, and income even among uneducated Brazilian men and women (Thomas & 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 & 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, & 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, Tonglet, & Lerberghe, 1998), and compelling arguments that publicly provided and financed health care services were important in mortality declines in some countries (Johansson & 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 can take the form of the direct financing of hospital care (Filmer, Hammer, & Pritchett, 2002).

The evidence for the impact of education on private wages is more strongly established. Calculations of the annual private returns to educational investments average about 6% in industrialized countries and 11% in developing countries (Psacharopoulos, 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 & Spiegel, 1994; Bils & Klenow, 2000; Pritchett, 1996). But a study that measures labor force quality, based on international mathematics and science test scores, finds that is strongly related to national growth rates (Hanushek & 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. 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 health care workers, who necessarily have large discretion in decision making, therefore make it hard for consumers to assess quality.

For reasons such as these, 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 are a variety of mechanisms through which health and education service delivery can be made more accountable to clients. These include (a) strengthening citizens’ power with respect to providers, either by granting them authority over or participation in health and education facilities or by allowing them more market choices; (b) making contracts between government and frontline providers explicit, so that provider performance is linked to rewards and sanctions; and (c) 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 river blindness 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 Brazil and 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 health care and education. From the perspective of social rights, participation, empowerment, transparency, and accountability in service delivery are important for ensuring health care and education quality; and in some forms, such as 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, they are also constitutive of the kind of social respect that is critical for self-esteem. From the economic perspective, participation, empowerment, transparency, and accountability 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 suboptimal because the quality and cost of education and health care (particularly health insurance) are related to who else is one’s school or health care program, which leads people of similar backgrounds to sort themselves into the same schools or programs.

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 both view political systems, including electoral democracies, skeptically. 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 such as 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, clientelist, 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 & 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 decision making and monitoring. One solution to the aggregation problem involves group deliberation and the development of trust (Dryzek & 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 decision making 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, the processes of service delivery are critical in the economic approach, even if 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. If systematic discrepancies appear among large populations, rights advocates take this as evidence that services are unavailable or inadequate for some groups. Typically, the rights approach views these discrepancies as direct evidence of inequality, 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 weaken their agency and the social basis of their self-esteem. Economists, of course, are also concerned with the distribution of outcomes. But usually, 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 normative concern for excluded groups, or with the development of new behavioral assumptions regarding women or ethnic groups.

Third, rights approaches accommodate adaptive preferences. Some constraints to the fulfillment of rights are external. For example, many cannot afford the direct or opportunity costs of schooling, 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. Especially in the guise of the capabilities framework, rights approaches emphasize, in addition to these, constraints internal to individuals, such as 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. Still, the approaches 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 incommensurability of human dignity. 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. 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. Because ambiguities in tradeoffs stem from disagreement about priorities, and not only from lack of information about the priorities that people already 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, some rights advocates tend for the sake of simplicity to fall back on modest versions of social rights, such as the right to subsistence, basic education, and minimal health, note that even these are not available in developing countries, and argue that, globally, resources are available to fulfill at least some basic rights without having to confront the most 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 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, or will engage in more costly activities (moral hazard), with the result that the government or the entity supporting the services will buy them at a higher social cost than anticipated. In health care, providing HAART for HIV patients might, 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 greater the number 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 designed 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, nongovernmental organizations (NGOs), and other actors started to argue for the right to HAART, surprising pressure to lower prices worldwide resulted. When Uganda abolished user charges in schools, enrollments increased far beyond expectations because the move established a new norm that everyone deserves to go to school (Deininger, 2003; Economist, 2001). 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 desirable changes in household behavior.

5. CONCLUSION

Rights are an increasingly important component of international development discourse. At the same time, they are also subject to a number of criticisms. In reality, the criticisms both over- and underestimate the contentions of rights advocates. They overestimate the contentions because most accounts of social rights interpret them as goals and grounds for moral criticism, not as legally binding constraints on the policies and programs of governments and international agencies. Most accounts also hold that rights cannot be realized at once, and that the provision of services can take several forms. The criticisms underestimate the contentions of rights advocates because they fail to recognize the enormous rhetorical importance of rights, both at the international level and within developing countries, and their historical role in the mobilization of social movements, professionals, and others in the expansion of education and health care services. Although there remain significant differences between a rights based approach and an economic approach to health care and education, particularly regarding the issues of long-term deprivation, tradeoffs, and the behavioral effect of subsidies, their policy consequences overlap considerably. Both 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 intrasectoral reforms in governance, particularly those that strengthen the hand of service recipients, are essential.

Three implications for development policy follow. First, the analysis shows that not only are sectoral reforms that strengthen the bargaining positions of students, families, and patients useful for enhancing service delivery, but that, because they are constitutive of the social basis of self-respect, they are intrinsically valuable. Seen this way, existing efforts to restructure sectoral governance in health and education become even more important. Second, the analysis highlights the problem of internal constraints, and particularly the
tendency for people accustomed to deprivation to lower their expectations, for the achievement of health and education outcomes. Initiatives to augment information and participation in health care and education could also, as Appadurai puts, incorporate efforts to enhance the "capacity to aspire" (Appadurai, 2004). Third, the analysis shows that, in typical formulations, both the economic and right-based approaches ignore behavioral changes that might follow interventions: the right-based approach can miss the effects of subsidies, and the economic approach can fail to anticipate discontinuous changes following the emergence of new norms. The identification of the potential, unforeseen consequences of policy change remains critical both for development research and practice.

NOTES


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 subgroup 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. The later a constitution was written, the more likely it incorporated a right to education (correlation = 0.22) and a right to health care (correlation = 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.


4. For discussions of the parochialism of human rights from the East Asian perspective, see Bauer and Bell (1999).


7. An argument of this kind is found in Nussbaum (2000a, 2000b). Somewhat similar is Shue (1996), who argues that basic subsistence is essential to the exercise of human capacities; see also O’Neill (1986, 2000).

8. As Walzer (1993, p. 87) 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.

9. This disagreement was acute during the Cold War, leading to the bifurcation of the international instruments meant to codify the Universal Declaration of Human Rights into one on economic, social, and cultural rights, and another on civil and political rights; see Lauren (1998). Libertarian critics contend that only restraints are justified because taxation for the purposes of economic re-distribution or social support amounts to unjustified taking; see Epstein (1998) and Nozick (1974).

10. 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, 2000a, 2000b). 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.

11. 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, or 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.

REFERENCES


