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Reframing child rights to effect policy change

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ABSTRACT

Background: Much of the discourse surrounding children's advocacy in the United States relies on a rights-based approach. We argue that this approach has limitations that impede progress in advancing children's well-being.

Purpose: The purpose of this article is to explain alternatives to a rights-based approach in advocating for children, such as developmental, economic, capabilities, and mutualism frameworks.

Methods: Our analysis is based on the independent work of two separate university-based groups studying children's rights; the authors were each members of one of the groups and subsequently integrated their findings for this article.

Discussion: US policies for children, especially in the domains of health and education, depict an unevenness that results in many children failing to receive certain critical services and benefits. Relying on a rights-based approach to correct these disparities and inequities is contentious and has yet to sufficiently change state and federal policies or improve children's health outcomes. Other approaches are needed to advance children's well-being.

Conclusion: Nurses individually and collectively need to be mindful of the pitfalls of a rights-based approach and use other frameworks in advocating for children and youth.

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Introduction

Much of the discourse surrounding children's advocacy since the 1960s relies on a rights-based approach, which states that children are entitled to specific rights such as health care, food, and shelter. We argue that the rights-based approach has limitations that impede progress in advancing children's well-being and we propose alternative strategies. We contend that advocates for children in the United States rely too much on a rights-based approach to improve the well-being of children and need to expand their framing of the complex relationships and concepts needed to advocate for children.

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The purpose of this manuscript is two-fold: (a) to explain the limitations of a rights-based approach to advocacy for children and youth in the United States and (b) to offer strategies that might augment the rights-based approach, or serve as an alternative, when appropriate. We start with an overview of the status of children in the United States to substantiate why advocacy for children is so important. Second, we provide a brief overview of the United Nations Conference on the Rights of the Child (UNCRC) and offer explanations of why the United States is the only country yet to ratify it. Third, we discuss limitations to a rights-based approach and propose alternative tactics and frameworks. Fourth, we present legal and historic precedents of childhood so as to understand some of the legacies that persist today. We then illustrate how state and federal policies affect children's well-being and outcomes by examining education and health care policies for children. We conclude with implications of our analysis for nursing practice and scholarship.

Our analysis is based on a synthesis of findings from two groups of the authors working on child rights without knowledge of the other. In the early 2000s, three of the authors were members of an interdisciplinary work group on child rights under the auspices of the Yale Interdisciplinary Center for Bioethics. Two of the three were co-leaders. Based on presentations from scholars in health care, bioethics, law, education, and other disciplines, the authors identified cross-cutting themes and conferred with bioethics scholars. They also reviewed literature on child rights from the disciplines listed above and drafted a paper for dissemination. Coincidentally, several years later, one of the other authors started studying legal issues pertaining to child rights and reached similar conclusions. When the two groups learned about each other's work, they compared and synthesized findings and developed this manuscript.

Status of Children and Youth in the United States

The United States "is a country that professes to care about children at their youngest and fragile" (Lowrey, 2018, para 3). But many of the U.S. child health outcomes are unsatisfactory (Caplan & Hotez, 2018), especially given the wealth that abounds across the nation. In 2016, the United States child poverty rate was 18%, which although a decrease from previous years, (Federal Interagency Forum on Child and Family Statistics, 2018) is still higher than most other countries in the Organization for Economic Cooperation and Development (Lowrey, 2018). In 2016, 18% of children lived in households that were classified as "food insecure" (Federal Interagency Forum on Child and Family Statistics, 2018) and 62% of children age 17 and younger lived in counties with pollutant concentrations above the levels of the current air quality standards (Federal Interagency Forum on Child and Family Statistics, 2018). Opioid use and misuse among youth 18 and younger, along with emergency department visits for youth this age, increased between 2006 and 2012. Most of the visits for youth age 15 to 17 were due to intentional poisonings (Federal Interagency Forum on Child and Family Statistics, 2018).

Unsatisfactory indicators of child well-being in other areas and disparities in relevant outcomes among children of different races and ethnicities (Annie E. Casey Foundation, 2018; Villarosa, 2018,) substantiate the urgent necessity of political action. This is especially true if one considers how children's patterns of health behavior set the stage for adult development (Halfon & Hochstein, 2002). Simply put, if children are not healthy, they cannot learn and develop into productive adults. If one also considers the costs that infant and childhood morbidity and mortality impose on individuals, families, government, and private entities, one could argue that the State has a compelling interest in ensuring that all children have access to health care.

United Nations Convention on the Rights of the Child

Most scholarly discourse on children's rights since the late 1990s includes the United Nations Convention on the Rights of the Child (UNCRC), which the United Nations unanimously adopted on November 20, 1989. After significant delay, the United States joined most of the world's nations in signing the UNCRC in 1995. But since October 2015, the United States has been the only nation that has not ratified the document (Convention on the Rights of the Child, 2018).

This laggard behavior on the part of the United States can be explained by a belief among many interest groups, individuals, and policymakers that the convention interferes with sovereign jurisdiction over domestic policymaking. That is, it restricts a government's rightful control over the laws and policies within its jurisdiction. Other United States opposition to the UNCRC comes from those, mostly political conservatives, who oppose federal regulation and expansion of the federal bureaucracy. It is a notion reinforced by our country's historical resistance to the State's interference in family life (Developments in the law: The Constitution and the family, 1980), and which is frequently reflected in domestic, as well as international, policymaking. Finally, discussions about children's rights, generally, and the UNCRC, specifically, often raise questions about the rights of parents compared to the rights of children.

Caplan and Hotez (2018) claim that these unsatisfactory outcomes arise from "failure to heed established scientific evidence in lieu of ideological or personal beliefs" (p. e3000010). This is not surprising because ideological claims, along with power and political arguments, often override valid evidence in

determining the winners and losers of policy debates (Baumgartner, Berry, Hojnacki, Kimball, & Leech, 2009; Patashnik, Gerber, & Dowling, 2017).

It is beyond the scope of this paper to discuss the pros and cons of the UNCRC or why the United States did not ratify it. Our main point is that the United States's failure to ratify the UNCRC should not be as an explanation for: (a) why so many children fare poorly in this country and (b) why a rights-based approach is needed to improve children's outcomes.

Limitations of and Alternatives to a Rights-Based Approach

Although nurses and other advocates use a rights-based approach in advocating for improvements in population health, there are downsides to this strategy. We focus on the limitations specifically as they apply to children. But it would be wrong to criticize the rights-based framework without offering alternatives, which we do at the end of this section.

Limitations of a Rights-Based Approach to Children

There are several reasons why a children's rights focus may not be politically expedient. Many Americans, particularly conservatives, find the mere mention of children's rights problematic. George Lakoff's explanation for the difference between liberals and conservatives across many issues, including child rights, is that conservatives frame policy through a paternalistic lens and liberals use a more nurturant framework, which is at times problematic and even contradictory. He raises questions about the rights of individuals and groups, such as criminals, who might harm others, such as children.

Hence, as Lakoff writes:

How can liberals claim to favor the rights of children, when they champion the rights of criminals, such as convicted child molesters? How can liberals claim empathy for victims when they defend the rights of criminals? (Lakoff, 2016, p. 26).

For conservatives, a moral code of right and wrong ensures that parents, not governments, make decisions about what's best for children. Hence, the UNCRC and any state or federal policies that might enforce it run counter to staunch conservative beliefs in limited regulation and the primacy of the family in children's lives. Using an approach that large numbers of Americans reject out-of-hand is not likely to prove successful, especially at present with a conservative populist president (Donald J. Trump) and a conservative Republican majority in the Senate.

A rights-based approach also fails to account adequately for the reciprocal nature of rights-based relationships—their reliance on a dyad. One person's rights are closely tied to another person's entitlements. Alstott (2004), in her book, *What Parents Owe Their Children and What Society Owes Parents,* argues that all children have a need for and are entitled to continuity of care, which parents are obligated to provide. Parents, thus, are "bound to their children; they have an obligation not to exit" (Alstott, 2004, p. 47). At the same time, society is bound to parents in that it must find ways to support parents while they provide the best support possible to their children. Fundamental to any rights-based approach is consideration of obligations to others. Regarding children, the rights-based approach requires that parents and society give themselves so that children receive the care needed to grow and thrive.

Fourth, rights-based language can pit the needs of one group of children against those of another. With limited public funds, deciding how best to prioritize services among children at various levels of family income or educational achievement, or with certain illnesses, disabilities, or with language, racial or other cultural identities can engender competition among groups of children (and their political proxies)—clearly an undesirable political and ethical scenario. In such a contest, what determines winners? Those whose parents speak the loudest? Have access to the most financial resources? Or, those whose advocates are aligned with the most influential policy entrepreneurs?

Multidisciplinary Considerations and Alternative Approaches

Alternatives to the rights-based approach build on other disciplines, such as child development and economics. Some of these approaches are mutually exclusive and others depict combinations of different disciplines and ideas.

Developmental Framework

The children's rights framework emerged from an acknowledgment of the importance of the developmental process and inherent dependency, which is muted under strident aspects of a rights-based legalist approach. Copious multidisciplinary research continues to support that early life exposures influence health and wellness trajectories across the life course (Halfon & Hochstein, 2002; Halfon, Larson, Lu, Tullis, & Russ, 2014). Perhaps it is time to return the rights-based approach to its "developmental roots" and demonstrate how children face certain vulnerabilities, depending on their stages of development. Thus warranting policies for their well-being and protection.

Seminal research by Felitti et al. (1998) on adverse childhood experiences and Marmot et al. (1991) on social determinants of health support that early life experiences shape in adult health. In addition, a

growing body of research in neurobiology demonstrates that childhood exposure to toxic stress yields damaging and permanent changes to brain structure and function (Shonkoff & Garner, 2012).

The proportion of children of different racial and cultural backgrounds who have had at least one adverse childhood experiences varies: 61% of Black non-Hispanic children, 51% of Hispanic children, 40% of White non-Hispanic children, and 23% of Asian non-Hispanic children. Nationally, nearly half of all children have had some type of adverse experience (Sacks & Murphy, 2018).

The legal doctrine of *parens patriae* embodies a developmental framework in that it recognizes that children's immaturity requires special protection, either from parents, or when parents are unwilling or unable, from the State. In a developmental framework "best interests of the child" might be defined based upon developmental level. The life course health development framework posits that health disparities originating in childhood perpetuate poor health trajectories across the life span and that negative exposures during critical points during the life span can be mitigated via positive protective factors (Burke-Harris, 2018; Halfon et al., 2014; Mistry, 2012; Shonkoff & Garner, 2012). Viewing children's rights with a developmental or a problem-solving perspective is less contentious than a rights-based approach and garners support across health science, education, legal, public health, and other arenas.

Economics Framework

Economic arguments have been increasingly used in efforts to enhance investments in education, child care, and child health. Nobel Laureate economist James Heckman has focused his work on measuring the short- and long-term economic effects of early childhood programs. Heckman focuses on investments in the critical "sensitive" periods of early childhood. Health investments within these periods lead to compounded gains in both health potential and health reserves. Heckman and his team showed how "high quality birth to five programs for disadvantaged children can deliver a 13% return on investment" (Heckman, 2017, p. 1). Other studies have also shown that investing in early childhood programs, such as the Nurse–Family Partnership, can improve children's outcomes and produce economic returns (Cannon et al., 2017; Nurse-Family Partnership, 2018).

Economic approaches have the benefit of engaging the business community and others from the private sector. This widens the community of participants involved in policy deliberations for children. Disadvantages of the economic framework are that it can lead to policymakers viewing children as a means to an end (e.g., a more productive workforce, reduced government spending) for the benefit of society as a whole or certain segment of the child population, rather for the greater good of all children and youth.

Capabilities Framework

Much of the language surrounding children's rights, especially regarding education, is reminiscent of Nussbaum's capabilities approach in that it addresses not only what children can do today, but also their right to develop to the best of their potential (Dixon & Nussbaum, 2012; Nussbaum, 2006). Nussbaum (2006) describing 10 central human capabilities: life, bodily health, bodily integrity, senses/imagination/thought, emotions, practical reason, affiliation, access to other species, play, and control over one's environment asserting that these are "central to a life of dignity…as an account of minimum core social entitlements" (p. 75).

Basing her work on John Rawls's notions of social justice, Nussbaum contended "a society that neglects one of [the capabilities] to promote the others has short-changed its citizens…." (p. 75). Nussbaum explained the universal appeal of her capabilities approach, which distinguishes it from others, especially one based on rights. "[P]eople differ about what the *basis* of a rights claim is…and whether the rights are prepolitical or artifacts of laws and institutions" (p. 285). In contrast, capabilities are "prepolitical" and deal with people on the basis of their birth into the "human community" (Nussbaum, 2006, p. 285).

Although the capabilities approach applies to all individuals and living things (even nonhuman animals) Dixon and Nussbaum (2012) and Ilea (2008) identify two situations when children warrant special priority over adults. The first is when children are particularly vulnerable because of "their legal and economic dependence on adults, as well as their inherent physical or emotional vulnerability" (p. 554). The second is "where the marginal cost of protecting children's rights" is so low that not protecting them "would be a direct affront to their dignity" or where the cost-effectiveness of protecting a child's rights far exceeds protecting the "equivalent right for adults" (p. 554). Dixon and Nussbaum also explain that there are situations when limiting parents' and other individuals' rights and freedoms are important "to protect the future rights or capabilities of children" (p. 554). Hence, the capabilities approach to children's rights is more nuanced than the social contract framework of human or children's rights and provides an important framework for action.

A Mutualism Framework

Murray (1996) addressed child rights in the context of family relationships (choices about having children, caring for children, meeting children's needs). He

viewed language of rights as an ill-fitting ethic for the family.

Instead, Murray suggested a model that acknowledges the benefits both child and parent reap from the well-being of each other. The nurturing of children and their growth and development has direct impact on the well-being of parents. He noted, "...there are circumstances in which we can further our own good only by working for the good of another..." (p. 62). This, Murray purports, describes the possibility that human acts can transcend both egoism and altruism, the two commonly ascribed motivations: "It is some inextricable blend of concern for other and concern for self" (p. 62).

Melton (2008) also recognized the "reciprocity of care" and noted that being conscious of another's rights tends to promote reciprocity of similar thinking. In Melton's words, "...when children ...are treated as members of the community, everyone's sense of worth increases" (p. 913). Although Murray was speaking in the context of parent–child relationships, both authors show an approach that can easily be applied to public systems. For example, investments in public recreational sports programs will improve children's health and teach social skills, provide parents with safe outlets for their children's energies, and engage the broader community who enjoy the entertainment of competing local sports programs.

Our discussion thus far has centered on the political, economic, ethical, and social aspects of children's rights and the status of children. Next, we turn to the legal and historical perspectives that have set precedents for policies for children in the United States.

Legal and Historic Perspectives on Childhood

The state of childhood is legally defined as until a child reaches the age of majority, which confers all the attendant rights and responsibilities of adulthood. Most states have laws that define the age of majority as 18 years. But criminal prosecution, medical treatment decision making, and emancipation are all instances where children can be assigned adult rights and responsibilities prior to reaching the age of majority. Children can be awarded the right to make other decisions if a court determines that the child holds a level of maturity appropriate to the type of decision (Abrams, Ramsey, & Mangold, 2015).

Historically, childhood is a relatively new concept. Until the early to mid-1800s, parents treated children as their possessions and expected them to contribute to the economies of the family unit. In the late 1800s, a combination of available labor (from European immigrants and African Americans migrating from the south to the north) and emerging acknowledgment of the importance of child development began to spark a critical eye toward conditions under which children lived (Feld, 1999; Imig, 2006).

Progressive era activists in the late 1800s to early 1900s fought for the welfare of children and the need for the State to take responsibility for them when parents did not. These advocates saw a "need" to advance children's education, safety, and well-being based on the vulnerabilities of childhood. They perceived children's access to services in these and other areas as rights or entitlements (Holt, 2012; Marten, 2014; Report to the president, White House conference on children, 1970; United States Senate, 1909).

Progressives' advocacy for children started in the mid to late 1800s. One of the major milestones was creation of the first juvenile court system in Illinois in 1899. In 1903, Lillian Wald and Florence Kelly came up with the idea of a federal children's bureau to gather and distribute information about children. As Wald stated, "If the Government can have a department to look out after the nation's farm crops, why can't it have a bureau to look after the nation's child crop?" (U. S. Administration for Children, Youth, and Families, (n.d.). Slide 1903.).

One of the staunchest advocates for children in the Progressive Era was Julia Lathrop, the first director of the Children's Bureau, established in 1912. The United States was the "first national government in the world to create an agency dedicated to the welfare of children" (Marten, 2014, p. 17). The Children's Bureau today is part of the Department of Health and Human Services, Office of the Administration for Children and Families. Its scope is narrower than when it was first created, perhaps because there are other federal agencies with children's programs in their purview. Perhaps children are not as high of a national priority as they were during the Progressive Era.

In the mid to late 20th century, interest groups and individuals concerned about children's well-being (and to some extent, their rights) fought for policies such as compulsory kindergarten education (Beatty, 1995), expanded child health coverage (Sardell, 2014), publicly sponsored child care (Cohen, 2001; Michel, 1999), and other issues (Skocpol, 1992). These issues continue be on state and national government agendas.

Education and Health Care

To illustrate how United States state and federal policies can affect children's well-being and outcomes, we provide overviews of education and health care policies for children in terms of recent history, major concepts, scope, target populations, and persisting challenges. We selected these two policy domains because of their interconnectedness and impact on children and youth through their trajectory as adults.

Education

The United States Constitution does not explicitly guarantee a right to an education (San Antonio Independent School District v. Rodriguez, 1973). If a state chooses to provide public education, the Equal Protection Clause of the Fourteenth Amendment requires that no child living in that state may be denied equal access to that education (Plyer v. Doe, 1982). In addition, each state has the responsibility "to legislate and monitor" its compulsory education policies, which require children in the state to receive education from early childhood through teen years (Findlaw, 2019).

Public education has been the battleground for legal fights over children's rights. By 1900, although most industrialized northern United States states had mandatory school attendance, many southern legislators remained reluctant to provide Black children with equal access to the educational system; a posture that persisted even in the wake of the landmark case, Brown v. Board of Education (1954). Although the 1964 Civil Rights Act (P.L. 88-352) facilitated the integration of southern education and entry of Black children into public schools (Eidenberg & Morey, 1969; Imig, 2006), implementation of that law was problematic. Persistent racial inequities contributed to gaps in achievement between children of different races for most of the 20th century and continue to present day (Noltemeyer, Mujic, & McLoughlin, 2012). For, example, in 2017, Black and Hispanic students' reading scores in grades 4, 8, and 12 were at least 20 points lower than their White counterpart (Musu-Gillette et al., 2017). Moreover, "there are significant achievement gaps between low- and high-income students on most measures of academic success" (National Education Association, n.d., p.2). These measures include high school and college completion rates, standardized test scores, and college enrollment rates.

During the civil rights movement of the 1950s to early 1970s, Congress passed and President Lyndon B. Johnson signed into law the first federal general aid for education—the 1965 Elementary and Secondary Education Act (P.L. 89-10). It signaled a major shift in the government's role in education, which heretofore had been solely the responsibility of state and local educational agencies (Congressional Research Service, 2017). The law, often considered a civil rights law, provided federal grants for elementary and secondary education to schools in under resourced communities. The most recent version of the Elementary and Secondary Education Act is the Every Student Succeeds Act (ESSA; P. L. 114-95), which President Barack Obama signed in 2015. It included the goal of "fully preparing all students for success in college and careers" (U.S. Department of Education, n.d.). ESSA reflected a consensus among policymakers, educators, and other stakeholders that reducing inequities among students in terms of access to and achievement of high-quality education was a national imperative. ESSA also had provisions for funding preschool. This reflected a growing interest and investment in universally available education for three and four-year-old children. They might all benefit from the developmental and other learning provided in such settings.

Contemporary Education Challenges

Widening disparities among communities and concern for low-quality public education have shifted the education system toward a "marketplace" approach (Egalite & Wolf, 2016), which has fostered the advent of multiple options for parents to select from including public, private, charter and virtual schools, and home schooling. Vouchers for funding education, including in faith-based settings, raised additional questions about the rights of parents to select their children's form of education and the child's right to be educated in a setting other than the local district school. Specifically, the viability of allowing public funds to finance education in faith-based settings raised questions about the First Amendment's Establishment Clause, which prohibits the government from making any law "respecting an establishment of religion" and government action favoring one religion over another.The Supreme Court has ruled that vouchers can be used for private, religious education (Zelman v. Simmons-Harris, 2002). More recently, that a public benefit should not be denied to an otherwise eligible recipient, such as a church affiliated school, solely on account of religious status was passed (Trinity Lutheran Church of Columbia, Inc. v. Comer, 2017), yet the issue remains a source of debate.

Education and the Rights of Children with Special Considerations

Children with Disabilities

The rights of children with disabilities warrant additional note because for approximately 50 years, they have been the only children who have had a federal statutory right to a free appropriate public education. In 1975, President Gerald Ford signed the Education for All Handicapped Children Act (P.L. 94-142) which guaranteed a free, appropriate public education (FAPE) in the least restrictive settings to children with disabilities, 3 to 21 years of age. Implicit in the law were requirements to improve identification and education of disabled children and provide due process protections for these children and their families.

Amendments to the Education for All Handicapped Children Act of 1975 were enacted in 1983 (P.L. 98-199), 1986 (P.L. 99-457), 1990 (P.L. 101-476) and 1997 (P.L. 105-17). The 1986 amendments strengthened state requirements for education for disabled children under age 5 and provided financial incentives for states to address education needs of disabled children from birth to age 2. The 1990 law changed the law's name to the Individuals with Disabilities Education Act (IDEA). In December 2015, Congress reauthorized the IDEA as part of the ESSA. (P.L. 114-95).

IDEA and Section 504 of the Rehabilitation Act of 1973

Under the IDEA, Congress required that children with disabilities have "access to the general education curriculum of the regular classroom" as much as possible. In 2004, Congress reauthorized the IDEA, replacing it with the Individuals with Disabilities Education Improvement Act (IDEIA) (P.L. 108-446), which had more stringent state requirements regarding rights of children with disabilities.

The IDEIA required states to ensure that children with disabilities be given the opportunity to perform as well as their peers (IDEIA, 2004). This means that school administrators and teachers need to provide education that will enable all children—including those with disabilities—to reap the benefits of learning together in the same classroom, while not compromising any one child's individual right to education or achievement goals. But the mandates of IDEA and IDIEA have not been fully resourced at the local level and few children access the supports they need without substantial effort and advocacy by their parents (see e.g., Endrew F. v. Douglas County School Dist. RE−1, 2017).

Mechanisms to Enforce Disabled Students' Rights to Free and Public Education

Two federal laws guide school officials in working with parents of eligible disabled students in elementary and secondary schools: the IDEIA and the Section 504 of the Rehabilitation Act of 1973 (PL 93-122). Under the IDEIA, school administrators must provide disabled students (age 3−21) with an individualized education plan developed with an interdisciplinary team of specialists working in partnership with parents. An individualized family service plan provides similar services for children two and younger. "Under the IDIEA a child with a disability means a child who has been evaluated in accordance with IDEA requirements as having a specified disability and to need special education and related services because of that disability. The IDEA and its implementing regulations include 13 disability categories" United States Department of Education, Office of Civil Rights, 2016, p. 42).

Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act (referred to as "Section 504″) prohibits discrimination on the basis of disability. The law guarantees that individuals who "have a physical or mental impairment that substantially limits a major life activity or bodily function" (United States Department of Education, Office of Civil Rights, 2016, p 0.42) have equal access to a free, appropriate public education. Schools must provide aid such as assistive devices and other modifications or services to enable eligible students to learn. Although Section 504 eligibility is much broader than eligibility for IDIEA, fewer procedural safeguards are available to the child with a disability and their parents than under IDIEA.

Although the federal provisions described above create legal entitlements for children with disabilities and certain impairments, navigating the maze of federal regulations and other directives for implementing them is often a complicated process. Local differences in personnel funding and other resources, including state Medicaid support, combined with variations in family culture and capacity, means that despite the right to a free and appropriate education in the least restrictive setting, disabled children often are unable to assert their rights.

Health Care

Children are developmentally vulnerable, experience different patterns of morbidity and mortality than those of adults, and remain dependent on assistance from adult caregivers and communities to access and receive health care services. As a result, for children, health care differs contextually from other policy domains. Children must rely on "advocacy by proxy" measures to attain policymakers' interest and attention (Fellmeth, 2011).

A Child's Right to Self-Determination

In the United States "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law" (*Union Pacific Railway Company v. Botsford*,1891, p. 251). This right of self-determination, along with a right to informed consent and the constitutional right to privacy, are characteristically granted to competent adults. These undergird what can be called *health care rights*. Importantly, these rights require that that the person be an adult and be competent (Abrams et al., 2015). Thus, adults who are deemed competent are awarded the right to make medical choices rather than be subjected to unwanted interventions or treatments.

Whether a child's right to self-determination exists, under what circumstances, and how it might be effectuated becomes extremely complicated at the legal, ethical and philosophical juncture. Children have generally been considered incapable of providing informed voluntary consent, thereby lacking substantial ability to be involved in determining their own receipt or refusal of health care treatments (Abrams et al., 2015). Based on case law, however, many states allow minors to consent to treatment for sexually transmitted infections, including human immunodeficiency virus, care for the prevention or treatment of pregnancy or physical abuse, and obtain treatment or counseling for substance abuse (Abrams et al., 2015). Moreover, minors who show a court that they possess the maturity to choose or reject treatment despite their chronological age may be judged to be a "mature minor" and capable of consenting to treatment (Abrams et al., 2015).

Children's Access to Health Care

Health insurance coverage is a significant determinant of access to preventive care and treatment of acute and chronic conditions and injuries. The United States lacks a law or policy that provides for universal coverage of children. In contrast, almost all adults over 65 who are US citizens or legal residents are eligible for and receive Medicare coverage (Barry, 2016).

In 1965, Congress enacted Medicaid (Title XIX of the Social Security Act (P. L. 89-97). As a shared federal-state entitlement program, federal regulations require that all states provide Medicaid coverage for children whose families meet the income criteria set as a percentage of the federal poverty level. Over the decades, Medicaid has expanded the income eligibility levels and services provided. It remains an entitlement program (all those who are eligible have a legal right to receive coverage), functioning as the main source of insurance for approximately one-third of US children. As of April 2018, almost 51% of enrollees in Medicaid and the Child Health Insurance Program (CHIP) were children (United States Centers for Medicare and Medicaid, Medicaid.gov, December 2018). Even so, spending per child enrolled in Medicaid (not including CHIP) is predicted to increase by 5% between 2014 and 2023, whereas per enrollee Medicaid spending for adults for that same time is predicted to increase by 12.7%. Although some of this growth is related to covering the adult expansion population from the Affordable Care Act, it has also resulted in positive gains in coverage among their children (Hudson & Moriya, 2017). The emphasis on adult coverage demonstrates that health spending on children is not prioritized relative to other categories of the federal budget (Isaacs, Lou, Hahn, Ovalle, & Steuerle, 2017).

Historic trends in Medicaid (and CHIP) enrollment and spending for children since the late 1960s reflect national and state policy revisions at certain key junctures. The politics of these policy changes reveal how reluctant policymakers have been to provide universal child health coverage to children compared to the nearly universal coverage of older adults under Medicare.

In the first few months of 2018, President Donald J. Trump approved continued funding for the CHIP. Shortly thereafter, in response to conservative criticism of spending associated with the budget act, President Trump attempted to rescind $7 billion in CHIP funding (Acker, 2018). Although he received a cool response from Congress, the delays and partisan blame game surrounding CHIP reauthorization epitomize the dysfunctional approach to addressing child health and well-being in the United States Access to and coverage of child health care is simply not a fundamental right in the United States as it is in other countries. Nor, is children's access and coverage in the U.S. commensurate with coverage for the elderly in our country. What does this mean about a rights-based approach to advancing children's health, especially when legislators often approved child health policy expansions only because they were linked with other issues, such as funds for tobacco settlements or omnibus budget bills? (Sardell, 2014). Essentially, it shows the gaps in the premise that all children are entitled to health care and the challenges of defining what that care includes and how it should be financed.

Contemporary Challenges for Child Health Care

As Todres (2006) explains, without health, no other rights can be enjoyed, thereby making a child's right to health care contentious, but arguably most critical. This could also be argued within the context of education, as functional democracy requires an informed constituency.

Although the Patient Protection and Affordability Care Act (ACA; P.L. 111-148) focused primarily on adults, its significant reforms and subsequent effects on the health system directly and indirectly affect children's health care (Fry-Bowers, Nicholas, & Halfon, 2014). The ACA increased access to care for children by covering comprehensive preventive services with no cost sharing, eliminating exclusions for preexisting conditions, prohibiting lifetime dollar limits, extending dependent health benefits to 26 years of age, and expanding coverage to many previously uninsured parents.

To date, the ACA has survived court challenges and multiple repeal and replace attempts, many of which have also attempted to restructure Medicaid into a block grant program or institute per capita caps, proposals that conservatives have been pushing for decades. What might these proposals mean for the health of American children? Ninety five percent of American children currently have health insurance due to the

combined efforts of the ACA, Medicaid, and CHIP (Artiga & Ubri, 2017). Together, Medicaid and CHIP cover nearly four in ten children, overall, and 44% of children with special health care needs (Artiga & Ubri, 2017). Moreover, these programs are essential in addressing health inequity through coverage of more than half of all Hispanic and Black children (Coyer & Kennedy, 2013). Yet, inequities among children of different backgrounds persist.

Note, that as of February 10, 2019, the fate of the ACA remains uncertain. On December 14, 2018, a federal district court judge ruled the entire ACA unconstitutional (*Texas v. Azar*). He later reaffirmed his decision but issued a stay and partial final judgment, which allows for the decision to be appealed. The law remains in effect as the appeal process continues. If the decision is upheld on appeal, every provision of the ACA, including those that impact children and youth such as Medicaid expansion, pre-existing conditions protections, limits on out-of-pocket spending, and coverage of comprehensive preventive services, as well as other consumer protections would be eliminated.

Summary of Education and Health Care Policies as They Pertain to Children

Our analysis of education and health care policies as they pertain to children revealed several similar themes in both policy domains. First, those in most need of assistance are typically children of color, often poor. Therefore, reversing childhood poverty and addressing the unequal structures of American society are perhaps more important than the politics and policies of any one issue or domain. Second, both domains have different players, with little overlap, largely due to the siloed nature of United States domestic policymaking. Yet, the same children are affected across domains and each domain is relevant to the other. Unhealthy children cannot learn in any type of education situation. Moreover, lack of education can impede health prevention and other interventions.

This prompts many questions about children's rights. What are children entitled to? Are not all children entitled to access to the same services? If outcomes among children of different racial or ethnic groups or among children of families with different incomes persist, then who is responsible for addressing those disparities? What are the best strategies?

Application to Nursing

It is important for nurses and other professionals who work with children and families to frame their advocacy for these populations in broader language than the rights—or entitlements-based approach or framework. What might the alternatives to the rights-based approach, mean for nursing practice, research and scholarship, and policy?

First, they provide a lens for focusing on children without pitting the rights of one entity (e.g., parents, State, or children) against another. For example, Murray's mutualism framework encourages policies and practices that emphasize the importance of parents in their children's lives and vice versa. Or, when working with foster children, children of incarcerated parents, and other families where separation of children from their parents raises challenging developmental and policy issues. Mutualism might promote innovative policies that enable parent–child relationships to flourish within safe and protective parameters. Similarly, the capabilities approach acknowledges that children might warrant special consideration because of their vulnerabilities and parents' capabilities also need to be considered and supported.

Second, other frameworks provide meaningful ways of linking practice and policy by reminding nurses and other clinicians about the importance of avoiding organizational or government policies that enable children in one group (e.g., those with certain family incomes or of certain racial background) to access services that children in other groups (different family incomes or racial identities) lack. Policies that target one population first might be incremental toward a universal access or policy goal. In the long run, they leave behind millions of children, typically children of color and low socio-economic status, to wait until the next juncture of legislative reform to hope for better policies coming their way.

Third, how might nurses apply Nussbaum's capabilities framework to children? We might consider how children and individuals of all ages could work together to improve the circumstances of many in society, not just specific age, economic, or cultural groups. Second, we might rely on one of the capabilities to integrate the others. Thus, for example, the capability of control over one's environment might offer angles for improving bodily health (health care) and education of children.

The alternate frameworks might also be more applicable to research than a narrowly construed rights-based approach. Instead of considering if something is or is not a child's right, the other frameworks offer ways to integrate rights with concepts such as mutualism and capabilities and a lifespan approach.

Fourth, a narrow rights-based argument, such as children's rights to health care or other services, fails to explain who is responsible for providing those services and what the quality of those services should be. It stops short of those discussions usually because they often lead to contentious politics or moral conflicts.

Fifth, in terms of scholarship, these alternatives integrate economic, bioethical, philosophical, legal, and other ways of thinking with nursing's theories to improve the health of all children and families. They also might promote and enhance interdisciplinary collaboration.

As we finish this manuscript in February 2019, thousands of children have been separated from their parents as they enter the United States without proper documentation. There has been little discourse about these children's rights to education, health care, fresh air, freedom from toxic adverse events, or access to their parents. It leads us to question how far a rights-based approach or any other framework can go in guaranteeing children, regardless of citizenship status, have certain basic needs met, at least in the United States If rights, capabilities, and other frameworks fall short, it is time to begin a new dialogue on how to enhance children's health and developmental outcomes. Go beyond what we presented here to theories and frameworks of group, mobilization, social media, and policy change and embrace them under nursing.

Conclusion

By stepping back from the rhetoric and conflict-ridden nature of a rights-based approach, several other potential frameworks emerged. They focus on children's development and capabilities and the mutual benefits of investing in children. The challenge is to engage children's advocates from organized interests, government, and professional practice, as well as from the private sector, working across policy domains. Collectively, they have enormous potential to use some of the frameworks outlined here as the starting point for new ways to raise the voices for children "beyond rhetoric." In doing so, children will hopefully achieve the best of their potential, bring benefit to future societies and economies, and in turn, understand the reciprocal and mutual benefits of care for each individual.

Supplementary Materials

Supplementary material associated with this article can be found in the online version at 10.1016/j.outlook.2019.02.012.

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