

STRETCHING THE LIMITS OF "RIGHTS TALK": SECURING HEALTH CARE ENTITLEMENTS FOR CHILDREN

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Health care rights by their very nature have to be considered not only in a traditional legal context structured around the ideas of human autonomy but in a new analytical framework based on the notion of human interdependence. "A healthy life depends upon [social] interdependence: the quality of air, water, and sanitation which the [state] maintains for the public good; the quality of one's caring relationships, which are highly correlated to health; [as well as] the quality of health care and support furnished officially by medical institutions and provided informally by family, friends, [and the community]."¹

INTRODUCTION

In a traditional liberal vision, rights are the strongest bases for claiming legal entitlements. The weightiest arguments demonstrate how a "right" has been infringed, regardless of whether a legal conflict involves property, contracts, torts, or civil liberties. In most societies, rights cannot be absolute because where diverse rights compete, they must be balanced and one must prevail. However, where rights conflict with individual or societal interests, rights generally will trump those interests and be respected and enforced by liberal democracies.²

Many scholars reject the viability of basing a legal framework entirely on the notion of sacrosanct rights. Some of these scholars, writing from a feminist perspective, argue that conventional "rights-talk" based on concepts of autonomy and individualism fails to consider the realities and perspectives of women.³ As a result of women's historically diminished

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1. *Soobramoney v. Minister of Health (Kwazulu-Natal)*, 1997 (32) SA ¶ 54 (CC) (Sachs, J., concurring) (quoting remarks made by Martha Minow at an interdisciplinary discussion held at Harvard Law School, *infra* note 17, at 3), available at <http://www.concourt.gov.za/judgments/1997/soobram.html> (last visited Feb. 10, 2003).

2. See MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION AND AMERICAN LAW 296 (1990) (discussing the concept of rights as "trumps").

3. See CAROL GILLIGAN, IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT 19, 147 (1982) (discussing a moral perspective that includes a notion of interdependence); MINOW, *supra* note 2, at 194 (discussing a relational approach to rights); Jennifer Nedelsky, *Reconceiving Rights as Relationship*, 1 REV. CONST. STUD. 1-2 (1993) (relying on the feminist theory of relationships in order to understand and institutionalize the meaning of "rights" Nedelsky proposes a "dialogue of democratic accountability"); Elizabeth M. Schneider, *The Dialectic of*

social and legal status, they have been precluded from holding and exercising the same rights as men.

An additional difficulty with basing legal claims on rights is that rights impose a correlated obligation on other individuals, institutions, or the state.⁴ Even if a right is recognized, it has little value unless it can be enforced. Generally, enforcement requires the identification and interpretation of the pertinent contract, statute, or constitution that established the right in question.⁵ Unless a legal document explicitly recognizes the right advanced, complex questions arise as to who has responsibility to enforce the claimed right. Moreover, granting positive rights to a resource or service creates issues concerning the nature and scope of the state's role in securing social and economic welfare for its citizens.

On an even more basic level, characterizing children's health care as a right creates two dilemmas that can arise whenever a rights-based discourse is employed. First, the traditional understanding of rights presumes an autonomous rights-holder, who is able to independently recognize and exercise her legal claims,⁶ but this paradigm does not fit the context of children's rights for many of the same reasons that feminists reject the idea for women. The immense physical, emotional, and psychological dependence children have on their families, their communities, and the state, makes placing them within the traditional rubric of individual rights impossible. The notion of rights in relationship—a concept formulated and developed by feminists—thus becomes indispensable to a viable framework of rights for children.

Second, characterizing health care as a right raises the difficulty of where to situate responsibility for respecting and enforcing this entitlement. Although some legal documents contain explicit guarantees of health services, some states resist inferring such a right.⁷ The Supreme Court of

Rights and Politics: Perspectives from the Women's Movement, 61 N.Y.U. L. REV. 589, 597–98 (1986) (arguing that feminist rights critique, which is based on patriarchy, fails to consider the "relationship between the assertion of rights and political struggle in social movement practice").

4. Audrey R. Chapman, *Introduction*, in *HEALTH CARE REFORM: A HUMAN RIGHTS APPROACH* 1, 4 (Audrey R. Chapman ed., 1994).

5. Health systems in different countries illustrate how these three types of rights may arise in the context of health care. For example, in the United States, given the absence of a publicly-funded universal health care system, many individuals enter contracts with private insurers or with employers who provide coverage for the cost of health care services. Chapman, *supra* note 4, at 1–3. However, in Canada, a statutory right to universal health care is guaranteed by the state. Canada Health Act, R.S.C., ch. C-6, § 10 (1985) (Can.), available at <http://www.canlii.org/ca/sta/c-6/whole.html> (last visited Oct. 28, 2002). In South Africa, the constitution guarantees access to health care, sufficient food and water, and social security. S. AFR. CONST. ch. 2, § 27(1), available at <http://www.concourt.gov.za/constitution> (last visited Feb. 10, 2003).

6. See, e.g., GILLIGAN, *supra* note 3, at 147 (contrasting the feminist view with the "individually-centered" approach).

7. See *supra* note 5 and accompanying text.

the United States, for example, has held that neither federal nor state governments are obliged to secure equal access to health services.⁸ Notwithstanding this ruling by the Supreme Court, infinite justifications exist for conferring a right to health care to American children. Such justifications, however, do not resolve the question of where the correlated duty falls. Thus, while most Americans favor access to universal health care in the abstract,⁹ political opponents have been able to effectively block specific policy proposals that would have established the larger right to health care.¹⁰

Even in Canada or South Africa, where the state bears a responsibility for providing health services to citizens, dilemmas occur when a patient requires scarce medical resources or extraordinary procedures. In such cases, it remains unclear whether an individual has a right to such specialized care and, if so, whether the state is obligated to bear the cost. In these societies, children may have a theoretical right to health care, but financial constraints and other barriers can limit its practical value.

Despite the initial shortcomings of a rights-based discourse, recognition of children's rights remains a fundamental starting point for guaranteeing the resources required for their physical, emotional, and cognitive well-being. While recognition of individual rights alone has been insufficient to insure the success and completion of this movement, this process is a necessary springboard from which these developments can extend into the realms of economics and politics, thereby gaining strength and momentum.¹¹ Extending a rights-based framework to children will not independently address all factors that threaten their health and safety. But it can and should be used to initiate a social movement that incorporates the distinct voices and interests of children.

Such a movement must consider all dimensions of childhood in order to craft a set of rights that accounts for the complexities of children's lives.

8. See *Harris v. McRae*, 448 U.S. 297, 311 (1980) (concluding that Title XIX does not require states participating in Medicaid to pay for medical services for which federal reimbursement is unavailable); *Maher v. Roe*, 432 U.S. 464, 469 (1977) ("The Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents.").

9. Chapman, *supra* note 4, at 26.

10. *Id.* at 23, 25.

11. Examples of the utility of rights discourse are found in the feminist movement, and in the political mobilization of blacks in South Africa. Though not sufficient by itself to bring about social equality and respect, the use of a rights-based analysis and the recognition of legal rights for women and for blacks in South Africa has been a necessary starting point for the social and political development of these groups. See Schneider, *supra* note 3, at 598 (noting that there are drawbacks to a rights-based discourse, but that one benefit is that such a discourse can enhance growth and help develop collective identity); see also Makau wa Mutua, *Hope and Despair for a New South Africa: The Limits of Rights Discourse*, 10 HARV. HUM. RTS. J. 63, 68 (1997) (noting that post-apartheid developments have relied exclusively on rights discourse to effect social change).

These considerations include recognition of individual identities, dependence on family and community, need for privacy, protection from domestic harm and neglect, respect for children's individual voices, and recognition of their inability to speak or articulate independent opinions.¹² A children's rights movement will be further complicated by the diversity that exists among children as a group. It will be difficult to organize a single movement representing the interests of all children with diverse ethnic and religious backgrounds, states of health, family relationships, living environments, and economic resources.

Despite these challenges, I have faith in the ability of rights-based movements to establish the groundwork for bringing social and legal change to historically marginalized groups. I support such a movement for children, whose interests and entitlements have been easily pushed to the periphery of our social, political, and economic concerns. Through my focus on children's specific right to adequate and appropriate health care, I hope to contribute to a broader movement that aims to secure every dimension of children's well-being.

This essay explores the various dimensions of children's rights to adequate health care. It examines three specific concepts: the inherent value of a rights-based discourse, the distinctiveness of children's rights, and the viability of transforming health care into a right. Relying on an understanding of rights within relationships—where an individual is perceived as part of a web of interdependent relationships between family, community, and state—I conclude that children's rights and a right to health care are both acceptable and justifiable concepts. I also consider challenges to structuring health care claims for children as rights. There are several compelling arguments against according health care the status of a right. However, these arguments do not overcome the benefits of using a rights-based discourse that focuses on children's distinct needs.

This essay thus acknowledges both the limits and the value of framing children's health entitlements as rights. Pursuant to this analysis, I

12. The United Nations Convention on the Rights of the Child contains provisions which recognize each of these needs for children as "rights." Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3, available at www.untreaty.un.org (last visited Feb. 10, 2003). The forty-fourth session of the General Assembly of the United Nations adopted the Convention without a vote on November 20, 1989. Cynthia Price Cohen, *Introductory Note*, in United Nations Convention on the Rights of the Child, 28 I.L.M. 1448, 1459-65 (1989). Although the inclusiveness of the Convention is laudatory, one also must question how meaningful each of these rights will be, given the conflict between certain provisions. This is underscored by the notion of indivisibility (that is, equality of rights) within the U.N.'s rights system. See Urban Jonsson, *An Approach to Assess and Analyse the Health and Nutrition Situation of Children in the Perspective of the Convention on the Rights of the Child*, 5 INT'L J. CHILD. RTS. 367, 372-74 (1997) (noting that the United Nations considers all rights, including the categories of "civil/political" and "social/economic/cultural," to be equal).

ultimately take the view that right discourse—when recast to take the particular realities of children into account—provides a viable mechanism for securing children's health and well-being.

I. THE INHERENT VALUE OF A RIGHTS-BASED DISCOURSE

The strength of rights within the liberal democratic tradition suggests the value of rights-based arguments for advancing a set of claims or interests. Historically marginalized groups such as women, racial and cultural minorities, and disabled persons have fought for social advancement with a discourse primarily premised on rights. These groups have also used the language of rights, or "rights talk," to gain political voice and strength.

Despite their potential, some scholars have identified important critiques of rights-based approaches.¹³ The challenge that arises most frequently, and is perhaps the easiest to address, relates to the historic association of rights with individualism.¹⁴ The conventional understanding of rights presents the "rights-owner" as independent, self-sufficient, and unconnected to the world that surrounds her. This portrayal fails to capture the realities of most individuals, particularly women, who historically lacked the social and legal independence required to bear rights within this framework.¹⁵ To overcome this difficulty, several scholars have developed an alternative understanding of rights that underscores an individual's relationships to other persons and institutions.¹⁶ These works contribute to rescuing the rights-based discourse from its traditional focus on individualism.

A focus on rights can also be criticized for its failure to recognize correlative duties. A typical understanding of rights presents a unilateral picture, emphasizing the entitlements of rights-bearers and not the obligations of those who must respect and enforce them. This leaves many questions unanswered, including who has the responsibility to enforce these rights, and to what degree these rights must be respected. Scholars such as Ken Anderson argue that such issues are never resolved, and call instead for a discourse based on obligation rather than rights in the context of health care.¹⁷

13. See *supra* note 3 and accompanying text.

14. See *supra* note 3 and accompanying text.

15. See *supra* note 3 and accompanying text.

16. See, e.g., Schneider, *supra* note 3, at 597-99 (arguing that there is a need to look beyond apparent opposition and examine the dialectical relationship between individual and community).

17. HARV. L. SCH. HUM. RTS. PROGRAM, ECONOMIC AND SOCIAL RIGHTS AND THE RIGHT TO HEALTH: AN INTERDISCIPLINARY DISCUSSION HELD AT HARVARD LAW SCHOOL (Sept. 1993), 5-6

Economists criticize rights rhetoric for attempting to make absolute claims to scarce resources. Although Michael Mandler concedes that a rights-based analysis is a good way to initiate discussions about social and economic entitlements, he maintains that it is not the ideal forum for public debate:

Rights talk makes economists uncomfortable. They are troubled by the power of rights to make uncompromising claims on resources, to set priorities for social expenditures and the redistribution of goods, regardless of the economic reality of scarcity. Such decisions must, of course, be made, but does rights talk provide the best vocabulary for ranking priorities? In fact, the rights approach can, at its worst, discourage reasoned discourse and degenerate into alternating assertions and denials.¹⁸

This argument suggests that rights constrain individual entitlements, rather than encouraging a more just and caring allocation of social and economic resources.

A final critique of rights-based discourse stresses the limitations of rights for realizing social transformations that enhance equality and freedom for historically marginalized groups and individuals.¹⁹ South Africa's Constitution, which came into effect in 1996 after the fall of apartheid, manifests an intense faith in rights as an engine of social change.²⁰ According to Justice Albie Sachs of the Constitutional Court, South Africans are "clinging to the right to be naïve," and have an "essential faith in justice and rightness" to help transform social realities.²¹

However, this lack of skepticism about the viability of rights in the new South Africa is not universal. Makau wa Mutua argues that dependence on a rights-based discourse for reshaping the country is a mistake because it freezes the racial hierarchies of apartheid.²² The "double-edged nature of rights" allows for their invocation not only by those seeking to bring about social change, but also by powerful members of society interested in preserving the status quo.²³ Given the ability of the empowered class to recognize and exercise their rights, wa Mutua maintains that the rights

(Harvard Law School Human Rights Program ed., 1995) [hereinafter ECONOMIC AND SOCIAL RIGHTS] (remarks by Ken Anderson), available at <http://www.law.harvard.edu/programs/HRP/Publicationseconomics1.html> (last visited Feb. 10, 2003).

18. *Id.* at 7 (remarks by Michael Mandler).

19. *Id.* at 42 (remarks by Albie Sachs).

20. S. AFR. CONST. pmbl., ch. 1 § 1, ch. 2 §§ 7-39, available at <http://www.concourt.gov.za/constitution> (last visited Feb. 10, 2003).

21. ECONOMIC AND SOCIAL RIGHTS, *supra* note 17, at 42 (remarks by Albie Sachs).

22. wa Mutua, *supra* note 11, at 68.

23. *Id.*

discourse embedded in South Africa's new constitution will enable the realization of the elite's goals at the expense of the weak and excluded.²⁴ Thus, a more equitable redistribution of political, social, and economic power in South Africa is unlikely to result solely from a rights-based constitutional framework.

Criticisms about how rights perpetuate rather than transform social power structures are not unique to South Africa. In the United States, the Critical Legal Studies (CLS) movement that emerged in the late 1970s emphasized how legal frameworks based on rights solidify power imbalances.²⁵ CLS scholars maintain that rights-based movements keep members compliant and dependent upon existing power relationships by permitting them to exercise their rights only to the degree allowed by their society or the state. In this way, a focus on rights weakens movements aimed at actualizing social transformation.²⁶

Although several authors have critiqued rights-based social developments, most of them ultimately conclude that a rights framework is a fundamental and necessary starting point to secure the interests and entitlements of marginalized individuals. For instance, while accepting many of the challenges levied against rights by feminists and CLS scholars, Elizabeth Schneider finds such criticisms incomplete. From her perspective, they fail to consider the "complex" and "dialectical, relationship between the assertions of rights and political struggle[s]" within a social movement.²⁷

Schneider advances several arguments that favor a rights-based framework for promoting the entitlements of groups seeking social and legal change. Two of her ideas are of particular relevance to a movement that would aim to secure health care rights for children. First, Schneider describes how rights, although advanced in a specific legal case, may express the broader politics, vision, and demands of a social movement.²⁸

24. See *id.* at 112 (stating that rights-based discourse has worked to preserve the privileges and gains of the white minority).

25. See Peter Gabel & Duncan Kennedy, *Roll Over Beethoven*, 36 STAN. L. REV. 1, 26-37 (1984) (presenting a dialogue between two law professors about the CLS movement).

26. See generally Peter Gabel, *The Phenomenology of Rights-Consciousness and the Pact of the Withdrawn Selves*, 62 TEX. L. REV. 1563, 1576-78 (1984) (discussing the relationship between the battle to overcome personal alienation and the battle over the interpretation of the law); Peter Gabel & Paul Harris, *Building Power and Breaking Images: Critical Legal Theory and the Practices of Law*, 11 N.Y.U. REV. L. & SOC. CHANGE 369, 369-72 (1982-83) (discussing the CLS theory that the legal system pacifies disenfranchised groups and legitimizes inhumane social orders).

27. Schneider, *supra* note 3, at 597. Rights analysis provides incremental reforms but does not address the core issues that create the problems. *Id.* at 597-99. Furthermore, rights analysis is problematic for those who want to preserve and recognize their differences with the paradigmatic group, but still maintain a claim to the same rights. MINOW, *supra* note 2, at 215.

28. See Schneider, *supra* note 3, at 611 (arguing that rights discourse can help define personal identity as well as community relationships and goals).

In turn, this promotes the political self-definition of the group advancing rights-based claims.²⁹ Second, rights claims have a public nature because they raise political issues about human entitlements and responsibilities. Schneider points out the importance of this feature to women's rights, given that gender discrimination and subordination have historically been understood as private matters. The attachment of rights to this issue effectively removed it from the hidden domestic sphere, subjecting it to public view and scrutiny.³⁰

Schneider also recognizes various challenges to basing social movements entirely on rights. She concludes that the recognition of rights should be considered only as a starting point. A focus on rights "energized the women's movement and started the conversation" about women's entitlements.³¹ However, reliance on rights alone could not complete the task of social reconstruction.³² Before power structures based on gender could begin to change, the social and economic responsibilities and roles of women required radical redefinition.³³

Schneider's work considers the potential of rights either to advance or to impede a political movement. Her work is fundamental because it portrays rights discourse as a necessary starting point for any political or legal strategy that seeks to implement change. This conclusion is particularly important when considering possible mechanisms for securing children's entitlements. Unlike adults, children lack the social and cognitive ability to recognize and articulate their concerns. Given that children hold the most marginal levels of power in any society, they should be accorded the strongest claims so that their needs and interests can be fulfilled.

The voice of a children's movement depends on an external recognition of their social and economic entitlements. Children's distinct physical, political, social, and economic situations make it difficult to perceive them

29. See MINOW, *supra* note 2, at 306-09. "Legal vocabulary, including that of rights, can be invested with meanings" to develop new vision. *Id.* at 307. Jonathan Mann identified a similar value to a rights framework, which he described as a "conceptual tool" that promotes discussion and enables individuals to articulate their own specific needs. HARV. L. SCH. HUM. RTS. PROGRAM, *supra* note 17 (remarks by Jonathon Mann).

30. Schneider, *supra* note 3, at 626.

31. *Id.* at 650.

32. *Id.* at 651.

33. *Id.* at 650-51; see also wa Mutua, *supra* note 11, at 113-14. Similarly, in the context of South Africa, wa Mutua maintains that although a rights discourse was fundamental for "energizing the anti-apartheid movement," it "cannot and should not be the primary" nor the only instrument of social change in South Africa. *Id.* Rather, reversing the legacies of apartheid and ensuring that blacks capture the state power required to enhance their social, economic, and political realities requires the employment "of several tools, policies, and approaches," of which rights rhetoric is just one example. *Id.* (emphasis added).

as full and active citizens. Therefore, a movement that strives to accord political agency to children requires a social and cultural dynamic that establishes endowments for them, while simultaneously commanding political energy. Designating rights is the most effective way to empower children. By recognizing children's rights, society promises to pay attention and give priority to children's entitlements, as well as to undertake the steps necessary to ensure their fulfillment.³⁴

The experiences of North American feminists and blacks in South Africa suggest that rights discourse alone cannot alter the political and social realities of marginalized groups. At the same time, these experiences also reveal the utility of rights talk for building a platform for the social and political mobilization of these groups. Children and their advocates can rely on rights talk in a similar manner. They can thus use rights to initiate a movement that recognizes and guarantees children's entitlements to the resources required for their well-being.

II. VIABILITY OF A RIGHTS-BASED APPROACH FOR CHILDREN

To give children's rights meaning and worth, it is first necessary to examine the concept of an autonomous rights-holder. Because this ideal is inapplicable to many individuals, some scholars conceived new theoretical underpinnings for rights that captured the realities of all social groups. Feminists such as Gilligan, Minow, Nedelsky, and Schneider redefined the idea of rights in relationship.³⁵ Rather than portraying rights-bearers as autonomous individuals with competing interests, they constructed a framework that reflects our needs and capacities and entwines these factors through a network of social relations.

A web of interdependent rights that underscores a connection to and a reliance on the world outside the self is fundamental for children. Minow writes that extending rights to children is beneficial in the sense that it draws them into a community where they can be seen and heard.³⁶ This transition raises their identity from outsiders to included members of the

34. See MINOW, *supra* note 2, at 297-98 (asserting that including children as participants in a community changes their place from outsiders to members); see also Chapman, *supra* note 4, at 7 (discussing the importance of assuring the rights of the disadvantaged in a human rights model).

35. See GILLIGAN, *supra* note 3, at 171-73 (observing that women's identities and self-worth are entwined in their relations and connections with others); MINOW, *supra* note 2, at 215-16 (contrasting the rights approach with the social relations approach to legal treatment of differences); Nedelsky, *supra* note 3, at 11-13 (asserting that the notion of individual is flawed, since humanity is comprised of a network of relationships, and individuals are shaped and influenced in their choices by those relationships); Schneider, *supra* note 3, at 619-25 (discussing how feminist thought evolved to center around the notion of "interdependent" rights).

36. Recognizing the rights of children makes them "insiders" rather than "outsiders." MINOW, *supra* note 2, at 296-99.

community.³⁷ Nevertheless, children generally wield less political and economic power and are more vulnerable than adults.³⁸ This social reality will remain unaffected by merely extending rights to children and ensuring their social inclusion.³⁹ A structure of rights for children that reinvents their roles and entitlements requires both a recognition of their rights and an imposition of duties on public and private actors to respect and enforce them.⁴⁰

An understanding of how children have been perceived and treated by the law throughout history is necessary to appreciate the magnitude of the challenge presented by this interdependent framework. According to Minow, children have historically been considered a group whose difference justified their exclusion from rights.⁴¹ Over time, a complex pattern of rules developed that treated children as growing into competency. In this way, children are able to bear rights at different ages, depending on the matter in question.⁴²

Traditionally, rights for children were secured through a focus on their need for protection. By the 1960s, however, American reformers began to demand the extension of specific adult constitutional rights to children.⁴³ As a result, children acquired rights to equal protection under the law,⁴⁴ due process,⁴⁵ free speech,⁴⁶ and procreative choice.⁴⁷ While the United States Supreme Court recognizes these rights, the Court's uncertainty about the nature and scope of rights for minors is reflected in its jurisprudence.⁴⁸ For

37. *Id.*

38. *Id.*

39. *Id.*

40. See John Eckelaar, *The Importance of Thinking That Children Have Rights*, in CHILDREN, RIGHTS, AND THE LAW 221, 227 (Philip Alston et al. eds., 1992). While Eckelaar chooses to remain within the framework of a "rights" discourse, his work suggests a perspective based on relationships given his recognition that extending *duties*, as well as powers or entitlements, are equally important in achieving "righthood." *Id.*

41. MINOW, *supra* note 2, at 283. Under the law, children are defined by official relationships with their parents rather than as autonomous individuals. *Id.*

42. *Id.* at 283-85. Children progressively acquire the autonomous position that adults have over time and in stages. *Id.*

43. *Id.* at 286.

44. *Brown v. Bd. of Educ.*, 347 U.S. 483, 493 (1954) (holding that school segregation violates children's rights to equal protection by denying them equal educational opportunities).

45. *In re Gault*, 387 U.S. 1, 27-28 (1967).

46. See *Tinker v. Des Moines Indep. Cmty. Sch. Dist.*, 393 U.S. 503, 511 (1969) (holding that the Constitution provides First Amendment protection to teenaged students protesting the Vietnam conflict).

47. See *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976) (holding that a state may not require parental consent for a minor to obtain an abortion during the first twelve weeks of her pregnancy).

48. See Martha Minow, *Rights for the Next Generation: A Feminist Approach to Children's Rights*, 9 HARV. WOMEN'S L.J. 1, 10-13 (1986) (discussing cases that present certain counter-principles regarding children's rights).

example, in *Parham v. J.R.*, the Court established minimal procedural requirements for the institutionalization of minors and held that parents who seek to hospitalize their children are presumed to act in their children's best interests.⁴⁹ In *Hodgson v. Minnesota*, the Court invalidated as unconstitutional a statute requiring minors to notify both parents before terminating a pregnancy.⁵⁰ Nevertheless, it also held that a single-parent notification requirement, or a dual-parent notification with a judicial bypass procedure, would not violate the minor's substantive due process rights.⁵¹ Thus, even though children's rights have been recognized in some limited contexts, they are still far from equal to the rights enjoyed by adults.

Conflicting ideas about rights for children have also appeared outside of the United States. In Canada, the judicial discourse on children's rights is relatively undeveloped. When faced with cases addressing the ambit of children's rights, the country's highest court chose to examine the issues through the lens of parental rights and obligations.⁵² Lower courts, however, have considered children's rights issues, particularly in cases involving minors' decisions about medical treatment. In these cases, the ambiguity surrounding the concept of children's rights persists. Although certain "mature minor" statutes indicate the age at which a child is permitted to make some independent medical decisions, the rules are not necessarily decisive.⁵³

When faced with cases involving a child's refusal to accept medical treatment, the courts' primary consideration has been the child's maturity level. If clear evidence demonstrates that the child has the cognitive and emotional capacity to understand a medical decision, the court will uphold

49. *Parham v. J.R.*, 442 U.S. 584, 600-04 (1979).

50. *Hodgson v. Minnesota*, 497 U.S. 417, 422-23 (1990).

51. *Id.* Cf. *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 887, 895 (1992) (holding that a statutory abortion notification requirement to a spouse constitutes an "undue burden" that violates an adult woman's substantive due process rights).

52. *See B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315. The Supreme Court of Canada, in opposition to the wishes of the parents of a sick child, upheld a wardship granted in order to give a child a blood transfusion. *Id.* The Court noted that in such cases where parents' conduct is not socially acceptable, "[the state] is limiting the constitutional rights of parents, not vindicating the constitutional rights of children." *Id.* Similarly, where a father who is a Jehovah's Witness sought visitation rights despite the objections of his former spouse, the Supreme Court of Canada focused on parental rights when it considered the mother's argument that the father's religious practices were harmful to the children. *Young v. Young*, [1993] 4 S.C.R. 3. Although the father's freedom of religion was balanced against the "best interests" of his children, the entitlements and needs of these children were not given "rights" status and were relegated to the status of interests. *Id.*

53. *See Medical Consent of Minors Act, R.S.N.B.*, ch. M-6.1, §§ 3(1), 3(2) (1976) (Can.) (permitting a minor under sixteen years of age to consent to treatment where the minor understands the nature and consequences of the treatment and the procedure is in the minor's best interest); *Civil Code of Québec*, art. 14 (allowing a person over the age of fourteen to consent to care that is required by his or her state of health), available at <http://www.canlii.org/qc/sta/ccq/whole.html> (last visited Feb. 10, 2003).

the decision if the decision is enlightened and reasonable.⁵⁴ Conversely, irrespective of a minor's age, a minor may not make an independent choice about health care if the court finds her judgment skewed by parental influence or irrational belief.⁵⁵ If that is the case, the court may consider her incompetent to make a consent decision regarding health care.⁵⁶

The lack of consistent legal precedent renders children's rights ambiguous. Although it frustrates a search for precise rules to determine the legal, social, and political status of children, it also benefits children's rights advocates. By acknowledging that children's roles and rights in society are not determinate, it is possible to argue for more enhanced entitlements that aim to fully secure children's needs and interests. Understanding a child's network of relations enables the formulation of a broader rubric of rights. Children's rights can be seen as equal to those of adults, or as distinctive, highlighting their need for additional protection from the community and the state.⁵⁷ In a discussion about health care rights acknowledging the similarities and differences between children and adults is extremely helpful. Traditionally, society either recognized a minor's rights or offered protection, leaving no room for the possibility that children may need both protection and autonomy simultaneously, but for different purposes.⁵⁸

Because the right to health care depends on social and economic resources, it is more precarious than civil or political rights. The latter require governments to refrain from interfering with the exercise of recognized rights and liberties. In contrast, a right to health care conferred by a statute or constitution obliges the state to provide the necessary resources for this entitlement.⁵⁹ Thus, the ability of health care claims—

54. See *Re L.D.K.*, [1985] 48 R.F.L. 2(d) 164. The court denied an application to declare a child in need of state protection that would have resulted in a blood transfusion. The child and her family harbored a religious objection to the transfusion and desired to pursue alternative treatment for leukemia. *Id.*

55. See *Re Dueck*, [1999] 171 D.L.R. 4th 761, 767 (refusing to recognize a child's health care choice when the child was not a mature minor and was "deeply under the influence of his father"). The court in *Dueck* found that the child's father had misinformed the child in a way that risked placing the child in "medical peril." *Id.*; *Protection de la jeunesse-884*, [1998] 816, 827 R.J.Q. (finding that a thirteen year old child was not a mature minor, was in need of protection, and that the Minister could consent to care for the minor in lieu of the minor's consent).

56. See *supra* note 55 and accompanying text.

57. See Minow, *supra* note 48, at 13-14 (noting that when we choose to see children as either universally the same as or different from adults, we ignore the possibility that a child might be best suited by having independence in certain areas and custody and care in others).

58. *Id.*

59. See *Jonsson*, *supra* note 12, at 372-73 (noting that social, economic, and cultural rights require action by the state "to facilitate and fulfill" them.). Social, economic, and cultural rights, which require the state to refrain from doing something, seem to receive less protection than civil and political rights, which require positive action. *Id.* For example, Article 4 of the U.N. Convention on the Rights of the Child provides that "[w]ith regard to social, economic and cultural rights, states parties shall

regardless of whether they are premised on a legal "right"—to withstand competing arguments about scarce resources and their equitable allocation becomes a serious issue.⁶⁰

The inherent fragility of health care entitlements results from the traditional, individualistic understanding of rights. A social relations approach which focuses on context and interdependence may help to broaden and solidify the notion of health care as a right. Extending this framework to children enables a recognition of their dependence on adults, as well as the vulnerability resulting from their physical, emotional, cognitive, and legal incapacities. Moreover, this approach urges us to question how context and interdependence affect the particular needs and interests of the individuals involved.

An analysis which looks at the context and dependency relationships of children forces a realization that the conferral of special rights is necessary to ensure every dimension of their well-being. While most adults can communicate feelings of illness, seek out professional treatment, and ensure that medical fees are paid, children must rely on adults to access appropriate health care. This fact justifies the formulation of specific health care rights for children that may extend beyond those normally recognized for adults.

Some critics have recognized the need to improve children's access to health care in America.⁶¹ In a critique of the American health care system, Kopelman and Palumbo conclude that the traditional, market-based approach to health care has been neither efficient nor just.⁶² They analyze children's health care rights under four different theories of justice: utilitarianism, egalitarianism, libertarianism, and contractarianism.⁶³ Despite

undertake such measures to the maximum extent of their available resources." *Id.* (quoting Convention on the Rights of the Child, *supra* note 12, art. 4).

60. See *Soobramoney v. Minister of Health (Kwazulu-Natal)*, 1997 (32) SA ¶¶ 30-31 (CC) (Chaskalson, J.) (noting that "the state has to manage its limited resources in order to address all [of the social services] claims"). In Canada, this discussion has arisen in the debate surrounding the scarcity of emergency and highly technical facilities. See Janet Bagnall, *ERs Suffer Across Canada*, MONTREAL GAZETTE, Jan. 8, 2000, at B2 (commenting on how patients waited up to forty-eight hours for hospital services at Montreal emergency rooms); Aaron Derfel, *Therapists Warn of Heart Attacks: Portable Oxygen Cylinders Increase Risks for Patients Waiting in Halls. They Insist*, MONTREAL GAZETTE, Jan. 8, 2000, at A4 (reporting on the dangers of overcrowded emergency rooms in Montreal); Krista Foss, *Hospitals Reeling From Flu Onslaught: Influenza Outbreaks Occurring up to Six Weeks Earlier Than Expected in Cities Across Canada*, GLOBE AND MAIL, Dec. 29, 1999, at A4 (discussing a flu outbreak and noting that several hospitals could not accept any additional patients because they were full, and that a children's hospital that does not turn away patients saw in excess of 250 patients in a single day as a result of the influenza outbreak).

61. E.g., Loretta M. Kopelman & Michael G. Palumbo, *The U.S. Health Delivery System: Inefficient and Unfair to Children*, 23 AM. J.L. & MED. 319, 319-21 (1997) (stating that the U.S. health delivery system is inefficient and unfair as evidenced by the more than nine million uninsured U.S. children).

62. *Id.* at 337.

63. *Id.* at 323-30.

these four divergent ideological underpinnings, the authors ultimately conclude that each theory would characterize the current allocation of health care resources among American children as unjust.⁶⁴ Kopelman and Palumbo interpret this as evidence of an urgent need for a more equitable redistribution of pediatric health care resources.⁶⁵

Kopelman and Palumbo's work demonstrates how children's advocates may seize upon the distinctiveness of children to craft arguments for enhanced rights. Their essay does not tackle the entire American health system; rather, it focuses on how the system has affected children and how the particular realities that children face may entitle them to claims over and above those of adults. These additional entitlements are especially necessary to secure access to health care, which requires an affirmative allocation of social and economic resources.

While Kopelman and Palumbo highlight important justifications for paying special attention to children within the health care system, they do not go so far as to characterize children's entitlements as a right. Although their conclusions rest entirely on reflections about legal theory, they do not explore justifications for according children more extensive health care rights. It is not clear whether Kopelman and Palumbo believe that children's stake in an equitable allocation of medical resources is based on their needs, interests, entitlements, or rights.

Jeffrey Blustein's work on children's entitlements within the American health care system reflects a similar difficulty.⁶⁶ Blustein argues for increased access to care as a "moral" entitlement for children.⁶⁷ Blustein maintains that parents have a moral obligation to provide children with required care because of their dependence on adults.⁶⁸ When parents cannot meet this obligation, the state has a moral duty to ensure that children's health care needs are met. Like Kopelman and Palumbo, Blustein demonstrates the potential for focusing on the distinctive features of children to argue for greater rights of access to health care, but like Kopelman and Palumbo, Blustein is content to call children's access to health care a moral

64. *Id.* at 330.

65. *See id.* at 319-20. Statistics show that: (1) the United States is the richest country in the world; (2) the United States has many uninsured citizens despite spending a larger percentage of GNP on health care than most industrialized countries that provide near-universal health coverage; (3) female children in the United States have the highest death rate among affluent countries; and (4) children in low-income families are the most severely affected. *Id.*

66. Jeffrey Blustein, *A More Equitable Health Care System for Children: The Moral Argument*, in *HEALTH CARE FOR CHILDREN: WHAT'S RIGHT, WHAT'S WRONG, WHAT'S NEXT* 263 (Ruth E.K. Stein ed., 1997) (arguing that as a society we are not committed enough to taking responsibility for children's health care).

67. *Id.* at 267-68.

68. *Id.* at 268.

entitlement. These authors simply refuse to characterize this as a legal right, even though it would provide greater security for children's needs and interests.

As these works suggest, stronger entitlements for children can be obtained through an emphasis on children's needs for added protection and care. By focusing on children's lack of independence, it is possible to justify the extension of a more robust set of health care rights for them. In this way, children are both seen and treated differently from adults. However, as discussed above, a social relations approach to rights for children may permit the simultaneous recognition of their autonomy and equality with adults as well as their need for protection. To guarantee children's equal access to health care, specific mechanisms are needed to ensure the provision of appropriate and sufficient medical attention.

Legal instruments that specifically recognize health care entitlements as rights are the most logical mechanisms to ensure children's access to health care. These instruments must be based on an understanding of interdependent social relationships, particularly those that are relevant for children. The discussion that follows reveals that several existing legal instruments recognize a right to health care. However, to be meaningful, these instruments must be accompanied by the public and political will to recognize health as an unequivocal entitlement.

III. CONSTRUCTING A MEANINGFUL RIGHT TO ADEQUATE AND APPROPRIATE HEALTH CARE

The United Nations Convention on the Rights of the Child obliges signatories to secure children's access to "the highest attainable standard of health."⁶⁹ Other international treaties confer explicit rights to health or health care to all citizens of a nation-state. The Universal Declaration of Human Rights confers a right to "a standard of living adequate for the health and well being of himself and of his family."⁷⁰ This right expressly includes access to food, clothing, housing, medical care, and necessary social services.⁷¹ Moreover, the International Covenant on Social, Economic, and Cultural Rights recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁷² State parties must undertake four specific measures to achieve

69. Convention on the Rights of the Child, *supra* note 12, art. 24.

70. Universal Declaration of Human Rights, art. 25, G.A. Res. 217A (III), U.N. GAOR, 3rd Sess., at 71, U.N. Doc. A/810 (1948), reprinted in 43 AM. J. INT'L L. SUPP. 131 (1949).

71. *Id.*

72. International Covenant on Economic, Social, and Cultural Rights, opened for signature Dec. 19, 1966, art. 12 § 1, 993 U.N.T.S. 3, 8, available at <http://untreaty.un.org> (last visited Feb. 10,

this standard: (1) they must reduce still-birth and infant mortality rates and ensure the healthy development of children; (2) they must improve all aspects of environmental and industrial hygiene; (3) they must prevent, treat, and control epidemic, endemic, occupational, and other diseases; and (4) they must assure medical attention for all who become sick.⁷³ Finally, Article 5 of the International Convention on the Elimination of all Forms of Racial Discrimination obliges signatories to prohibit and eliminate racial discrimination.⁷⁴ Subsection (e)(iv) requires them to provide equal enjoyment of the right to public health, medical care, social security, and social services.⁷⁵

While many countries adhere to these conventions, their domestic laws and social realities do not comply with the standards that the conventions create. The health care systems of Canada, the United States, and South Africa provide examples of this inconsistency. In Canada and South Africa, rights to health care are conferred by statute and constitution, respectively.⁷⁶ However, these theoretical rights are insufficient to protect children whose access to health services may be blocked by an array of socio-economic factors.

The United States presents a different and more complex context for studying health care entitlements. As a country that has not ratified the Convention on the Rights of the Child, the United States is not subject to the obligations that the convention imposes on nation-states. It is thus more difficult to criticize the absence of a constitutional or statutory universal right to health care, or of a right to health care specifically designed for children.

American initiatives to increase health care entitlements often face substantial resistance. In 1983, a President's Commission issued a report that supported a societal obligation to ensure equal access to health care. Nevertheless, the report deliberately chose not to frame health care as a right for all citizens. Instead, the report adopted an ethical obligations approach which places a moral duty on the state to provide universal access

2003). This covenant entered into force on Mar. 23, 1976; the United States, however, is not a signatory state. *Id.*

73. *Id.* art. 12 § 2.

74. International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Dec. 21, 1965, art. 5, S. TREATY DOC NO. 95-2, 660 U.N.T.S. 195, 220-22, *available at* <http://untreaty.un.org> (last visited Feb. 10, 2003). This treaty came into force with reservation in the United States on November 20, 1994. *Id.*

75. *Id.*

76. S. AFR. CONST. ch. 2, §27(1) (a) ("Everyone has the right to have access to . . . health care . . ."); Canada Health Act, R.S.C., ch. C-6, § 10 (1985) (Can.) (establishing a positive entitlement to health care), *available at* <http://canlii.org/ca/sta/c-6/whole.html> (last visited Feb. 10, 2003).

to medical care.⁷⁷ As Schneider observed, this rejection of a right to health care broke with the public discourse on a matter that previously favored the concept of positive social welfare rights.⁷⁸

Many American theorists take solid stances against the establishment of health care rights, and argue that the creation of such rights would result in an inequitable and inefficient system of care. According to Richard Epstein, granting positive rights to citizens invests the government with vast powers over taxation, regulation, and employment.⁷⁹ In turn, these powers risk legitimizing state interference with the rights and liberties of those who do not benefit from these entitlements.⁸⁰ Epstein further argues that contributions to the health care system must remain a moral, rather than a legal, obligation.⁸¹ In addition, he argues that positive health care rights will likely induce an abuse of medical resources.⁸² Thus Epstein prefers the American status quo because it encourages citizens to be cautious and risk-averse in their conduct and decision-making.⁸³

Epstein's argument, however, ignores certain important realities. For most of us, the suffering and vulnerability that accompany illness or injury are reason enough to deliberate over decisions or behavior that may threaten our health. Within these mental calculations, the issue of costs for medical care is likely to receive minimal consideration, or perhaps no consideration at all.

Epstein's arguments resemble what Larry Churchill describes as the "Good Behavior Model" for health care.⁸⁴ According to this model, an individual's entitlement to health should be forfeited or weakened when she indulges in unhealthy behavior.⁸⁵ Churchill rejects this approach, pointing to its exaggerated emphasis on individual control over health status.⁸⁶ Instead, he adopts a "Response Model" to care in which a right to health

77. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMED. RESEARCH, I SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 4 (1983).

78. Schneider, *supra* note 3, at 592 n.14.

79. RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 3, 6 (1997).

80. *See id.* at 5-6 (arguing that any claimed right is accompanied by correlative costs which some third party must bear).

81. *Id.* at 39-41.

82. *Id.* at 45-46.

83. *Id.* at 56-58.

84. Larry R. Churchill, *Aligning Rights and Responsibilities*, in HEALTH CARE REFORM: A HUMAN RIGHTS APPROACH 140, 143 (Audrey R. Chapman ed., 1994).

85. *Id.*

86. *See id.* at 144 (noting that some factors such as working environment, social class, and addiction are beyond an individual's control).

services is recognized but subject to an individual's responsibility to use only those resources that are medically necessary.⁸⁷

While Churchill envisions health care as a right that must be shared throughout a society, he does not satisfactorily connect the notion of rights and responsibility. By limiting individual access to health care based on need, this model hints at Epstein's argument regarding the propensity to abuse, or at least overuse, a health care system premised on rights. However, Churchill's Response Model fails to delegate the responsibility for determining when an individual has used more than her "fair share" of medical resources. Should it be the individual patient? Health care providers? The state? These unanswered questions exert tremendous influence over the nature and scope of health care rights.

Other scholars favor arguments for a rights-based discourse within the context of American health care. According to Virginia Leary, elevating health care to the status of a right places fairness, social justice, and equity at the center of American health care reform.⁸⁸ A market-based approach to health care has prevailed in the United States for many decades.⁸⁹ However, Leary rejects this approach and argues that health is more than a mere commodity to be allocated by economic forces.⁹⁰ Quality health care is a human right, given its importance to the life and dignity of individuals.⁹¹

Leary's argument is difficult to dispute. Items like food, shelter, and clothing are traditionally considered basic human necessities. Adequate and appropriate medical care should be added to this list, given its fundamental link to human sustenance.⁹² In the absence of good health, we lose all hope for the ability to function physically, mentally, and even emotionally. For children, a healthy state of being is essential to physical growth and cognitive development. Access to quality health care is no less important than access to the items traditionally considered indispensable to humanity.

While many American and non-American scholars agree with this conclusion, they point to the practical difficulties that might accompany the creation of health care rights.⁹³ First, they recognize that merely conferring a right to health care on paper will do little to change reality if public

87. *Id.* at 145-46.

88. Virginia A. Leary, *Defining the Right to Health Care*, in HEALTH CARE REFORM: A HUMAN RIGHTS APPROACH 87, 88 (Audrey R. Chapman ed., 1994).

89. See Chapman, *supra* note 4, at 19 (arguing that the United States characterizes health care as "a private consumption good").

90. Leary, *supra* note 88, at 97.

91. *Id.*

92. *Id.* at 92, 94.

93. See EPSTEIN, *supra* note 78, at 43-48 (pointing out practical obstacles to health care rights).

opposition to such a right remains.⁹⁴ Health care reform requires more than the formulation of rights. Public debate, discussion, and agreement about the state's role in health care must accompany these initiatives. The issues that must be considered extend beyond the state's financial obligation to its health system. They must also examine the institutions and expertise required to ensure respect for and enforcement of the rights and obligations in question.⁹⁵

The inability to address dilemmas raised by competing entitlements is a second potential stumbling block to the success of a health care system based on rights. Patients, health care providers, insurers, and taxpayers have varied and often conflicting claims based on their individual rights. Although a legal structure may confer rights on patients that match those of other rights-bearers in the health system, it provides little guidance for resolving the conflicts that may arise between them. Moreover, a rights-based system proves to be even less helpful for dealing with health care issues that involve the allocation of scarce resources. This is particularly problematic for those individuals that require highly technological equipment, complicated procedures, or specialized medical personnel.⁹⁶

This discussion reveals the shortcomings of the traditional language of rights for developing viable entitlements within health care systems. The context of health care requires a move beyond conventional rights discourse to a framework that underscores social relations and interdependence.⁹⁷ An analysis that ignores an individual's ties to family, community, and the state will consider only a fraction of the factors that underlie her state of health and her need for care. A social relations approach that perceives the individual in a network of relationships, in which she holds *both* rights and duties, is a necessary foundation for a health care right that can be both comprehensible and acceptable to all.

94. See Chapman, *supra* note 4, at 11–12 (noting that Americans generally support universal health care but are opposed to limiting their own access to care as a means of ensuring that there are enough resources to provide basic care to everyone).

95. In an international context, the need for institutional support and expertise for monitoring and enforcing the rights conferred by the International Covenant on Economic, Social, and Cultural Rights has been discussed by Philip Alston. See HARV. L. SCH. HUM. RTS. PROGRAM, *supra* note 17, at 35 (remarks by Philip Alston) (discussing the practical problems of obligations and the U.N. Commission on Human Rights).

96. This is reflected by the South African Constitutional Court's decision in *Soobramoney v. Minister of Health (Kwazulu-Natal)*, 1997 (32) SA ¶¶ 3–5, 36 (CC) (Chaskalson, J.). Although the patient in this case had a constitutional "right" to health care services and emergency medical care, such a right did not determine the outcome of this case, given that the care in question implicated the allocation of renal dialysis treatment, which was considered a scarce medical resource in South African public hospitals. *Id.* ¶¶ 3, 31, 54.

97. Janet O'Keefe, *The Right to Health Care and Health Care Reform*, in HEALTH CARE REFORM: A HUMAN RIGHTS APPROACH 35, 59 (Audrey R. Chapman ed., 1994).

This framework of rights and duties would extend to children as well as adults. Typically, children are perceived as the objects of our compassion, sensitivity, and charity. The approach adopted here, while acknowledging the inherent vulnerability of children, envisions them as bearers of rights, as well as obligations and responsibilities. Of course, the nature and scope of these duties will correlate to a child's age and capacity to understand and assume them. Even young children can comprehend the importance of ensuring and protecting their own health.

If provided with intelligible information about how to lead safe and healthy lifestyles, children should hold a duty to apply this information by avoiding conduct that they know could cause harm to themselves or to others. Moreover, children who enjoy greater health privileges should be encouraged to help others who fare less well. For example, school-aged children can play a vital role in helping their peers re-integrate into their classrooms after an absence due to illness. Small gestures like delivering homework assignments to sick children and their inclusion in class and play can help to achieve this integration. Such measures forge bonds between children and avoid stigmas that often result when children are ill, particularly where their illnesses are chronic and they are repeatedly absent.

CONCLUSION

I have argued that society should recognize that children bear a *right* to adequate and appropriate health care. There are several ways that this right can be created. A right to health care may be rooted in national constitutions or legislation, or it may be argued rhetorically, as a normative principle of justice and fairness. This discussion envisions rights as a means to empower children's movements politically, and thereby support children's social and economic entitlements to health care. Rights language generates political mobilization and social identity in marginalized groups, such as children. This in turn allows the concerns and needs of these groups to be voiced to the outside world, rather than restricted to a conversation among their individual members. Thus, in cases where no statute or constitution provides a right, rights talk may nonetheless provide a platform from which to launch an exploration of—and an advocacy for—ideas and policies developed for children.

The traditional understanding that rights trump other interests is inapplicable to the context of children and health care. The autonomy required to hold and exercise conventional legal rights is inconsistent with the realities of children, who are dependent and vulnerable members of society. Furthermore, the perception of rights as being invariably tied to an

individual impedes the development of a meaningful right to health care. A legal framework that recognizes and incorporates social interdependence in the context of health is required to make such a right meaningful and acceptable.

The feminist vision of rights in relationship can be harmonized with the traditional liberal understanding of rights and children's health care entitlements. By this approach, autonomy and individualism are no longer prerequisites for holding and exercising rights. Moreover, the connections between an individual, family, community, and state are recognized and help to explain and justify the conferral of positive social and economic rights. Relying on this framework, it becomes possible to recognize children's rights, and in particular, their right to adequate and appropriate health care.

