Canadian Health Care and Child Rights – What Are the Links?

Richard C. Mitchell, MA

When the Convention on the Rights of the Child (CRC) was ratified in 1991, Canada undertook Article 24.1 obligations to provide both “the highest attainable standard of health” and Article 42 commitments to “make the principles and provisions of the Convention widely known to adults and children alike”. How are health care providers following up on these promises? How did the recently completed Romanow Commission engage, or even gauge, the views of young people in the reform debate? The author presents an argument for the wider adoption of a “rights-based approach” to facilitate health care reform and health promotion for young people, and clarifies a minimum standard for establishing this claim. While the approach has been discussed in a Senate of Canada policy paper,¹ the author cites qualitative findings from health promotion research in British Columbia to take the notion a step forward.² Further comparative theoretical and empirical support is presented to illustrate why this approach is germane to health care reform debates in Canada, and contemporaneous cabinet-level initiatives planning for children’s health and well-being.

Comparative theory and children’s rights

While an explicit conceptual relationship connecting health and human rights has been well forged,³⁻⁶ there are both theoretical and applied knowledge deficits in the discourse supporting Canada’s children.⁷⁻⁹ Ongoing national efforts to promote this child rights/child health nexus have been coordinated primarily in Ottawa to this point.¹⁰⁻¹³ Currently, a broad range of participants are developing and promoting children’s rights through Canada’s National Plan of Action for Children, with the Ontario Public Health Association a typical representative organization.¹⁴ Notwithstanding these efforts, how aware are provincial, territorial and local health providers of their own obligations under this international treaty for children?

The United Kingdom has a policy discourse in health increasingly built upon notions of young people as competent rights-bearing citizens, well founded theoretically¹⁵⁻¹⁸ and empirically.¹⁹⁻²¹ For example, Lightfoot and Sloper discuss research from the National Health Service on the value of consulting with chronically ill and disabled young patients – a core child rights principle. Staff reported significant changes in their own professional behaviour. “It really did change my whole outlook on nursing... [I began to ask] have we asked patients what they want?”²² In contrast, Dixon-Woods, Young and Heney report children have been given little voice in medical consultations to date, and are rarely consulted in the evaluation and planning of health services.²³ They concede that children’s rights will have little chance of being realized until more research on outcomes of shared decision making, competence of children, and sharing of information have been conducted. Alderson has researched effective methods for helping children as young as three years of age cope with major surgery²⁴ and suggests that childhood theories²⁵ are critical for health professionals to consider in issues of consent and a child’s right to express their views freely.

A decade ago, critical links to child health outcomes and a child’s rights to physical integrity were published by the British Columbia Institute against Family Violence.

[P]hysical punishment is ineffective as a disciplinary procedure and is harmful in its long term effects on children’s social development. In an extensive investigation into physical

*child abuse, most cases were found to have started as physical disciplinary actions that then escalated out of control (Kadushin and Martin 1981). Strauss (1991) found that physical punishment tended to “increase the probability of deviance, including delinquency in adolescence and violent crime both inside and outside the family as adult.” In a longitudinal study, Newson and Newson (1990) found, after controlling for poverty and unemployment, that frequent physical punishment as a child was associated with juvenile crime.*²⁶

Still, rights for Canadian young people that facilitate participation in health care policy and practice decisions remain unfulfilled, perhaps even unknown, across much of the nation. Why might health professionals be reluctant to engage young people in this growing policy discourse? A comparative overview of childhood theories provides one useful entry point to begin to explain the apparent rupture between Canadian health professionals and many of their counterparts abroad.

From the mid-1980s, the “sociology of childhood”¹⁵ has supported and informed British discourses, portraying children as competent, capable social actors. Notions of childhood as socially constructed, and children and young people as rights-bearing citizens inform policy-makers alongside dominant assumptions found in development literature. Oakley (1994) reflects on how children have been most often conceptualized in the past.

*We learn not about children’s perspectives, but about adults’ concepts of childhood. This is why the assumption of children’s non-competence is generic to all such theories, so that it becomes their prime distinguishing feature. In this sense, most work on the concept of childhood is adultist...also overwhelmingly classist.*²⁷

This new social study of children and their childhoods has informed many of the new directions in policy. New appointments include local authority child rights officers, Children’s Rights Commissioners in Wales, Scotland, Northern Ireland, and the City of London, and a Children’s Rights Director for England,²⁸⁻³¹ each with their own remit that includes related health issues.

Doctoral Candidate, Dept. of Applied Social Science, University of Stirling, Stirling, Scotland
Correspondence and reprint requests: R.C. Mitchell, 3/1 34 Battlefield Rd., Glasgow, Scotland, G42 9QH, Tel: 0141-434-0213, Fax: 0141-9503474, E-mail: r.c.mitchell@stir.ac.uk

Population health links with children's rights

While the views of young people were significantly under-represented during consultations for the Romanow Commission,³² the Prime Minister has apparently taken a different tack. In 2002, he appointed the Federal Health Minister and the Minister for Human Resources Development to prepare a National Plan of Action for Canada's Children "in fulfillment of its commitment undertaken at the United Nations Special Session on Children in May 2002."³³ These consultations provide new opportunities for dialogue with representative populations of young Canadians about their rights and their health care.

Perhaps unwittingly, Canadian health policy-makers and service providers have been committed to implementing the CRC since 1991, and as noted, Article 24.1 obligations to "the highest attainable standard of health and to facilities for the treatment of illness."³⁴ Further, Article 12 suggests that service providers "assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child" – including health care and health promotion. Concerns over falling standards of the health of various populations of children have been previously linked with child rights violations.³⁵⁻³⁷

However, without congruent policies among federal, provincial and territorial partners guiding health policies with young people, negative outcomes impacting the most vulnerable and socially excluded may continue. While the highest attainable standard of health was certainly achieved for most adults during the 1990s,³ did it occur at the expense of the nation's children? In the *Health of Canada's Children – 3rd Profile*, Dr. Graham Chance acknowledges:

The Canadian 1991 ratification of the UN Convention on the Rights of the Child (1989) was...of key importance for Canadian children. The Convention challenges its nation signatories to seek to attain benchmark behaviours towards the needs, rights and freedoms of children. As a co-signatory, the Canadian government is obliged to report on its progress toward full implementation of the Convention...When much of the

TABLE I

Links Between Population Health Policy in Canada and Children's Rights

Determinants of Population Health	CRC Articles
Income and Social Status – This is described as the single most important determinant of health.	Articles 2-4, 6-8, 12-17 & 27
Social Supports and Networks – Support from families, friends and communities is associated with better health.	Articles 2, 3, 6, 12-17 & 24-29
Education – Health status improves with the level of education.	Articles 24.2, 28, 29, 32 & 33
Social Environments – Social stability, appreciation of diversity, security, harmonious working relationships and cohesive communities.	Articles 2, 3, 6, 12-17 & 24-29
Physical Environments – Factors in the natural environment (air and water quality) are critical influences on health. The human-built environment is also noted as an important influence.	Articles 2, 6, 9, 19 & 32-37
Personal Health Practices and Coping Skills – Through research in such areas as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socioeconomic experience to vascular conditions and other adverse health events.	The entire CRC with special emphasis on Articles 2, 3, 4, 6, 12, 13, 19 & 23-29
Healthy Child Development – The effect of prenatal and early childhood experiences on subsequent health, well-being, coping skills and competence is very powerful.	The entire CRC with special emphasis on Articles 2, 3, 4, 6, 12, 13, 18, 19 & 23-29
Health Services – Maintenance and promotion of health, prevention of diseases, and restoration of health contribute to healthy populations.	Articles 24 & 27
Gender – Gendered norms also influence health practices, along with values, roles and power that are socially ascribed to each gender on a differential basis.	Articles 2, 3, 6 & 12
Culture – Some persons or groups face additional health risks due to a socioeconomic environment which is largely determined by more dominant cultural values contributing to conditions of marginalization, stigmatization, loss or devaluation of language and a lack of access to culturally appropriate health care and services.	Articles 2-6, 8-15, 18-20, 23-29, specifically 30, 31-36, 39 & 40

*information in the Profile is examined in the light of the 'best interests' standard, it is clear that it has not been attained in many instances.*³⁶

The author contends that ongoing health care reform debates in Canada must also include those who stand to inherit the results – young people currently under the age of eighteen. There has been a broad consensus for some time regarding the factors that determine life-long wellness through support for healthy child and youth development.^{38,39} Surprisingly, however, this 'population health' approach has a missing policy link^{7,8} – the nation's international commitments under the UN Convention on the Rights of the Child.

Population health and children's rights

Table I illustrates some of the links between current population health policy in Canada and children's rights, and is based on findings from participatory action

research in British Columbia implementing the Convention on the Rights of the Child in a healthcare setting.²

This analysis shows that the population health/healthy child development policies^{7,8,38} guiding successive federal Health Ministers are also found in the CRC. Highlighted in Article 42 of the CRC are the core interconnected organizing principles of the treaty, which provided an entry point for health policy-makers and service providers engaged in the author's British Columbia pilot study.

- **Article 2** – the young person's rights to non-discrimination on the basis of race, religion, gender, or socioeconomic status
- **Article 3** – decisions will be taken in the best interests of the child – now an international legal standard
- **Article 6** – the child's right to maximum healthy development
- **Article 12** – the young person's right to be heard, to participate in meaning-

ful democratic dialogue, not just consultation

These four core principles are also highlighted by Canada's representatives in New York,^{40,41} while being utilized to frame Canada's 2nd CRC Report to be reviewed this year in Geneva. Why not apply this same framework as a rights-based approach in health promotion and reform? Building an awareness of these four principles is argued here as a *minimum framework* for a rights-approach in health policy, promotion and practice with Canada's young people.

CONCLUSION

While the voices of children and young people appear to have been ignored during recent health care reform discussions, a rights-based approach should be more widely taken up in policy. Linkages with Canada's population health and comparative social theory for children, along with findings from a British Columbia case study piloting this approach, support this contention.

Specifically, this rights-based approach has been shown to begin with Article 42 of the Convention on the Rights of the Child – “making the principles and provisions widely known” – as a minimum framework. With little domestic research available to explicate this child health/child rights nexus, there is a burgeoning discourse in the United Kingdom for comparative study. Both the Romanow Commission and the appointment of the federal Health Minister to develop a National Plan of Action for Canada's children and young people underscore the relevance of adopting this rights-based approach more directly in health care.

REFERENCES

- Collins T, Pearson L, Delany C. Discussion Paper on Rights-based Approach. Ottawa: Senate of Canada 2002; [cited 2003 May 6]. Available on-line at: http://www.sen.parl.gc.ca/lperson/htmfiles/hill/17_h_t_m_files/Committee-e/Tara-ARightsBased.pdf.
- Mitchell RC. Implementing children's rights in British Columbia using the population health framework. *Int J Children's Rights* 2000;8(4):333-49.
- Jolly R, Fukuda-Parr S, Jahan S. *Human Rights and Human Development*. United Nations Development Programme. New York, NY: Oxford University Press, 2000.
- Mann J, Gostkin L, Gruskin S, Brennan T, Lazzarini Z, Fineberg H. Health and human rights. *Int J Health Human Rights* 1994;1(1):1-13.
- Noël A. A Law Against Poverty: Quebec's New Approach to Combating Poverty and Social Exclusion. Canadian Policy Research Network. Dec 2002; [cited 2003 May 6]. Available on-line at: <http://www.cprn.com/cprn.html>.
- Knoppers BM (Ed.). *Canadian Child Health Law: Health Rights and Risks of Children*. Montreal, QC: Thompson Educational Publishing, Inc., 1992.
- Horizons Policy Research Initiatives – Emerging Developments and Knowledge in Public Policy. 1999;2(3):1-24. Ottawa: Policy Research Secretariat [cited 2003 May 6]. Available on-line at: <http://policyresearch.gc.ca/doclib/horizonsv2n3e.pdf>.
- Health Canada Population Health Resources. [cited 2003 May 6]. Available on-line at: http://www.hc-sc.gc.ca/hppb/phdd/resources/subject_approach.html.
- Canadian Policy Research Network Child Care Policy Conference – Final Report. Oct. 2002; [cited 2003 May 6]. Available on-line at: <http://www.cprn.com/cprn.html>.
- Health Canada Childhood and Adolescent Division. Children's Rights and International Policy. [cited 2003 May 6]. Available on-line at: <http://www.hc-sc.gc.ca/hppb/childhood-youth/spsc/research/>.
- National Children's Agenda. National Child Care Strategy: Getting the Architecture Right Now [cited 2003 May 6]. Available on-line at: <http://www.johngodfrey.on.ca/pages/nca-strategy.htm>.
- Canadian Child Care Federation. [cited 2003 May 6]. Available on-line at: http://www.cccf-fcsge.ca/home_en.html.
- Canadian Institute of Child Health. [cited 2003 May 6]. Available on-line at: <http://www.cich.ca/>.
- Ontario Public Health Association. Regarding the Development of National Plans of Action for Canada's Children. [cited 2003 May 6]. Available on-line at: http://www.opha.on.ca/advocacy/letters/children_nationalplan.html.
- James A, Prout A (Eds.). *Constructing and Reconstructing Childhood – Contemporary Issues in the Sociological Study of Childhood* 2nd Ed. Hampshire: Routledge/Falmer Press, 1997.
- Moss P, Petrie P. *From Children's Services to Children's Spaces – Public Policy, Children and Childhood*. London: Routledge/Falmer, 2002.
- Woodhead M. Reconstructing developmental psychology – some first steps. *Children and Society* 1999;13:3-19.
- Mayall B (Ed.). *Children's Childhoods: Observed and Experienced*. London: Falmer, 1994.
- Cairns L. Investing in children: Learning how to promote the rights of all children. *Children and Society* 2001;15:347-60.
- Kirby P, Bryson S. *Measuring the Magic? Evaluating and Researching Young People's Participation in Public Decision Making*. London: Carnegie Young People Initiative, 2002.
- Morrow V. Children's experiences of 'community': Implications of social capital discourses. In: Swann C, Morgan A (Eds.), *Social Capital for Health: Insights from Qualitative Research*. London: Health Development Agency, 2002.
- Lightfoot J, Sloper P. *Health in Partnership Initiative: Involving Children and Young People with a Chronic Illness or Physical Disability in Local Decisions about Health Service Development*. York: University of York, 2002.
- Dixon-Woods M, Young B, Heney D. Partnerships with children. *BMJ* 1999;319:778-80 [cited 2003 May 5]. Available on-line at: <http://www.bmj.com/cgi/content/full/319/7212/778>.
- Alderson P. *Children's Consent to Surgery*. Buckingham: Open University, 1993.
- Alderson P. Theories of consent. *BMJ* 1998;317:1313-15 [cited 2003 May 6]. Available on-line at: <http://bmj.com/cgi/content/full/317/7168/1313>.
- British Columbia Institute Against Family Violence. Beyond a mixed message: A child's right to physical integrity. *Aware* 1993;2(3) [cited 5 May 2003]. Available on-line at: <http://www.bcifv.org/resources/newsletter/1993/fall2/mixedmessage.html>.
- Oakley A. Women and children first and last – Parallels and differences between women's and children's studies. In: Mayall B, *Children's Childhoods: Observed and Experienced*. London: Falmer, 1994;13-32.
- British Council Online Resources Catalogue of Human Rights and Rights of Children 2003; [cited 2003 May 6]. Available on-line at: <http://www.britishcouncil.ru/egovernance/index.php?action=catalog&categoryid=34&lower=1&sortorder=rating&pattern=>.
- Dept. of Health Consultation for Children's Rights Director 2002; [cited 2003 May 6]. Available on-line at: <http://www.doh.gov.uk/childrensrightsdirectorconsultation/index.htm>.
- Dept of Health Quality Protects Research Briefing Number Three on Young People's Participation – Research in Practice; [cited 2003 May 6]. Available on-line at: <http://www.rip.org.uk/publications/QPB/qpb3.html>.
- Payne L. Children's commissioners. *Children & Society* 2002;16(2):284-86.
- Jackson K, Zagon S, Jenkins R, Peters J. Public Input on the Future of Health Care – Results from the Consultation Workbook. Ottawa: Can Policy Research Networks, Ekos Research Associates, Systemscope; 2002;19.
- Pearson L. Civil Society Engagement Process in Canada's National Plan of Action for Children. Ottawa: The Senate of Canada, 2002 [cited 2003 May 6]. Available on-line at: http://www.sen.parl.gc.ca/lperson/htmfiles/hill/17_h_t_m_files/Committee-e/NPA-Letter.pdf.
- Human Rights Directorate Dept. of Canadian Heritage. Convention on the Rights of the Child. Hull: Minister of Supply and Services, 1991.
- Campaign 2000 (2003) Child Poverty in Canada – A national Disgrace. [cited 2003 May 6]. Available on-line at: <http://www.campaign2000.ca/>.
- Canadian Institute of Child Health. *The Health of Canada's Children*, 3rd Ed. Ottawa: CICH, 2000;296-97.
- Mitchell RC. The United Nations Convention on the Rights of the Child and Canadian implementation efforts for indigenous children and youth. *Child and Family Social Work* 1996;1(4):243-54.
- Federal/Provincial/Territorial Advisory Committee on Population Health. Working Group on Healthy Child Development – Investing in Early Child Development: The Health Sector Contribution. Ottawa: ACPH, 1999.
- ISUMA – Kids. *Can J Policy Research*. 2000;1(2):Editorial. [cited 2003 May 5]. Available on-line at: http://www.isuma.net/v01n02/index_e.shtml.
- Pearson L. Statement by The Honourable Landon Pearson – Personal Representative of Canada's Prime Minister to the Special Session on Children Preparatory Committee Meeting. 30 May 2000; Permanent Mission of Canada to the United Nations: Government of Canada.
- Manley J. Statement by the Honourable John Manley – Deputy Prime Minister of Canada to The Twenty-Seventh Special Session of the United Nations General Assembly on Children. 9 May 2002; Permanent Mission of Canada to the United Nations: Government of Canada.