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

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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 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.26 Physical 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.22

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.
Population health links with children’s rights

While the views of young people were significantly under-represented during consultations for the Romanow Commission, 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.” 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.” 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.

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, 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 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.”

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.

Surprisingly, however, this ‘population health’ approach has a missing policy link – 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.

This analysis shows that the population/health/healthy child development policies 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, 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