

# HEALTHY CHILD DEVELOPMENT: LEGISLATIVE AND POLICY APPROACHES IN WESTMINSTER DEMOCRACIES

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*Healthy child development depends upon parents, families and communities, backstopped by enabling and supportive public institutions and legislation. Governments around the world have made moral and legal commitments to protect and nurture their youngest citizens. This paper outlines and assesses the strengths and weaknesses of health and child development-related legislation from Canada, Australia, the United Kingdom and New Zealand. An effective system should provide holistic and comprehensive services (and be able to identify and fill gaps), as well as include incentives and processes for continuous quality improvement and appropriate accountability both of public servants to the Legislative branch and elected officials to the public. Such systems also need to collaborate and coordinate across the various sectors that can influence the many social determinants of health.*

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*La croissance normale d'un enfant dépend de ses parents, de sa famille et de la communauté, avec l'appui d'institutions et de mesures législatives créant des conditions favorables et sur lesquelles on peut compter. Les gouvernements, à l'échelle mondiale, se sont engagés sur le plan moral et juridique afin de protéger et de veiller au développement de leurs jeunes citoyens. Le présent texte décrit et évalue les forces et les faiblesses des mesures législatives en matière de santé et de développement de l'enfant au Canada, en Australie, au Royaume-Uni et en Nouvelle-Zélande. Un système efficace devrait fournir des services globaux et complets (et être en mesure de reconnaître et de corriger les lacunes). Il devrait aussi comprendre des mesures d'incitation et des procédures visant l'amélioration continue de la qualité et la responsabilisation adéquate des fonctionnaires vis-à-vis l'organe législatif et des représentants élus envers le public. Enfin, un tel système devrait également être en mesure d'assurer la collaboration et la coordination entre les différents secteurs pouvant exercer une influence sur les nombreux facteurs liés à la santé.*

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### 1. Introduction

Healthy development and growth opportunities during the earliest years are an important determinant of children's long-term health and well-being.<sup>1</sup> For example, adult obesity, heart disease, mental illness, criminal activity and employment issues are all associated with problems in early childhood.<sup>2</sup> Children who live in poverty face a higher risk of developmental delay, underachievement in school and employment, behaviour problems and increased incidence of chronic illness.<sup>3</sup> In addition, an upbringing where a child is exposed to smoking or where family members have low levels of literacy decreases the child's potential for positive outcomes.<sup>4</sup> However, there is evidence that some pregnancy and early childhood interventions are effective at averting or ameliorating long-term adverse impacts.<sup>5</sup>

Providing healthy development and growth opportunities in the early years requires a collaborative societal effort: parents, families and communities play vital roles, with the essential support of enabling public institutions and legislation. Governments around the world have made moral and legal commitments to protect and nurture their youngest citizens. Historically, social welfare and health surveillance have been the

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<sup>1</sup> Federal, Provincial and Territorial Advisory Committee on Population Health. *Strategies for Population Health: Investing in the Health of Canadians*, 1994; Margaret Norrie McCain and J.Fraser Mustard, "Reversing the Real Brain Drain: The Early Years Study Final Report," (Toronto: Ontario Children's Secretariat, 1999); Margaret Norrie McCain and J.Fraser Mustard. "The Early Years Study Three Years Later - From Early Child Development to Human Development: Enabling Communities" (Toronto: Canadian Institute of Advanced Research, 2002); Margaret Norrie McCain and J.Fraser Mustard. "The Early Years Study Three Years Later - From Early Child Development to Human Development: Enabling Communities" (Toronto: Canadian Institute of Advanced Research, 2002).

<sup>2</sup> Child and Youth Officer for British Columbia, "Special Report. Healthy Early Child Development in British Columbia: From Words to Action" (Victoria: Government of British Columbia, 2005).

<sup>3</sup> Lori G. Irwin, Arjumand Siddiqi, and Clyde Hertzman. *Early Child Development: A Powerful Equalizer*. World Health Organization Commission on the Social Determinants of Health, 2007.

<sup>4</sup> Max S. Cynader and Barrie Frost. *Mechanisms of Brain Development: Neuronal Sculpting by the Physical and Social Environment*. (Toronto: The Canadian Institute for Advanced Research, 1998).

<sup>5</sup> Helen Roberts, "Socioeconomic Determinants of Health: Children, Inequalities and Health" (1997) 314 B.M.J. 1122.

tools of choice to set children on healthy pathways. In line with this, the legislative and regulatory processes in place in most jurisdictions were designed to address and meet the needs of children at risk and to ensure the reduction of injury and illness. Social welfare approaches focus on protecting children in vulnerable and abusive situations. Khoo, Hyvönen, and Nygren suggest that Canadian social work practice remains driven by a framework where the chief task is to determine the child protection features of any possible case; this determines eligibility for government intervention or support.<sup>6</sup> Health surveillance tools were meant to provide population level screening and protection from food borne and environmental illness. These hygienic and disease prevention efforts, characteristic of traditional public health, have been challenged by the emergence of the 'new public health' with its more ecological emphasis.<sup>7</sup>

Social welfare and health surveillance approaches tend to be narrow in scope but this no longer seems sufficient to ensure healthy child development. As evidence from Australia suggests, inclusion of a broader, social determinant perspective is required in legislation and policy development to foster healthy child development.<sup>8</sup> The concept of social determinants of health has been widely acknowledged in the epidemiological and public health literature for many years.<sup>9</sup>

The basic idea is that health of individuals is influenced by a wide range of biological, environmental and epidemiological determinants. Examples of programs aimed at early childhood with the intention of influencing longer term health include free literacy programs in lower income areas, community arts and activity programs, subsidized or free food boxes, and healthy low cost meal preparation training for new parents.

The purpose of this paper is to review legislative and policy approaches to child protection and the promotion of healthy child development (HCD) employed by different jurisdictions in the English-

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<sup>6</sup> Evelyn G. Khoo, Ulf Hyvönen and Lennart Nygren, "Gatekeeping in Child Welfare: A Comparative Study of Intake Decisionmaking by Social Workers in Canada and Sweden" (2003) 82 *Child Welfare* 507 at 520.

<sup>7</sup> John Ashton, Paula Grey and Keith Barnard, "Healthy Cities – WHO's New Public Health Initiative" (1986) 1 *Health Promotion* 319.

<sup>8</sup> Sandra Leggat, "Healthy Children, Healthy Country: The Use of Governing Instruments in Shifting the Policy Paradigm" (2004) 1 *Australia and New Zealand Health Policy*.

<sup>9</sup> Thomas McKeown, *The Role of Medicine: Dream, Mirage, or Nemesis?* (London, England: Nuffield Provincial Hospitals Trust, 1976); Robert G. Evans, Morris L. Barer and Theodore R. Marmor (eds.), *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*. (Hawthorne NY: Aldine de Gruyter, 1994).

speaking world. In this, we evaluate child development policies and regulation to determine how well they focus on social determinants that influence early life health. Several different approaches are described along with advantages and disadvantages of each in light of their ability to support accountability and continuous program improvement, as well as their degree of comprehensiveness. Through this, the intent is to assess which models would address social determinants and provide a durable platform for meeting changing needs in HCD.

The approaches reviewed in this paper are grouped into four broad categories. First, governments can promote HCD through legislating specific and enforceable rights and obligations. Second, HCD can be promoted through the organization and delivery of specific programs or services. Third, governments can systematically plan for, set standards for, monitor and evaluate the implementation and outcomes of programs and services. Fourth, oversight bodies or systems can be established. We touch on each of these in turn and then, in the discussion, we return to identifying which policies are promising avenues for incorporating the social determinants approach to healthy child development.

The jurisdictions included in this review are: six Canadian provinces (Alberta, Saskatchewan, Manitoba, Ontario, Quebec, Newfoundland and Labrador), six Australian states or territories (New South Wales, Victoria, Queensland, Tasmania, South Australia and the Northern Territory), New Zealand and the United Kingdom (UK). These jurisdictions were selected as they each have a developed publicly-funded health care system, they each have begun to develop and implement early childhood policies and they each provide examples of parliamentary liberal democracies.

## *2. Rights-Based Approaches*

One way in which governments approach child protection and the promotion of HCD is by legislating specific rights. Rights come in several different forms. One way of categorizing rights is to view them as claim rights, powers, immunities and liberties (or privileges).<sup>10</sup> Each right has a different implication for the relationship existing between the parties.<sup>11</sup> A claim right implies a reciprocal duty or obligation on another person such as the right of a patient to be provided with information from a medical

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<sup>10</sup> Wesley N. Hohfeld, "Fundamental Legal Conceptions," in N.E. Simmonds, ed., *Central Issues in Jurisprudence – Justice Law and Rights* (London: Sweet & Maxwell, 1986) at 129-40.

<sup>11</sup> S. Laufer, "A Code of Health Rights and Responsibilities: The Adequacy of Existing Recognition and Protection" (Canberra: Australia Commonwealth Publications, 1995).

practitioner about the material risks of a medical treatment. Liberties involve a right without any duty owed by another person, and may also be referred to as freedoms. This includes the concept of patient autonomy. Powers are liberty rights which are given legal effect through specific legislation but do not impose a co-relative duty on another person. An example of a power is where a medical official is granted the power to consent to necessary blood transfusions for a child where the parents refuse to consent. Finally, immunities involve rights which cannot be abrogated by legislatures.

Legally enforceable rights can be located in four sites which outline specific duties or obligations government must meet vis-à-vis its citizens: international conventions, constitutional documents, a general charter or code, and individual statutes.

#### *a) International Conventions*

There exist several international conventions addressing the rights of children. For example, the countries studied here have signed and ratified the *United Nations Convention on the Rights of the Child* which includes the right for children to be protected against all forms of discrimination.<sup>12</sup> This Convention also recognizes the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.<sup>13</sup> Canada has also ratified several other relevant conventions such as the *Universal Declaration of Human Rights*,<sup>14</sup> the *International Covenant on Civil and Political Rights*,<sup>15</sup> and the *International Covenant of Economic, Social and Cultural Rights*.<sup>16</sup>

These conventions form part of international obligations for child health. Not only do they provide moral force to particular child health considerations and the form that these should take but they also may be utilized as an interpretive tool. Courts generally avoid interpretations of domestic legislation which would violate a nation's treaty obligations.<sup>17</sup>

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<sup>12</sup> *Convention on the Rights of the Child*, 2 September 1990, U.N.T.S. 1577 at 3, Can. T.S. 1992 No. 3 (accession by Canada 13 December 1991), Article 2.

<sup>13</sup> *Ibid.* at Article 24.

<sup>14</sup> *Universal Declaration of Human Rights*, GA Res. 217(III), UN GAOR, Ed Sess., Supp. No. 13, UN Doc. A/810 (1978) 71.

<sup>15</sup> *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, arts. 9-14, Can. T.S. 1976 No. 47, 6 I.L.M. 368 (entered into force 23 March 1976, accession by Canada 19 May 1976).

<sup>16</sup> *International Covenant of Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3, Can. T.S. 1976 No. 46 (entered into force 3 January 1976, accession by Canada 19 May 1976).

<sup>17</sup> Hugh M. Kindred, Karen Mickelson, René Provost, Linda Reif, Ted L.

Treaties such as those listed above will bind the state as a whole but their provisions will not affect internal laws until the principles have been implemented by domestic legislation.<sup>18</sup> International conventions can be directly adopted as national legislation or be incorporated piecemeal into various statutes. International conventions may also be incorporated into domestic law by requiring particular decision-makers to consider a state's international obligations. For example, the Children's Commissioner in the UK is directed to have regard to the *United Nations Convention on the Rights of the Child* when carrying out his or her functions.<sup>19</sup> Similarly, the Children's Commissioner in New Zealand must have regard to the *United Nations Convention on the Rights of the Child* when executing his or her duties.<sup>20</sup> In New Zealand, the Families Commission also is directed to have regard to New Zealand's international obligations relevant to the interests of families.<sup>21</sup>

#### *b) National Charters or Bills of Rights (Constitutional Protections)*

Though it goes against the Westminster tradition, some Western countries have established constitutionally-entrenched rights defended by judicial review. For example, in Canada, federal and provincial governments alike are bound by the 1982 *Charter of Rights and Freedoms*.<sup>22</sup> The *Charter* applies to all government action including, according to the Supreme Court of Canada, the delivery of medically necessary services by hospitals and other health care bodies.<sup>23</sup> Legislation, as well as government policy and activity, must comply with the principles outlined in the *Charter* and if found to violate these principles, the legislation, policy or action may be declared to be null and void.<sup>24</sup> In this section we discuss the experience of entrenched rights in Canada as a guide to their usefulness in advancing a child and family health agenda.

Two sections of the *Charter* in particular have been applied in the area of health care – sections 7 and 15. Section 7 of the *Charter* guarantees: “Everyone has the right to life, liberty and security of the person and the

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McDorman, Armand L.C. de Mestral, and Sharon Williams, *International Law Chiefly as Interpreted and Applied in Canada*, 6th ed., (Toronto: Edmond Montgomery Publications Ltd, 2002) at 209.

<sup>18</sup> *Ibid.* at 188.

<sup>19</sup> *Children's Act 2004* Chapter 31 (U.K.) at s. 2(11).

<sup>20</sup> *Children's Commissioner Act 2003* (N.Z.), 2003/121, s. 11.

<sup>21</sup> *Families Commission Act 2003* (N.Z.), 2003/128, s. 12.

<sup>22</sup> *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [*Charter*].

<sup>23</sup> *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 [*Eldridge*].

<sup>24</sup> *Charter*, *supra* note 25, s. 24(1).

right not to be deprived thereof except in accordance with the principles of fundamental justice.” Section 15(1) of the *Charter* states that “every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.” Section 1 of the *Charter* states that these rights and freedoms are subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Canadian courts have ruled that section 7 may apply whenever state requirements or prohibitions affect important and fundamental life choices which include choices involving physical and psychological integrity. Section 7 is not limited to procedural fairness, such as how a particular law is administered, but also involves assessing the substantive merits of whether the person’s interests are properly balanced with the interests of society.

Section 7 includes an inherent limitation: the right not to be deprived of enumerated rights except in accordance with the principles of fundamental justice. For example, in *Alberta v. K.B.*,<sup>25</sup> the Court upheld a section of the *Protection of Children Involved in Prostitution Act*<sup>26</sup> that allowed a child suspected of being involved in prostitution to be confined in a safe house for three days before the Director under the *Child Welfare Act*<sup>27</sup> must show cause for the confinement. If the child was to be detained longer, the Director had to obtain an order from the Provincial Court under section 19 of the *Child Welfare Act*. The Court held that the provisions in the *Protection of Children Involved in Prostitution Act* achieved a constitutional balance between the need for interim measures to protect a child at risk and the requirement for an expedited post-apprehension hearing process. While several sections of the Act did deprive a child of liberty under section 7, this was not in violation of the principles of fundamental justice.

Other cases where section 7 is typically invoked by children arise where their religious beliefs lead them to decline life-saving medical treatment and the medical personnel ask that the child be made a temporary ward of the state so that child welfare services may authorize medical treatment. For example, in *Manitoba (Director of Child & Family Services) v. A.C.*,<sup>28</sup> A.C., a 14-year-old girl, suffered from Crohn’s disease.

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<sup>25</sup> 2000 ABQB 976, [2000] A.J. No. 1570 ( Alta.Q.B.) (QL).

<sup>26</sup> S.A. 1998, c. P-19.3.

<sup>27</sup> S.A. 1984, c. C-81.

<sup>28</sup> (2007), 276 D.L.R. (4th ) 41 ( Man. C.A.), leave to appeal granted [2007]

After an incident of internal bleeding, medical personnel decided that her life was at risk and that a blood transfusion was necessary. She refused as she was baptized into the Fellowship of Jehovah's Witnesses. The Director of Child and Family Services then brought an application for an order for a blood transfusion. The Court found that the order for treatment did implicate A.C.'s security interest under section 7; given concerns over protecting the lives of children in relation to essential medical treatment, however, and the difficulty in determining capacity in emergency situations, the choice of a "best interests" test for minors under sixteen utilized in the legislation was deemed not unfair or arbitrary.<sup>29</sup>

Section 15, involving the idea of equality before and under the law, also has been frequently utilized in litigation related to health care services in Canada. A three-step process has been outlined for determining whether a violation of s. 15 has occurred.

(1) Does the impugned law (a) draw a formal distinction between the claimant and others on the basis of one or more personal characteristics, or (b) fail to take into account the claimant's already disadvantaged position within Canadian society resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics?

(2) Is the claimant subject to differential treatment based on one or more enumerated and analogous grounds?

(3) Does the differential treatment discriminate, by imposing a burden upon or withholding a benefit from the claimant in a manner which reflects the stereotypical application of presumed group or personal characteristics, or which otherwise has the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect and consideration?<sup>30</sup>

Section 15 was also invoked in the A.C. case noted above.<sup>31</sup> The Court held that the legislation was not an arbitrary marginalization as it attempted to respond to dependency and limited maturity of children as a group. The scheme allowed for recognition of a continuum of maturity over which young people develop. As with section 7, there are also limits to the scope

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S.C.C.A. No. 194 (QL).

<sup>29</sup> *Ibid.* at 70.

<sup>30</sup> *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 at para. 88.

<sup>31</sup> *Supra* note 31.



of protection offered by section 15. Protection is limited to situations where the law is the source of the deprivation; section 15 only requires equality “before and under the law.” For example, in the *R.R. v. Alberta (Child Welfare Appeal Panel)* case,<sup>32</sup> the parents of two children with cerebral palsy applied for financial assistance for the cost of conductive education and related summer camp fees. Some financial assistance had been given in other cases for conductive education treatment for cerebral palsy. The Court held that the personal characteristics of the family were the basis of the decision. There was no discrimination based on the physical disability as other children with cerebral palsy had been awarded assistance. The Court noted, “Equal treatment under the law does not mean equal benefits.”<sup>33</sup>

Section 1 is also frequently at issue in *Charter* litigation related to the provision of health care services. Section 1 provides the government or government body with the opportunity to justify the rights violation where it can show the deprivation occurred in accordance with the principles of fundamental justice. In many cases, at the section 1 stage of the analysis, the courts have shown a reluctance to interfere with policy decisions where the government can show that it is balancing competing interests within a constrained financial environment. For example, in the *Cameron v. Nova Scotia* case,<sup>34</sup> the government refused to pay for a special form of *in vitro* fertilization; the Court agreed with the applicants that the government action was a form of discrimination based on a physical disability and thus violated section 15, but held that section 1 was a complete defense to the violation as the government was balancing competing interests.

Section 1 highlights the importance of ensuring that health care legislation, policies and decisions are based on evidence. Decisions that are justified by evidence, and are transparent, comprehensive and systematic rather than based on historical funding patterns or made case-by-case may have the advantage of being more justifiable under section 1 of the *Charter*.<sup>35</sup>

While it is important to consider the principles outlined in the *Charter*, particularly sections 7 and 15, when developing healthy child legislation and policy, we must recognize that the *Charter* is not adequate to shape the structure of health services such as policy and budget choices about the

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<sup>32</sup> 2000 ABQB 1018, [2000] A.J. No. 580 (Alta.Q.B.) (QL).

<sup>33</sup> *Ibid.* at para. 39.

<sup>34</sup> (1999), 177 D.L.R. (4<sup>th</sup>) 611 (N.S.C.A.).

<sup>35</sup> Donna Greschner and Steven Lewis, “*Auton* and Evidence-Based Decision-Making: Medicare in the Courts” (2003) 82 Can. Bar Rev. 501 at 517-19.

nature and scope of the medical services provided.<sup>36</sup> The appeal of attempting to utilize the *Charter* to shape health services is that it is a law which is immutable and supreme and which binds governments. The *Charter* has been described, however, as “a blunt instrument for resolving social welfare issues”<sup>37</sup> as the rights in it are generally negative; the *Charter* does not require the government to take action but rather protects rights where government action has impacted them. Grover, for instance, in her analysis of Alberta’s *Protection of Children Involved in Prostitution Act*, argues that it provides no guarantee of access for child victims to positive government support which would assist young people in moving forward successfully with their lives and improving their social, economic and material prospects.<sup>38</sup>

Where positive action is required under the *Charter*, the action has tended to involve equal application of or equal access to already existing state programs. As well, the *Charter* typically involves situations where an individual has been impacted by state action or inaction, and is generally reactive in nature rather than a document for promoting systematic overall policy. Finally, the rights guaranteed by the *Charter* are primarily individual in nature; it does not offer much guarantee of access to the social and economic prerequisites for healthy development. As a result, the *Charter* may not be the ideal tool for developing health care policy which involves the challenge of resource allocation where there are limited resources, complex policies that balance numerous issues and interests, and the need for programs and policies that are prospective in nature.

### c) *Codes of Rights*

Governments might also attempt to delineate the rights of children and others by promulgating a non-constitutional statute that enumerates certain rights to care (social rights) – commonly titled a “Patient’s Charter” or “Code of Rights.” For instance, New Zealand has enacted a *Code of Health and Disability Services Consumers’ Rights*. These rights include the right to be treated with respect; the right to freedom from discrimination, coercion, and harassment; the right to dignity and independence; the right to services of appropriate standards; the right to effective communication; the right to be fully informed; the right to make an informed choice and give informed consent; the right to support; the right to complain; and rights in respect of teaching and research. In another clause, the Code

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<sup>36</sup> Benjamin Berger, “Using the *Charter* to Cure Health Care: Panacea or Placebo?” (2003) 8 Rev. Const. Studies 20 at 21.

<sup>37</sup> *Ibid.* at 23.

<sup>38</sup> Sonja Grover, “On Meeting Canada’s Charter Obligations to Street Youth” (2002) 10 Int’l J. of Children’s Rights 313.

provides that if the rights are not met, then the provider must show that it was reasonable in the circumstances not to provide those rights.<sup>39</sup> Other jurisdictions that have developed a similar code include Queensland<sup>40</sup> and the Northern Territory in Australia.<sup>41</sup>

Is it necessary to have a separate code of health rights, or are common law actions such as negligence, and trespass to the person, and existing legislation such as the *Charter*, human rights legislation, privacy legislation, and legislation governing different medical practitioners sufficient? It can be argued that increased clarity, comprehensiveness and consistency would occur if rights were codified. The common law related to negligence and trespass is compiled on a case-by-case basis, whereas a code developed by the legislature would likely involve more public participation in the shaping of the rights than those developed through the court system and be more comprehensive.

Some limitations of a code include its inflexibility — unlike the common law which can evolve over time, a code once written may not fit new situations and may not be easy to change. Regular review of the code may address this problem. Furthermore, as the rights need to be drafted in broad statements or principles, the Code may provide insufficient protection in certain situations.

Canada's Royal Commission on the Future of Health Care in Canada, chaired by Roy Romanow, recommended the establishment of a Canadian Health Covenant, an aspiring statement about the values informing the health care system.<sup>42</sup> The Commission also stated, however, that this Covenant should not contain legal rights and obligations akin to a "Patient Bill of Rights."<sup>43</sup> As one author has noted, the implication is that the application of the Covenant will be decided by politicians rather than enforced by the courts. This approach implicitly prefers political negotiation over judicial enforcement of rights without an explicit rationale for this preference.<sup>44</sup>

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<sup>39</sup> *Health and Disability Commissioner Act 1994* (N.Z.), 1994/88, s. 20.

<sup>40</sup> *Health Rights Commission Act 1991* (Qld), s. 37

<sup>41</sup> *Health and Community Services Complaints Act 2003* (NT), s. 104.

<sup>42</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 48 (Recommendation 1).

<sup>43</sup> *Ibid.* at 51.

<sup>44</sup> Donna Greschner, "Public Law in the Romanow Report" (2003) 66 Sask. L. Rev. 565 at 570-71.

#### *d) Individual Statutes*

Beyond any general statement of rights contained in a national constitution, governments can legislate in more specific terms about the delivery of services for children and families. Particular populations can be granted the right to certain services, and governments may also enshrine the right of these groups to receive service in a certain manner. As well, officials may be mandated to perform certain tasks or deliver certain programs.

##### *1) Legislated Rights to Specific Services*

Quebec's *Health Services and Social Services Act* enumerates the right to be informed about health and social services resources available; the right to receive health and social services, with continuity and in a personalized and safe manner; the right to choose the professional or institution from which to receive those services; the right to receive care where life or bodily integrity is endangered; the right to information about the state of health and welfare and different treatment options prior to granting consent; and the right to be informed of any accident that occurs during the provision of services.<sup>45</sup>

Also in Quebec, the *Youth Protection Act* provides that a child is entitled to receive adequate health, social and educational services in all scientific, human and social levels, continuously and according to his or her personal requirements, taking into account the legislative and regulatory provisions governing the organization and operation of the institution or educational body providing such services and the human, material and financial resources at its disposal.<sup>46</sup> In this instance then, the right to receive adequate services is significantly qualified; it is therefore more difficult for affected youth to enforce.

Legislating a right to certain services will likely encourage consistency, accountability and access. The right to receive services in a certain manner will likely increase transparency and accountability in the way services are provided. These advantages must be carefully weighed against the administrative costs, potential duplication with other existing legal rights, increased litigation, and the difficulty of changing such rights.

##### *2) Mandated Duties*

The flip-side of rights is duties. Governments may pass legislation that

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<sup>45</sup> *Health Services and Social Services Act*, R.S.Q. c. S-4.2, ss. 4-8.

<sup>46</sup> *Youth Protection Act*, R.S.Q. c. P-34.1, s. 8.

contains clauses mandating or requiring the performance of general responsibilities, certain tasks or the delivery of certain programs and services. Either a minister or a particular department or agency is the locus of obligation. These may be more or less legally enforceable by aggrieved citizens, depending upon the specific wording employed.

Many statutes lay general responsibilities upon a minister or department. In Quebec, for instance, the Minister of Health and Social Services must assure the social protection of individuals, and families and other groups.<sup>47</sup> The Minister of Health in Ontario has the duty to advise the government on the health of people in Ontario, and to oversee and promote the health and physical and mental well-being of people in Ontario.<sup>48</sup>

More precise obligations are imposed under Quebec's *Youth Protection Act*, which outlines considerations that must be taken into account by every person making decisions with respect to a child under the Act. Considerations include ensuring that information is furnished to a child in appropriate language, ensuring that parents have understood the information, and ensuring that action is taken diligently considering a child's perception of time.<sup>49</sup>

In Alberta, regional health authorities are mandated to promote and protect the health of the population and work toward prevention of disease and injury, ensure reasonable access to quality health services, and promote the provision of health services in a manner that is responsive to the needs of individuals and supports the integration of services and facilities. More specific tasks can also be assigned; for example, Alberta regional health authorities, like those in other provinces, are also expected to assess the needs of the population and determine priorities.<sup>50</sup>

In New Zealand, each district health board (DHB) is charged with actively investigating, facilitating, sponsoring and developing co-operative and collaborative arrangements to improve, promote and protect the health of people in its region.<sup>51</sup> In the UK, children's services authorities have a duty to make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children.<sup>52</sup> The 2004 *Children's Act* created, similar to the New Zealand case, a duty on children's services authorities to facilitate integration. Each children's services authority must make arrangements to promote co-

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<sup>47</sup> *Ministère de la Santé et des Services Sociaux Act*, R.S.Q. c. M-19.2, s. 3(a).

<sup>48</sup> *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26, ss. 6(1)-(3).

<sup>49</sup> *Youth Protection Act*, R.S.Q. c. P-34.1, s. 2.4.

<sup>50</sup> *Regional Health Authorities Act*, R.S.A. 2000, c. R-10, s. 5.

<sup>51</sup> *New Zealand Public Health and Disability Act 2000* (N.Z.), 2000/91, s. 23(b).

<sup>52</sup> *Children's Act 2004*, *supra* note 22 at s. 10(2).

operation between the authority, each of its relevant partners and other persons or bodies who are involved in activities in relation to children in the authority's area.<sup>53</sup> The types of agencies that the authority is required to work with include the county council, policy authority, local probation board, strategic health authority, primary care trust, and Learning and Skills Council for England.<sup>54</sup>

In some cases, the provision of specific programs or services is mandated by law. In Ontario, for instance, every board of health is required to attend to certain functions. Family health is one of these functions and is defined as including counseling; family planning services; health services to infants, pregnant women in high risk categories and the elderly; preschool and school health services; screening programs; tobacco use prevention programs; and nutrition services.<sup>55</sup>

The advantages of creating duties for the minister or other government bodies to carry out are that it provides direction to a department's activities, and sets identifiable objectives to be met. The minister or other government bodies are also accountable for carrying out such duties; its actions may be subject to review by a court if they fail to address the specified duties. The duty can be specific and concrete but still provide room for variation among different localities. The UK *Children's Bill* is a good example as children's services authorities are required to coordinate services with other bodies; how coordination is organized, however, is left to the discretion of each locality.

One disadvantage to mandating duties is that duties formulated as broad policy statements or in an aspiring format will provide limited accountability; achievement of such duties will be hard to ascertain and measure. Another disadvantage is that, as new areas of importance are identified, these may need to be added to the legislation, with all the possible delays such efforts entail. The key advantage to mandating specific programs in legislation is that it ensures that these programs are implemented. A disadvantage to this approach is that the program may cease to be relevant or necessary or need to be altered but may have to be continued until the legislation can be changed. As well, other priorities may emerge but cannot be implemented because of the legislative requirement for an existing but perhaps outdated program.

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<sup>53</sup> *Ibid.* at s. 10(1).

<sup>54</sup> *Ibid.* at s. 10(4).

<sup>55</sup> *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, s. 4.

### 3. *Government Organization for Integrated and Coordinated Service Delivery*

We now turn from the legislative function to the executive branch of government. Governments also indicate their priorities for child protection and promoting HCD through policy statements and through the organization of programs and service delivery systems they put in place to implement these policies. As noted earlier, HCD is a complex and multifaceted concept that requires a holistic approach. In all the jurisdictions reviewed, this demands intergovernmental, inter-ministerial and interdepartmental collaboration and the development of integrated delivery systems.

In federal systems, where different levels of government may each hold responsibility for certain services needed to provide a holistic and comprehensive network of early childhood development services, some mechanisms for intergovernmental collaboration are required. In Australia, there are several national policy initiatives relating to child and family health. The National Investment for the Early Years is a major initiative focusing on children up to three years of age. This initiative focuses on public health approaches to supporting pregnant women, establishing awards and tax incentives for businesses to be family-friendly, increased support and resources for parenting, continued development of public education facilities and addressing dangerous situations for children. Under this initiative, a Prime Ministerial Council on Development Health and Well-Being that would report to the Council of Australian Governments (which has Commonwealth, State and Territorial government membership) was proposed.<sup>56</sup> As the Commonwealth Task Force on Child Development Health and Welfare, this body developed a collaborative whole of government and cross-governmental response to child and family health and well-being in Australia, the National Agenda for Early Childhood.<sup>57</sup>

Agreements between Canada's federal or provincial governments and First Nations might also be seen as a form of intergovernmental coordination. Consider the Nisga'a Final Agreement, negotiated and signed by the federal and British Columbia governments, and the First Nation. It grants the Nisga'a Lisims Government the power to make laws in respect of

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<sup>56</sup> A National Agenda for Young Children in Australia (July 28, 2001), online: <<http://www.nifey.cyh.com/Documents/national%20agenda.pdf>> (date accessed 8 June 2007).

<sup>57</sup> The National Agenda for Early Childhood (May 2007), online: <[http://www.facs.gov.au/internet/facsinternet.nsf/via/early\\_childhood/\\$File/draft\\_naec.pdf](http://www.facs.gov.au/internet/facsinternet.nsf/via/early_childhood/$File/draft_naec.pdf)> (date accessed 8 June 2007).

health services on Nisga'a lands. The Agreement also provides that the parties will attempt to reach agreements for the delivery and administration of health services for all individuals on Nisga'a lands.<sup>58</sup>

The Nisga'a government manages its health care system through the Nisga'a Valley Health Board registered under BC's *Society Act*.<sup>59</sup> The Board is responsible for facilities, promoting medical and public health programs, and operating a diagnostic center. The Nisga'a Valley Health Board has a direct relationship with the British Columbia government and has held discussions with the regional health authority in the area regarding appropriate roles and responsibilities.

Health care legislation from other jurisdictions highlights other examples of methods for addressing health care commitments made under First Nations agreements. In New Zealand the *Public Health and Disability Act 2000* outlines mechanisms to enable Maori to contribute to decision-making and to participate in the delivery of health services as required under the Treaty of Waitangi. As well, DHBs are to establish and maintain processes to enable Maori to participate in strategies for Maori health improvement as required by the Treaty.<sup>60</sup>

Individual governments also need to find effective ways to organize themselves for achieving goals such as supporting healthy child development. Some Canadian provinces have experimented with a free-standing ministry for children, children's services or child development, although these are frequent victims of restructuring and restraint. Regardless of the existence of any such specific department, however, due to the many social and economic determinants of healthy child development, some degree of coordination across policy sectors will be necessary.

Independent, stand-alone bodies such as special operating agencies might be another locus from which to plan and deliver children's services. In the UK, the development of children's trusts is being encouraged to secure integrated service provision.<sup>61</sup> These trusts are to be established through the pooling of budgets and resources across each local education authority, children's social services, health services and in some cases

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<sup>58</sup> British Columbia, Nisga'a Nation and Government of Canada, *Nisga'a Final Agreement* (Victoria: Ministry of Aboriginal Affairs, 1998), ss. 11(82) to 11(85).

<sup>59</sup> "Prosper": *Nisga'a Final Agreement 2001/2002 Annual Report* (Ottawa: Indian and Northern Affairs Canada, 2002) at 34.

<sup>60</sup> *Public Health and Disability Act 2000*, *supra* note 54, ss. 4, 23.

<sup>61</sup> U.K., Department for Education and Skills, *Every Child Matters: Next Steps*, (Nottingham: DfES Publications, 2004) [*Every Child Matters*] at 16-18.



youth offending teams. Two possible avenues exist for the creation of trusts: an agreement under the *Health Act 1999*,<sup>62</sup> or the budget-pooling power of the *Children's Act*.<sup>63</sup> The establishment of trusts does not mandate staff transfer or change but leaves the structure within local discretion.

A key advantage of creating a separate body to integrate services is that it recognizes that HCD is facilitated by a variety of government departments. This approach recognizes the importance of ensuring that service provision is integrated to avoid duplication and gaps, increase accessibility, and facilitate sharing of information. A potential problem with this approach is that it adds another level of bureaucracy and administration which takes funding away from direct service programs. The quality of the policies developed will likely depend on the additional resources allocated and the separate body's ability to access information from the different departments and outside experts. The effectiveness of the separate body in making change will also likely depend on its ability to influence change in the different government departments delivering the services.

Another approach to coordinating policy for HCD is the formation of an inter-ministerial committee. For instance, in March 2000, Manitoba created Healthy Child Manitoba, a committee of Cabinet. The Committee included the Ministers of Energy, Science and Technology; Health; Aboriginal and Northern Affairs; Justice; Culture, Heritage and Tourism; Status of Women; Family Services and Housing; and Education and Youth. A similar Cabinet committee has been developed in the UK, titled MISC9(D). This Committee meets regularly to oversee the delivery of children's services.<sup>64</sup> Sub-committees also look in detail at particular issues such as teenage pregnancy and information sharing.

There are several advantages to forming a cabinet committee to direct HCD. The committee has a wide degree of discretion in setting policy and can flexibly adopt new programs and change or delete already existing programs. Another advantage is that, as the committee is composed of ministers from the departments involved in areas affecting child health, better integration of services may be achieved and less resistance to new or changing programs or policies may occur than where a committee is overseen by one department alone. Similarly, as policies are created at a high level of government, the political will for implementation should exist. A significant disadvantage of forming an inter-ministerial committee

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<sup>62</sup> *Health Act 1999* (U.K.), c. C-8, s. 31.

<sup>63</sup> *Children's Act 2004*, *supra* note 22 at s. 10(6).

<sup>64</sup> *Every Child Matters*, *supra* note 61 at 45.

is that, as the committee was created by the first minister and cabinet, they may also disband it at any time if interest in child development policy wanes. There is also limited public accountability for the committee as it sets its own priorities and monitors its own results. As a result, there are no legislative benchmarks by which to measure its performance or to guide its priorities or spending.

Cooperation at the interdepartmental level, between civil servants in various departments whose work relates to healthy child development, has also been pursued. Ontario has created the Office of Integrated Services for Children. This Office is responsible for the integration of children's services in and between the Ministries of Health and Long-Term Care, and Community and Social Services. The primary focus is on integration of health, education, recreation, and social services for families at risk with children from before birth to eight years of age. The Office undertakes a variety of activities including leading the implementation of the Healthy Babies, Healthy Children program; leading the implementation of the preschool speech and language program; leading the policy development and evaluation of the Better Beginnings, Better Futures program; and identifying and developing integration strategies and tools to guide children's services.<sup>65</sup>

A similar approach has been instituted in Western Australia through the creation of an Early Years Taskforce which includes the directors general of the Department of Community Development; Health; Education and Training; Local Government and Regional Development; Housing and Works; and Indigenous Affairs as well as the Premier and Cabinet, and the Disability Services Commission. The aim of the Taskforce is to focus on the effective alignment of existing and planned resources to ensure a comprehensive response to children up to eight years of age; to engage communities in the planning and development of community resources; and to ensure a strong interdepartmental response and local leadership in the implementation of the State's Children's Strategy.<sup>66</sup>

The same benefits of interdepartmental collaboration can be obtained, on a smaller scale, through intradepartmental collaboration – that is, drawing together and coordinating different services for children and

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<sup>65</sup> Ministry of Health and Long-Term Care, online: <[http://www.health.gov.on.ca/english/providers/pub/child/hbabies/implem\\_phase1.html#43](http://www.health.gov.on.ca/english/providers/pub/child/hbabies/implem_phase1.html#43)> (date accessed 3 April 2007).

<sup>66</sup> Early Years Framework, online: Department of Community Services, Western Australia <[http://www.community.wa.gov.au/NR/rdonlyres/CE81F73B-2EFF-46C9-838C-6297A0958D0E/0/DCDPOLEarlyyearsstrategicframework\\_Final170804.pdf](http://www.community.wa.gov.au/NR/rdonlyres/CE81F73B-2EFF-46C9-838C-6297A0958D0E/0/DCDPOLEarlyyearsstrategicframework_Final170804.pdf)> (date accessed 30 March 2007).

families that are delivered within particular line departments. For instance, the Our Kids Bureau is a dedicated unit in the Tasmanian Department of Health whose aim is to deliver on agreed outcomes through greater investment in prevention, service integration and new models of service delivery for children from preconception to eleven years of age. The Directors of Children and Families; Community, Population and Rural Health; Hospital and Ambulance Services; Housing Tasmania; and Strategic Development are core members of the Bureau. The State Pediatric and Children's Advisor is also a core member. A Secretariat has been created to enable the Bureau. The Secretariat's role is to gather information, consult, provide advice and establish networks with key stakeholders (both internally and externally), and to engage the whole government to progress the Our Kids Bureau's priorities.<sup>67</sup>

#### *4. Planning, Setting Standards, Monitoring and Evaluation*

Governments move their general goals and aims in regard to child health policies forward through specific processes of planning, setting standards, and monitoring or evaluating progress. These aspects of the planning cycle are frequently legislated and are reviewed in this section.

##### *a) Planning*

Requirements to implement planning activities can begin with ministers and their departments. Quebec requires that each government department or body outline its objectives and how these objectives are to be achieved. For example, each government department must publish a service statement setting out its objectives with regard to the level and quality of services provided. As well, each government department or body must develop a strategic plan which outlines the mission, context, directions, and objects of the department along with the targeted results and performance indicators.<sup>68</sup> Specifically in the health arena, the Minister of Health must develop a province-wide public health program that provides a framework for provincial, regional and local public health activities, must assess the outcomes outlined in the plan; must update it regularly; and must ensure that there is province-wide and interregional coordination in relation to the program.<sup>69</sup>

In Saskatchewan, the Minister of Health is responsible for the strategic direction of the health care system and is given the power to establish goals

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<sup>67</sup> Our Kids Bureau, online: Department of Health and Human Services, Tasmania <<http://www.dhhs.tas.gov.au/ourkids/>> (date accessed 30 March 2007).

<sup>68</sup> *Public Administration Act*, R.S.Q. c. A-6.01, ss. 6, 8 & 9.

<sup>69</sup> *Public Health Act*, R.S.Q. c. S-2.2., s. 7.

and objectives for the provision of services, set performance measures, evaluate provincial health care policies, and conduct planning in relation to the health care system.<sup>70</sup> The Minister may also establish goals for the health of the population, pursue policies to support the health of the population, facilitate public awareness of health issues, establish standards, and monitor and evaluate the effectiveness of programs.<sup>71</sup> Other provinces have similar structures in place.

Plans may also be mandated for local levels of government, such as regional health authorities in Canada or DHBs in New Zealand. Thus, in provinces such as Manitoba,<sup>72</sup> Alberta,<sup>73</sup> and Saskatchewan<sup>74</sup> there is a duty for health regions to prepare and implement a regional health plan. Manitoba requires regional health plans to:

- (a) state the objectives and priorities developed by the regional health authority for the provision of health services to meet the health needs in the health region, which shall incorporate provincial objectives and priorities;
- (b) state how the regional health authority proposes to carry out and exercise its responsibilities, duties and powers under this Act and the regulations and to measure its performance in carrying out and exercising those responsibilities, duties and powers; and
- (c) include a comprehensive financial plan which shall include a statement of how resources, including but not limited to financial resources, will be allocated to meet the objectives and priorities developed by the regional health authority and provincial objectives and priorities.<sup>75</sup>

New Zealand also has mandated a detailed planning process for its DHBs. Each DHB is required to develop a district strategic plan for fulfilling its objectives and functions. This plan is to be for a five- to ten-year period but must be reviewed every three years. In developing the plan the board must assess the health status of its population, the needs of the population and the contributions which services are intended to make. DHBs must also create and obtain agreement from the Minister on an annual plan which is to outline the intended outputs and how they relate to

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<sup>70</sup> *Regional Health Services Act*, S.S. 2002, c. R-8.2.

<sup>71</sup> *Public Health Act 1994*, S.S. 1994, c. P-37.1, s. 3.

<sup>72</sup> *Regional Health Authorities Act*, C.C.S.M. c. R34, s.24(3).

<sup>73</sup> *Regional Health Authorities Act*, R.S.A. 2000, c. R-10, s. 9.

<sup>74</sup> *Regional Health Services Act*, S.A. 2002, c. R-8.2, s. 51.

<sup>75</sup> *Regional Health Authorities Act*, C.C.S.M. c. R34, s.24(3).

the strategic plan as well as the funding proposed for those intended outputs.<sup>76</sup>

In the State of Victoria, Australia, each local council must in consultation with the Secretary of the Department of Health prepare at three intervals a municipal public health plan which identifies and assesses actual and potential public health dangers, outlines programs and strategies, and provides for periodic evaluation of any programs and strategies. As well, each council must provide to the Secretary annual reports relating to public health activities.<sup>77</sup> Each board of a metropolitan health service must, at the direction and in the manner specified by the Minister, prepare for approval a strategic plan in accordance with ministerial guidelines.<sup>78</sup>

Planning ensures some level of accountability as objectives and outcomes are defined and transparency is increased through the preparation and production of reports. Involving youth directly in the planning process in particular could help its legitimacy with this group.<sup>79</sup> The degree of accountability will vary depending on how specific the requirements are and on whether there is any external check or audit of the plan and its implementation. Planning is also a useful tool for focusing resources on particular objectives. Planning may assist in addressing identified gaps, such as lack of integration, through a systematic approach to the issue. A disadvantage of planning is that it is time-consuming, resource-intensive and may divert resources from direct services. The quality of review of a plan will also vary depending on the chosen outcome measures. As well, while a plan may be sound in theory, there may be barriers that prevent it from being effectively implemented.

#### *b) Setting Standards*

A variety of guidelines or standards can be promulgated by governments in order to further healthy child development. In the UK, the Secretary of State for Health may prepare and publish statements of standards in relation to the provision of health care by National Health Service bodies.<sup>80</sup> National Service Frameworks (NSFs) in the UK set standards in

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<sup>76</sup> *New Zealand Public Health and Disability Act 2000* (N.Z.), *supra* note 54, ss. 38(1)(a), 38(1)(c), 38(3)(a), 39(1) & 39(2)(b).

<sup>77</sup> *Health Act 1958* (Vic.), ss. 29B & 37.

<sup>78</sup> *Health Services Act 1988* (Vic.), s. 65ZF.

<sup>79</sup> Steineke Willis, Fiona Mullin, Geraldine Murphy *et al.*, "Are you Serious? Involving Young People in Children's Service Planning" (2003) 9 *Child Care in Practice* 213.

<sup>80</sup> *Health and Social Care (Community Health and Standards) Act 2003* (U.K.), s. 45(1).

particular areas of care. For instance, a National Service Framework for Children, Young People and Maternity Services was developed to set evidence-based standards for health and social care services for children, young people and pregnant women.<sup>81</sup>

In Victoria, Australia, the Minister, after appropriate consultation, has the power to prepare draft guidelines for the orderly development of health services, the adequacy of health services and the improvement of the quality of health care.<sup>82</sup> The guidelines must be issued in draft form and be available for comment. Following appropriate revisions, the guidelines may be recommended by the Minister to the Cabinet for approval.<sup>83</sup> One result from this process is the Maternal and Children Service Program Standards. Some of the goals included are to survey children's health; enhance maternal health, provide family and children additional support, and promote immunization.<sup>84</sup>

Standards and guidelines raise several administrative, clinical, and legal issues. One of the administrative issues is determining the best group or body to develop guidelines. The more authoritative the body developing the guidelines, the more likely the product will be widely accepted. Authoritativeness will likely depend on how respected and representative the organization is making the guideline, the organization's motivation for developing the guideline and the methodology utilized for developing the guideline.<sup>85</sup> Where physicians and other professionals are responsible for development, as with clinical practice guidelines for instance, a process for government certification may be required to clarify which guidelines are mandatory. To ensure that both the cost implications of guidelines and clinical standards are considered, a mixed body of physicians and health care decision-makers may be established.

Another administrative issue to consider is whether health care providers' adherence to guidelines will be monitored for accountability and, if so, how this is to be done. Penalties for non-compliance must also be considered. High costs in policing and enforcing standards are more

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<sup>81</sup> National Service Framework for Children, Young People, and Maternity Services, online: <[http://www.dh.gov.uk/en/PolicyAndGuidance/HealthAnd\\_SocialCare\\_Topics/ChildrenServices/ChildrenServicesInformation/DH\\_4089111](http://www.dh.gov.uk/en/PolicyAndGuidance/HealthAnd_SocialCare_Topics/ChildrenServices/ChildrenServicesInformation/DH_4089111)> (date accessed 8 June 2007).

<sup>82</sup> *Health Services Act 1988* (Vic), s. 12.

<sup>83</sup> *Ibid.*, ss. 13 & 14.

<sup>84</sup> Maternal and Children Service Program Guidelines, online: Department of Human Services, Victoria <<http://www.office-for-children.vic.gov.au/children/ccdnv.nsf/LinkView/F5C5807953CCEA5F4A2568040007EC98581ECF35F96F3A0EC A256E67002283DE>> (date accessed 30 March 2007).

<sup>85</sup> Arnold J. Rosoff, "The Role of Clinical Practice Guidelines in Health Care Reform" (1995) 5 *Health Matrix* 369.

likely to be avoided where the relevant parties agree that the standards and the body which creates them are legitimate. A process for updating and for disseminating guidelines as well as procedures for enforcement should also be established. In these ways, efforts to achieve standards will result in continuous on-going improvement in programs, services and practices.

The use of clinical practice guidelines will affect litigation in a number of different ways depending on how they are developed and implemented.<sup>86</sup> Courts will likely look at whether the guideline has been certified by an official body or by the government in order to determine if adherence to guidelines should be read as the legal standard of acceptable quality care. The degree of dissemination of the guideline and the length of time that the guideline has been in existence will likely be considered. Additionally, more legal weight will likely be given to a guideline where it is the sole standard in a particular area. It is possible that clinical guidelines could reduce the volume and complexity of medical malpractice litigation. Guidelines may lead to earlier settlements as the legal standard of care will be clearer and deviations from the standard more measurable. As well, less evidence may need to be brought, and fewer experts utilized to establish the standard of care potentially reducing the complexity and cost of litigation.

### *c) Monitoring*

Determining the success or failure of strategies to promote healthy child development depends to a large extent upon developing strategies to measure changes in child health over time. Not only must health outcomes be monitored in relation to targeted policies but the role of concurrent influences and risk factors on health outcomes must be accounted for. Efforts are underway in Canada and abroad to develop better ways of monitoring how specific policies affect the health of children in the context of family, community and society.

Monitoring is frequently included in the planning process; legislation may outline specific requirements or the responsible department or body may be left with the discretion to determine measures or indicators. Monitoring can focus upon broad population outcomes, as well as the processes and results from particular programs or strategies. Traditional population health statistics monitor health outcomes only indirectly, and focus on negative effects documenting damage that has already been suffered. There has been a shift in focus to measuring positive aspects of

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<sup>86</sup> Viv Harpwood, "NHS Reform, Audit Protocols and Standard of Care" (1994) 10 *Medical Law International* 241.

health and well-being across the entire child age-range from infancy through adolescence.<sup>87</sup>

Since negative outcomes such as infant morbidity and low birth weight are related to a number of factors that social policies target – such as nutrition, environmental exposures, social supports, and pre- and postnatal health care services — recent efforts in measuring child health outcomes have begun to focus on these interactive and mediating determinants of health as well. Hertzman *et al* have shown uses for community mapping in describing the environment where young children live as well as their physical health.<sup>88</sup> The Australian Council for Children and Parenting has identified a reporting framework for children to monitor changes in key determinants of child health as well as in traditional measures of physical health and morbidities.<sup>89</sup> Surveillance and monitoring of child and youth health is carried out by the Australian Institute of Health and Welfare; its national reports on the health status of Australia's children and youth are prepared regularly.<sup>90</sup>

Monitoring may occur at regular intervals, via annual reports, for example, or on a case-by-case basis. The UK, as well as Ontario, Newfoundland, and New Zealand, highlight examples of monitoring on a regular basis. National Health Service bodies in the UK have a duty to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care.<sup>91</sup> A National Care Standards Commission has been established to regulate a wide range of social care and private and voluntary health care services, including care homes, domiciliary care agencies and independent health care establishments such as mental health hospitals. The Commission is to keep the Secretary of State informed about the availability of provision of services, and the quality of services provided by such organizations. The Commission is also to encourage improvement and make information available about

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<sup>87</sup> European Union Community Health Monitoring Programme, "Child Health Indicators of Life and Development: Report to the European Commission" September 2002.

<sup>88</sup> Clyde Hertzman, Sidney A. McLean, Dafna E. Kohen, Jim Dunn and Terry Evans, "Early Development in Vancouver: Report of the Community Asset Mapping Project (CAMP)," August 2002, Canadian Population Health Institute, Canadian Institute for Health Information.

<sup>89</sup> Australian Institute of Health and Welfare, "Indicators of Child Development, Health and Wellbeing 2004," Australian Council for Children and Parenting Workshop: 'A picture of Australia's children' March 16, 2004.

<sup>90</sup> Fadwa Al-Yaman., Meredith Bryant M. and Hilary Sargeant, *Australia's Children: Their Health and Well-being 2002* (Canberra: AIHW, 2002).

<sup>91</sup> *Health and Social Care (Community Health and Standards) Act 2003* (U.K.), c. 43, s. 45.



such services. The Commission is responsible for regularly inspecting such organizations to ensure that their services meet the minimum standards set by government.<sup>92</sup>

Another jurisdiction that has established a regular monitoring regime is Ontario. The Minister has a duty to appoint assessors to carry out an assessment of each board of health. The purpose of the assessment is to determine whether the board is providing services in accordance with the *Health Promotion and Protection Act*, Regulations and guidelines; it also reviews the quality of the management and administration of the board.<sup>93</sup> Similarly, in Newfoundland, each regional community health board must establish a review committee to report annually on the care of all children receiving services.<sup>94</sup>

In New Zealand, the Minister of Health must determine a strategy for the development of nationally consistent standards and quality assurance programs for health services and consumer safety, and nationally consistent performance monitoring of health services and consumer safety.<sup>95</sup> Several strategies have been developed in relation to child and family health. The Strengthening Families Strategy was developed in 1997. As part of this Strategy, an annual report on cross-sector outcome measures and progress towards targets is undertaken.<sup>96</sup>

Examples of the case-by-case approach to monitoring can be found in the UK, Saskatchewan, New South Wales, and New Zealand. The aim is to investigate particular problems, hold civil servants to account, and identify strategies for improvement. In the UK, under the *Children's Act*, the Secretary of State may require *ad hoc* reviews of all children's services provided in a specified area of a children's services authority. The purpose of the review is to evaluate the extent to which the services under review improve the well-being of children and relevant young persons. This involves an integrated inspection framework for children's services to determine what it is like to be a child in a particular area and how well children and young people are being served in that area.<sup>97</sup>

In Saskatchewan, the Minister of Health may appoint one or more persons to inquire into and report on any matter respecting a regional

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<sup>92</sup> *Care Standards Act 2000* (U.K.), c. 14, ss. 5, 42, 7(1)(a) to (d), 23 & 31.

<sup>93</sup> R.S.O. 1990, c. H.7, s. 82(1); 82(2)(a) and (c).

<sup>94</sup> *Child Youth and Family Services Act*, S.N.L. 1998, c. C-12.1, s. 76.

<sup>95</sup> *New Zealand Public Health and Disability Act 2000*, *supra* note 54, s. 9(1).

<sup>96</sup> New Zealand Government, Strengthening Families, online: <<http://www.strengtheningfamilies.govt.nz/about/>> (date accessed 30 March 2007).

<sup>97</sup> *Children's Act 2004* (U.K.), *supra* note 22, s. 15(1) & 15(4).

health authority or a health care organization that the Minister considers advisable to investigate.<sup>98</sup> In New South Wales, the Director-General of the Department of Health has the power to inquire into the administration, management and services of any organization or institution providing health services.<sup>99</sup> In New Zealand, the Minister may appoint a Commission to conduct an investigation into the funding or provision of health services, the management of a health service organization or any complaint regarding the administration of the *New Zealand Public Health and Disability Act 2000*.<sup>100</sup>

Monitoring encourages accountability; to be useful, however, an effective and efficacious standard setting process is required. Monitoring is likely to be more successful where the body is independent from the service providers. To undertake monitoring, a system for information collection and guidelines for review must be established.

### 5. Oversight and Advice

Governments demonstrate their commitment to advancing HCD by putting into place mechanisms for obtaining impartial oversight and advice from a legislative officer like an ombudsman or commissioner, or an arm's length advisory body. Such institutions can act as public advocates for individual children and their families; they may also or instead have a role in commenting upon the strengths or failings of child health policy more generally. These are external mechanisms, in contrast to the internal monitoring and evaluation approaches discussed in the previous section.

#### a) Ombudsman

One mechanism adopted in legislation related to children and families is the establishment of an ombudsman, child advocate or child commissioner. These approaches recognize that children may need assistance in ensuring that they are treated properly by government authorities. Establishment of such bodies recognizes the potential for conflicts and provides a process for resolving these conflicts. An ombudsman, child advocate, or child commissioner typically focuses on conflicts between individuals and government.

In Quebec, a Health and Social Services Ombudsman ensures that users are respected and that their rights are enforced. The Ombudsman also examines and hears complaints made by users and may take action to

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<sup>98</sup> *Regional Health Services Act*, S.S. 2002, c. R-8.2, s. 59.

<sup>99</sup> *Health Services Act 1997* (N.S.W.), s. 123.

<sup>100</sup> *Supra* note 54, s. 71.

correct problems.<sup>101</sup> In Ontario, the Ombudsman investigates complaints about any decision or recommendation made in the administration of a government organization affecting any person. The Ombudsman must inform the relevant government organization before investigating and must report recommendations to the appropriate governmental organization; it cannot compel a response or institute change itself.<sup>102</sup>

The Children's Advocate is a form of ombudsman, where the officer's mandate is restricted to a particular population group and/or range of issues. For instance, Saskatchewan's Children's Advocate is granted the power to be involved in public education concerning the interests and well-being of children. Furthermore, the Children's Advocate has the power to receive, review and investigate matters concerning a child or group of children receiving services from the government. The Children's Advocate must notify the relevant Deputy Minister of the investigation, and must report recommendations to the appropriate Minister. The Children's Advocate also has the power to require a department or agency to notify the Children's Advocate of the steps taken to respond to recommendations and may set a time frame for those steps.<sup>103</sup> A similar approach is taken in Manitoba,<sup>104</sup> Newfoundland,<sup>105</sup> and New Zealand.<sup>106</sup>

The UK *Children's Act 2004* established a Children's Commissioner. Unlike an ombudsman or child advocate, the Commissioner would not investigate individual complaints. The Commissioner is in fact prohibited from conducting an investigation of the case of an individual child, unless the Secretary of State directs the Children's Commissioner to hold an inquiry into the case because it raises issues of relevance to other children. The Commissioner is rather enjoined to: encourage persons engaged in activities affecting children to take account of their views and interests; advise the Secretary of State on the views and interests of children; consider or research the operation of complaints procedures relating to children; and consider or research any other matter relating to the interests of children.<sup>107</sup>

A similar approach has been adopted in New Zealand where a Families Commission has been created to advocate for the interests of

<sup>101</sup> *Health and Social Services Ombudsman Act*, R.S.Q. c. P-31.1, ss. 7, 8 & 19.

<sup>102</sup> *Ombudsman Act*, R.S.O. 1990, c. O.6, ss. 14(1), 18(1) & 21(1).

<sup>103</sup> *Ombudsman and Children's Advocate Act*, R.S.S. 1978, c. O-4, ss. 12.6(2)(a), 12.6(2)(b), 20, 24 & 25.

<sup>104</sup> *Child and Family Services Act*, R.S.M. s. 8.2(1).

<sup>105</sup> *Child and Youth Advocate Act*, S.N.L. 2001, c. C-12.01, s. 3(a).

<sup>106</sup> *Children's Commissioner Act 2004* (N.Z.), *supra* note 23, s. 12(1)(a)-(f).

<sup>107</sup> *Children's Act 2004* (U.K.), *supra* note 22 at ss. 2(2), 2(6) & 4(1).

families generally. The Commission is precluded from acting as an advocate for a particular family on a particular issue; instead the Commission is to focus on identifying and considering factors that enhance families' resilience and strengths. The Commission is also to encourage and facilitate debate on the interests of families, to increase public awareness about family issues, and encourage and facilitate the development and provision by government of policies to promote children's interests. In undertaking these functions, the Commission must have regard to the diversity of families in New Zealand and to the needs, values and beliefs of different cultural and ethnic groups including the Maori and Pacific Islands peoples.<sup>108</sup>

One main advantage of instituting an ombudsman, child advocate or children's commissioner is that it provides a form of monitoring and ensures accountability. The degree of accountability depends on the independence, reporting procedures and the scope of powers granted for remedying problems given to the office. The role of the particular body can be tailored to fit within the other structures in a jurisdiction, to cover gaps in complaints processes or fill an advisory role. Another advantage is that the body can be a venue for reviewing and resolving individual complaints, thereby decreasing the rate of litigation. In reviewing complaints and investigating problems, the body may also identify broader policy issues to be addressed.

Some of the disadvantages of instituting these roles are that they require additional resources that do not go to direct service provision, require a separate administrative structure to be established and may be subject to capture by interest groups. As well, these bodies may have a limited ability to influence change depending on the scope of their powers, or may require changes that are not undertaken in a systematic fashion; this is particularly the case when findings arise from the investigation of individual complaints. Grover notes such additional challenges as the ability of such bodies to manage the potentially large volume of cases presenting, and the question of whether or not children and young people – those directly affected – have the ability and opportunity to access these mechanisms.<sup>109</sup>

#### *b) Advisory Bodies*

Another form of oversight involves the development of an advisory body

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<sup>108</sup> *Families Commission Act 2003* (N.Z.), *supra* note 24, ss. 7, 8, 10 & 11.

<sup>109</sup> Sonja Grover, "Advocating for Children's Rights as an Aspect of Professionalism: The Role of Frontline Workers and Children's Rights Commissions" (2004) 33 *Child & Youth Care Forum* 405.

- board, committee, council or other terms may be employed - to provide advice to the government on specified issues. Advisory bodies have a variety of functions, such as research and monitoring, and provide advice on several aspects of health services. Advisory bodies may provide advice to the government, a minister or department, or a local region or district.

As one example, in South Australia, a Children's Services Consultative Committee assesses the needs and attitudes of the community and advises on how to accommodate those needs and attitudes. The Committee is composed of a broad section of representatives including parents, people from organizations involved in children's services, people involved with groups of children with special needs, school boards, the public service employee association, parent clubs, non-governmental organizations and government children service departments.<sup>110</sup>

The Children's Interests Bureau, another advisory body in South Australia, is charged with increasing public awareness of the rights of children; carrying out research on matters affecting the welfare of children; developing within the Department services for the promotion of the welfare of children; providing the Minister with independent and objective advice on the rights of any child subject to the *Family and Community Services Act*; and monitoring policies of the Department.<sup>111</sup>

Advisory groups can be used to obtain direct input from children and young people into policy development as well. The literature describes some successful instances. For example, the San Francisco Youth Commission established in the mid-1990s provided a space for youth twelve to twenty-three years old to comment on service needs, policy priorities, and funding allocations in the municipal sphere.<sup>112</sup> Similar experiences are reported with younger children aged nine to eleven as well.<sup>113</sup>

Advisory bodies allow for regular reviews of the provision of health services in designated areas and for continuous improvement. An advisory body consisting of a wide range of expertise and community representation may be particularly adept at highlighting important issues to address and identifying gaps or overlaps – accessing possibly unique sources of

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<sup>110</sup> *Children's Services Act 1985* (SA), s. 20 & 15.

<sup>111</sup> *Family and Community Services Act 1972* (SA), s. 26(3)(a)-(d).

<sup>112</sup> Barry Checkoway, Tanene Allison and Colleen Montoya, "Youth Participation in Public Policy at the Municipal Level" (2005) 27 *Children and Youth Services Review* 1149.

<sup>113</sup> Francesca Alparone and Antonella Rissotto, "Children's Citizenship and Participation Models: Participation in Planning Urban Spaces and Children's Councils" (2001) 11 *Journal of Community & Applied Social Psychology* 421.

information. Advisory bodies can deliver public involvement and feedback about health care services to the government at a high level. Where an advisory body is independent from government and health care providers, the body may also ensure a weak form of accountability of service providers and provide an avenue for unbiased advice on issues.

The primary limitation of most of these bodies is that they do not have the power to require change or remedy any failings they might identify. As well, they may fail to represent differing community interests. An advisory body's advice may lead to a more ad hoc approach to policy development. This may increase the likelihood that the body will be subject to capture by current issues and by particular interest groups. A further disadvantage is that where there is no policy guiding the body's activities, it may not be accountable and its advice may not fit within the strategy developed by the government or by service providers. This may result in a disjointed approach to service provision.

## 6. Discussion

Numerous approaches have been developed in different jurisdictions for HCD. Several of the approaches — entrenching statutory rights and obligations; policy and program coordination at the intergovernmental, inter-ministerial, inter-departmental and intra-departmental levels; use of formal planning instruments, setting service standards, and monitoring and evaluating child health outcomes; and independent oversight through such institutions as an ombudsperson or children's commissioner — provide promising avenues for increasing accountability, identifying gaps in the system, and allowing for continued improvement in practices. We have illustrated these with examples from four countries, and provide a summary in Table 1.

The determinants of HCD are many and multifaceted, and thus there is no simple approach for policy and program development. Moreover, HCD policy and regulation must address the unique circumstances of a vast array of children. Many children will reside in single parent families. The majority of these will be headed by women, but it is also the case that single fathers are on the rise; between 2001 and 2006, the number of lone father-headed families in Canada increased at over two-times the rate of growth of female-headed lone parent households.<sup>114</sup> Urban and rural living, aboriginal, minority or other ethnic descent, are yet more factors that contribute to the uniqueness of children's lives and the needs for

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<sup>114</sup> Anne Milan, Mireille Vézina, and Carrie Wells, *Family Portrait: Continuity and Change in Canadian Families and Households in 2006: 2006 Census* (Ottawa: Statistics Canada, 2007) Catalogue Number 97-553-XIE.

appropriately sensitive responses to their needs from government institutions.

Australian research highlights some challenges for implementing a social determinant of health approach to HCD.<sup>115</sup> This research concludes that consensus-building policy initiatives undertaken by the Australian federal government reflect a lack of understanding about the importance of social determinants to HCD. Limited expenditures, particularly in Victoria, occur where resources on projects focused on impacting the social determinants of health in the early years are constrained to demonstration projects. Finally, considerable additional effort is necessary to sustain the interagency collaboration initiated and required to impact social determinants of health related to HCD.

Entrenched rights are central to accountability as they move beyond aspirations and good intentions to clear substantive and procedural outcomes that have a well-established legal and judicial system for enforcement. In this sense, outlining the rights of children and families is a necessary foundation for any political or social context. Rights alone can be too rigid, however; they are not easily or quickly adapted to changing circumstances. Rights based approaches bring about incremental and patchwork change. Furthermore, few of the social determinants of health are typically made the focus of legal rights. Child protection and development efforts based on rights enforcement are seldom preventative or proactive.

Some promising avenues for impacting the social determinants of health are therefore based upon how governments organize themselves for effective action on HCD. Given the many determinants, appropriate systems will need to establish a holistic and comprehensive network of programs and services that ensure sustained coordination and collaboration at various governmental, ministerial and departmental levels. Examples include the focus in the UK *Children's Act* on facilitating the integration of children's services, or the identification, establishment and coordination of early life programs by a cabinet committee, like Healthy Child Manitoba. A separate standing office or body could perform similar functions.

Through the use of planning instruments, standards and guidelines, and performance monitoring and evaluation mechanisms, governments can also provide benchmarks for the continuous fine-tuning and improvement of services. Each of these can be linked to social determinants and mandated for the relevant government agencies and bodies. Finally, oversight and advisory bodies, such as an ombudsman or

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<sup>115</sup> Leggat, *supra* note 10.

children's advocate, allow for regular public reporting for accountability purposes; these offices can also contribute to ongoing efforts to improve policy and programs both through investigation of individual cases and complaints, and through their careful consideration of the larger policy issues affecting child development.

The best systems will contain a mix of the elements identified here, which should be mutually reinforcing and together form a basis for the realization of core values (see Figure 1). Bringing these approaches together in a coordinated fashion should enable governments to establish a durable yet flexible platform for meeting changing needs in HCD policy.

This review was focused on cataloging the various approaches to HCD. The approach is primarily descriptive and does not provide an in depth evaluation of the effectiveness of each approach in impacting the social determinants of health. The combination of tools in a particular jurisdiction and how these tools could best work together also was not examined. Future research should follow promising approaches and identify factors which lead to greater impact on social determinants of health, and barriers to change within these approaches. As research refines which determinants are most significant, it will be beneficial to identify approaches and processes which allow for adoption of this knowledge.

### *7. Conclusion*

The legislative approaches discussed herein exist within a specific context. There are many matters that impact on HCD such as international laws and conventions, jurisdictional issues in those countries with a federal system, and the existing legal framework addressing such relevant associated policy areas as environmental protection, child labor laws, and tax legislation. These too are important to consider when developing approaches to HCD as they have an impact on both the substantive content and the procedural processes included in any approach. To maximize long term benefits to society, HCD legislative and regulatory approaches must take a broader view than the historical perspective, which includes a much greater focus on social determinants of health.



Table 1: Advantages and Disadvantages of Child Health Legislation and Policy Mechanisms Across Various Jurisdictions

Approach	Brief Description	Example	Advantages	Disadvantages
Rights-based Approaches				
<i>Legislated rights to specific services</i>	Grant a particular population the right to certain services, or grant the right to receive service in a certain manner	<i>Health Services and Social Services Act</i> (Quebec) – grants many rights including right to be informed about health and social services resources available	<ul style="list-style-type: none"><li>• Ensures certain populations have access to services</li><li>• Creates process for accessing services</li><li>• Creates procedural safeguards to ensure proper process is followed</li><li>• Creates minimum standards for service provision</li></ul>	<ul style="list-style-type: none"><li>• Adversarial relationship between service providers and service receivers is created</li><li>• Increased litigation</li><li>• Challenge of ensuring adherence to standards</li><li>• Potential duplication with existing approaches for maintaining service standards</li><li>• Challenge of determining content of rights</li><li>• Challenge of determining legal effect rights will have</li><li>• Difficult to change once given legislative force</li><li>• Administration costs</li></ul>
<i>Mandated Duties</i>	Outlines specific duties that must be carried out by government bodies or personnel	Children’s Services Authority (UK) – Each authority must carry out its functions	<ul style="list-style-type: none"><li>• Provides direction to government bodies and personnel</li></ul>	<ul style="list-style-type: none"><li>• Duties may be implemented differently in each jurisdiction</li><li>• Duties that are</li></ul>

Approach	Brief Description	Example	Advantages	Disadvantages
		with regard to the need to safeguard and promote the welfare of children  The <i>Youth Protection Act</i> (Quebec) requires that decisions made must take into account the best interests of the child	<ul style="list-style-type: none"><li>• Increased accountability</li><li>• Focuses decision-makers on key principles</li><li>• May be legally enforceable</li></ul>	<p>broadly stated will be difficult to enforce</p> <ul style="list-style-type: none"><li>• May be broad statements that are subject to various interpretations</li><li>• Broad statements may be less enforceable</li><li>• May be difficult to monitor and ensure adherence</li></ul>
<i>Mandated Programs</i>	Requirement that government body or personnel implement a specific program	Required programs to be offered by Boards of Health (Ontario)	<ul style="list-style-type: none"><li>• Ensures implementation of specific programs</li></ul>	<ul style="list-style-type: none"><li>• Too time consuming to pass legislation requiring implementation of every necessary program</li><li>• If needs change, time-consuming to alter requirements</li></ul>
<b>Government Organization for Integrated and Coordinated Service Delivery</b>				
<i>Policy Framework for inter-governmental collaboration</i>	Plan that outlines priorities for child health	National Investment for Early Years (Australia)	<ul style="list-style-type: none"><li>• Opportunity for review and assessment of existing services</li><li>• Opportunity for consultation</li><li>• Systematic plan</li></ul>	<ul style="list-style-type: none"><li>• Costly to prepare</li><li>• May be discontinued if no legal requirement for regular review</li></ul>

Approach	Brief Description	Example	Advantages	Disadvantages
<i>Integrated Service Delivery via a standalone Department or body</i>	Coordinate service delivery by establishing a separate body to oversee child health	UK Children's Trusts	<ul style="list-style-type: none"><li>• Avoid duplication and gaps</li><li>• Facilitate information sharing</li><li>• Increased accessibility to services</li><li>• Increased continuity of care</li><li>• Increased planning</li></ul>	<ul style="list-style-type: none"><li>• Additional level of bureaucracy</li><li>• Diverts funding from direct services</li><li>• Power to implement change may be limited</li></ul>
<i>Inter-ministerial Collaboration</i>	Committee appointed by head of government composed of government Ministers	Healthy Child Manitoba Committee	<ul style="list-style-type: none"><li>• Wide degree of discretion</li><li>• Better integration of services</li><li>• Increased likelihood of implementation</li></ul>	<ul style="list-style-type: none"><li>• Limited accountability</li><li>• No legislative guidelines to limit discretion</li><li>• Discretion to discontinue at any time</li></ul>
<i>Integrated Service Delivery via interdepartmental or intradepartmental collaboration</i>	Coordinate service delivery by establishing a body to coordinate services within department or between departments	Office of Integrated Services for Children (Ontario)  Our Kid's Bureau (Tasmania)	<ul style="list-style-type: none"><li>• Avoid duplication and gaps</li><li>• Facilitate information sharing</li><li>• Increased accessibility to services</li><li>• Increased continuity of care</li><li>• Increased planning</li></ul>	<ul style="list-style-type: none"><li>• Additional level of bureaucracy</li><li>• Diverts funding from direct services</li><li>• Power to implement change may be limited</li></ul>

Approach	Brief Description	Example	Advantages	Disadvantages
<b>Planning, Setting standards, Monitoring and Evaluation</b>				
<i>Planning instruments</i>	Process for setting objectives, monitoring results and reassessing objectives	District Health Board strategic plans (New Zealand)	<ul style="list-style-type: none"><li>• Increased accountability and transparency through reporting process</li><li>• Identifies gaps, and potential areas for improvement</li></ul>	<ul style="list-style-type: none"><li>• Time-consuming</li><li>• Resource intense</li><li>• Requires effective implementation</li><li>• Requires access to accurate, pertinent information</li></ul>
<i>Standards: Clinical Practice and other Guidelines</i>	Standards of practice set for services providers by a committee	National Service Frameworks (UK)  Maternal and Children Service Program Standards (Victoria, Australia)	<ul style="list-style-type: none"><li>• Increased consistency in standard of care</li><li>• Guidelines may reduce volume and complexity of litigation</li><li>• Increased transparency</li><li>• Increased accountability for service providers</li></ul>	<ul style="list-style-type: none"><li>• Challenge to ensure legitimacy of standards</li><li>• Challenge of dissemination and enforcement</li><li>• Difficult to monitor implementation</li><li>• Guidelines may be utilized in legal action against service providers</li><li>• Resource intensive as must provide mechanism for review</li></ul>
<i>Monitoring</i>	Systematic or ad hoc review of plans or policy frameworks, standards, and the implementation of programs or services	Annual assessment of each Board of Health (Ontario)	<ul style="list-style-type: none"><li>• Increased accountability and transparency</li><li>• Assists in updating standards, plans and policies</li></ul>	<ul style="list-style-type: none"><li>• Requires a system for information gathering</li><li>• Effectiveness varies depending on degree of scrutiny and on type of body responsible for monitoring</li></ul>

Approach	Brief Description	Example	Advantages	Disadvantages
Oversight and Advice				
<i>Ombudsman, Child Advocate, Child Commissioner &amp; Complaints Commission</i>	Body or Officer to investigate and resolve conflicts	Health and Social Services Ombudsman (Quebec) Children's Advocate (Saskatchewan)	<ul style="list-style-type: none"><li>• Increased accountability through monitoring</li><li>• Role of body can be tailored to fit needs of each jurisdiction</li><li>• Reduce litigation by providing alternate for dispute resolution</li><li>• Identify important issues that need to be addressed</li></ul>	<ul style="list-style-type: none"><li>• Costly process</li><li>• Ad hoc review provides less benefits than systematic review but is less costly</li></ul>
<i>Advisory Body</i>	Body that provides advice to government on specific issues such as policies and programs	Children's Services Consultative Committee (South Australia)	<ul style="list-style-type: none"><li>• May address a wide variety of issues</li><li>• Responsive to current issues</li></ul>	<ul style="list-style-type: none"><li>• Cannot require change</li><li>• Limited power to implement changes</li><li>• May be unrepresentative of community</li></ul>

Approach	Brief Description	Example	Advantages	Disadvantages
			<ul style="list-style-type: none"><li>• May have access to high level of government</li><li>• May monitor service provision</li><li>• May provide avenue for public comment</li><li>• May be independent body</li></ul>	<ul style="list-style-type: none"><li>• May be more ad hoc approach than systematic review process</li><li>• Subject to capture by current interests and powerful lobby groups</li></ul>

Figure 1: Aligning Legislative and Policy Mechanisms to Support Healthy Early Childhood Development

