Laws and Policies Affecting Adolescent Health

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WORLD HEALTH ORGANIZATION - GENEVA

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by

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CONTENTS

1. Introduction

This book is about that part of life known as youth. This is taken as covering the 10–24-years age group which accounts for nearly a third of the earth's population; more than 75 % of these young people live in the developing world. Although the transition between adolescence and adulthood has certain clearly defined characteristics, neither the process nor the problems lend themselves readily to generalizations; they are highly individualized, as is the effect on them of external influences. "For many adolescents and for some youth, their developmental health and social problems are closely entwined with those of their families, peer groups and local communities" (*1*).

It is thought that one of the common desires of adolescents is to have realistic opportunities and reasonable life experiences, despite the fact that they live in vastly differing situations and an increasingly stressful world. Though health concerns usually rank low on the list of immediate priorities of most young people, such concerns are legitimate and important, and in many instances form an integral part of general adolescent experience.

The major health-related problems of adolescents are wide-ranging, and have been described by WHO as including the following (*2*):

> socioeconomic deprivation and disadvantage; unemployment and underemployment; malnutrition; rural/urban migration; alcohol abuse and dependence; drug abuse and dependence; smoking; accidents and risk-taking behaviour; suicide; sexual and reproductive health problems; mental disorders; and mental retardation and other handicaps.

The present study, which focuses on some of these health-related needs, has its roots first of all in the recommendation made some years ago by a WHO Expert Committee, in a report entitled *Health needs of adolescents* (*3*), that the legal and policy aspects of adolescent health care be explored, and that legislation be used to facilitate "more and better" health services. Then, in 1979, the United Nations, in General Assembly Resolution A/34/151, designated 1985 as International Youth Year. Among the youth-oriented activities advocated in this resolution were those that would lead to the development of "comprehensive measures for intersectoral community-based health care".

On a global scale, adolescent health care issues continue to be neglected, possibly for two reasons — those who provide health care fail to recognize the special needs of adolescents and adolescents themselves tend not to utilize the services that are available.

This study looks at the way laws and policies throughout the world affect health care programmes for young people. It touches on what are perceived to be their major health problems, from sexual and reproductive to occupational, from mental illness to drug and alcohol abuse, from handicaps to accidents. It therefore aims to be "suggestive", in the sense that it will attempt to analyse the current situation and to suggest an array of legal and policy approaches that may be adopted in attempting to provide health care to adolescents. Not all of the alternatives will please all readers, nor will all be appropriate everywhere. This is only to be expected.

A cautionary note is in order here. There is a danger in preparing a study of this kind, namely that of appearing to glance rapidly at a number of the world's legal systems without being aware of the basic differences, substantive and procedural, as well as philosophical, that exist between them. It is quite possible that a legal approach that seems perfectly adequate in one setting will be wholly inappropriate in another for any number of reasons, not the least of which is that constitutional systems may differ or fundamental laws may exist which cannot be transcended. For example, the importance given to case law in the common law system may have little relevance in other legal systems where legal codes take precedence.

Equally, it may be unwise, indeed impossible, to adopt wholesale any of the legal approaches discussed in these pages. While it is expected that change in one country may prompt changes in others, experience indicates that it serves little purpose merely to copy a given law or regulation, especially where circumstances in the countries concerned differ widely. Nevertheless, the basic idea underlying a change in legislation may be widely applicable. The key is to adapt the approach so that it is woven comfortably into the local fabric. In this way, the change will become more than a mere academic exercise.

If there is a lesson to be learned from this study it is that there is no single legal model that can serve as an answer to all the legal and policy problems described here. Indeed, the word "model" is perhaps itself an unwise choice as it has come to be thought of as synonymous with "ideal". Many alternative legal and policy approaches exist, each of which can probably provide solutions, but the adoption of any particular one will depend on the nature and context of the legal and policy problem involved. Hence, what has been attempted throughout these pages is a description of as many alternative legal and policy approaches and solutions as can be found. It is the general approaches that recommend themselves, not the details of the legislation or regulations; these must be worked out at the national level.

In short, this book is designed to inform the reader, in a general way, about what law and policy have to say about adolescent health care, to look briefly at the ways in which they impose constraints on the development of adolescent health care programmes, to explore the various approaches that have been adopted around the world to

eliminate, overcome, or avoid such constraints, and to examine how law and policy have been utilized to ensure greater access by adolescents to health care. The book essentially views law and policy as facilitating rather than inhibiting such access. Finally, it should be seen as a source book for ideas rather than a definitive treatise.

References and Notes

1. *Adolescents and youth health: perspectives, problems, priorities.* Unpublished WHO document, MCH/IYY/SG/84.3a, p. 3.
2. *Young people's health: young people work for health. Position paper for WHO on International Youth Year.* Unpublished WHO document, MCH/IYY/SG/84.3b, pp. 1–2.
3. WHO Technical Report Series, No. 609, 1977 (*Health needs of adolescents:* report of a WHO Expert Committee), p. 45.

2. Background and General Legal Framework

Before launching into the substance of this study, it is important to dispose of a few technical points that will make it easier to understand the bulk of the material that follows. This chapter therefore contains a brief discussion of three important issues: (1) the definition of adolescence and how it is affected by the legal view of that age group; (2) the legislative framework governing adolescent health care; and (3) how the issue of consent affects the question of access to health care.

Definition of Adolescence

Adolescence is the process whereby an individual makes the gradual transition from childhood to adulthood. The concept is relatively new, and is not without its problems. In many ways, adolescence is a kind of limbo. Most cultures relate the beginning of adolescence to the onset of puberty, though they may differ widely over when it ends. However, the purely biological approach to definition overlooks important social and legal considerations. Because traditions and customs vary so widely from one setting to another, adolescence is difficult to define in specific, universal terms. The following remarks by Chui (*1*) give some indication why this may be so:

> In many developing countries, especially in rural and underdeveloped areas, a girl is often considered to be an adult at the time when menstruation is established regularly. They tend to marry early and do not go to school. The transition from childhood to adulthood in such cases is quick, and the notion of adolescence does not exist. On the other hand, in developed countries and increasingly in urban areas of developing countries where rapid social changes are taking place with modernization, young people go to school and tend to marry late. There is a long transition from childhood to adulthood, and the notion of adolescence emerges. There is thus a continuum between quick and slow transition in different societies.

Even so, attempts at definition have been made that purport to accommodate such variations. Thus, at the WHO Meeting on Pregnancy and Abortion in Adolescence in 1974 (*2*), adolescence was defined as the period during which:

(*a*) the individual progresses from the point of the initial appearance of the secondary sex characteristics to that of sexual maturity;

(*b*) the individual's psychological process and patterns of identification develop from those of a child to those of an adult;
(*c*) a transition is made from the state of total socioeconomic dependence to one of relative independence.

Despite the difficulty in framing a universal definition, some observations can be made with certainty about adolescents themselves. As the WHO Expert Committee on Health Needs of Adolescents observed: "There is, however, one unvarying factor; though no longer a child, the adolescent is not yet considered by society to be fully adult" (*3*). It is still true then, as Mr Justice Fortas of the United States Supreme Court wrote more than a decade ago, that the adolescent often "receives the worst of both worlds . . . he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children" (*4*).

The chronology of adolescence is often as slippery to grasp as the definition, partly because it varies from culture to culture, and indeed, from individual to individual. Social scientists and medical researchers have found it useful to take as broad a view as possible in establishing age limits, even to the extent of distinguishing the earlier phase of adolescence from the later, e.g., 10–14 years and 15–19 years. Some years ago a WHO Expert Committee (*5*) proposed that the age limits of 10–20 years be used to identify "adolescence", and this seems to represent the conventional wisdom on the matter. The overlapping notion of "youth", 15–24 years, has been employed by social scientists, and is the vogue in current usage because of the emphasis on 1985 as International Youth Year.

The law attempts, to a certain degree, to take into account the process of individual development called "adolescence", even though the term "adolescent" is not used in legal language. In legal parlance, prior to legal adulthood, a person is considered a "minor", a "juvenile", a "youth", or simply "underaged". The law, however, seeks uniformity and certainty, and rather arbitrarily selects the age at which legal adulthood is reached for some or all purposes. This is commonly referred to as the age of majority. In earlier times, the age limits corresponding to minority and adolescence were more or less identical. Recent developments have changed this situation.

In most countries, the age of majority—the age at which individuals are regarded as competent to handle their own affairs—was traditionally 21. The trend over the past 15 years has been to lower that age somewhat, usually to 18, and the law of various countries reflects this. However, 21 remains the age at which many of the trappings of legal adulthood are assumed in many countries.

No consensus exists, even within countries, with respect to the legal age of majority for all purposes. Minimum ages often vary, not only by sex, but also according to the purpose of the age limit—marriage, civil majority, criminal responsibility, voting rights, military service, access to

alcoholic beverages, consent to medical treatment, consent to sexual intercourse, etc. (*6*). None the less, the legal limits are important.

Legislative Framework of Adolescent Health Care

Health care is a legitimate concern of any nation. Legislation is used not only as a vehicle for expressing this concern but also as a method of creating a system of "rights" and "duties" with regard to health care. At its most simplistic, the right to health is said to be possessed by individuals, while the duty to provide health care in general falls to the state. These rights and duties are elaborated at various levels and take various forms.

General legislation

The constitution of a country often establishes the fundamental rights of citizens and the obligations of the state. Most countries have public health codes which establish the administrative machinery for health care, in addition to specifying some of the details concerning health care programmes. These are complemented by health-care-related legislation and regulations drawn from such disparate sources as criminal law, child welfare law, education law, family law, and labour law. In sum, the aim of this legislation is to ensure that health care is available to the population, though what is decreed and what occurs in reality may often differ considerably. It is unfortunate, but nevertheless a fact of life, that the burgeoning rural populations of many countries are virtually without health care of even the most rudimentary sort.

The recently adopted Constitution of Spain recognizes the right of its citizens to health care. Article 43(2) requires the public authorities to "organize and safeguard public health through preventive measures and the necessary benefits and services." In Cuba, the right to health protection and health care is guaranteed by the state, and these are provided in the form of free medical and dental care, plus access to health education, medical examinations, immunizations, and other services that prevent disease. Free health care at state institutions is also guaranteed under the constitution in Albania and the Soviet Union.

Such broad legislative statements apply to adolescents as to all other age groups, but some constitutional provisions are specifically concerned with the health interests of the young. In Greece, in addition to placing the responsibility for health care on the state, Article 21 of the Constitution requires the state to take special measures to protect the health of the young. In Sri Lanka, the state is under the general obligation to "promote with special care the interests of children and youth, so as to ensure their full physical, mental, moral, religious and social development".

The public health codes or their equivalent are central to any rational attempt to organize and regulate the various health care and

promotion services. Such codes exist in virtually every country and are often extensions of the constitutional statement. Thus the Romanian law of 6 July 1978 promotes the creation of conditions that "maintain and enhance the health of the population and . . . prevent diseases", and one of the main objectives is to protect and enhance the health of young people. To achieve this, health units are required to carry out educational and medical activities within families, at schools and work-places, to prepare young people for establishing families, and to provide medical supervision for pregnant women and care for children.

Access to health care is often a problem for adolescents because they cannot meet the costs. Certain countries have remedied this situation, at least for some adolescents. For example, Ordinance No. 73-65 of 28 December 1973 in Algeria made public health activities, diagnosis, treatment, and hospitalization free to certain groups of people. Decree No. 74-2 of 16 January 1974 made young people up to the age of 16 years eligible for free medical services.

The problem of cost is less of an issue in countries where health care is typically considered part of the larger social welfare scheme. In these countries, health care is available free or at a minimal cost to the recipient. However, in countries where a larger proportion of health care is provided by the private sector, legislation allowing minors to consent to health care treatment may fail to address directly the question of whether a minor can be held personally liable for the costs.

The provisions of public health codes, as a minimum, establish the general objectives of health care programmes, many of which have an impact on adolescents. These cover such areas as reproductive health, mental health, attempts to regulate tobacco, drug, and alcohol abuse, occupational health, immunization programmes, oral health care and treatment, biomedical research, organ and tissue transplants, and accident prevention.

Legislation on special categories of adolescents

If it is generally true that the state has an obligation to meet the health needs of adolescents, it is equally true that parents also have obligations. Under the General Health Law of Costa Rica, adolescents have a right to expect parents and the state to "safeguard" their health. For the parents, this means, in part, that they must comply with medical advice given them regarding the health of minors. In most legal systems, parents must ensure that their adolescent children are brought up under circumstances that enhance their health, physical as well as mental. While this may be viewed as an implicit feature of parenthood, such obligations are also explicitly imposed in legislation on child welfare. The Child and Youth Welfare Code in the Philippines requires that parents take special care to prevent children from indulging in practices that prejudice their health, such as alcohol or drug addiction, smoking and "other harmful vices".

However, the state is the ultimate arbiter in deciding when these obligations are being met. In many countries, it has authority to intervene when it can be shown that the interests of the adolescent are being disregarded. For example, when the parents are either unable or unwilling to provide proper care a court may determine that the adolescent is "neglected". One of the options then open to the state is to take the adolescent into care; another is to order that the adolescent undergo medical treatment, sometimes against the parents' wishes. However, medical treatment is usually ordered only if care is necessary to alleviate a condition that is life-threatening or seriously detrimental to health.

In every state of the USA, statutes have been enacted that authorize courts to intervene to protect neglected children (*7*). These statutes, either implicitly or explicitly, authorize courts to order medical treatment for minors where parental consent is withheld and a case for "medical neglect" can be made. Generally speaking, such action has been taken by courts only where the absence of medical treatment seriously endangers the minor (*8*), but in a number of states the statutes have been used to order medical treatment in circumstances that fall short of an "emergency" (*9*). However, in practice, these statutes offer little assistance to minors in need of health care, particularly if the treatment they are seeking relates to drug use or sexual activity, for the simple reason that the parents must be made a party to the judicial proceedings. This runs counter to the desire of minors not to inform their parents about such sensitive health problems.

The customary use of the *parens patriae* authority to take the place of the parents comes within the area of "neglect" proceedings (*7*). Such proceedings should not be confused with delinquency proceedings, since adolescents are taken into care for delinquency, not because their parents have failed to meet their obligations, but because the minor has committed acts that, if done by an adult, would constitute a violation of criminal law, and is, in addition, in need of rehabilitation, supervision, and/or treatment (*10*). The delinquent minor's antisocial conduct, however, is frequently combined with problems relating to the minor's health, including drug dependence, alcoholism, mental illness and need for reproductive health care. When and if the state intervenes is largely controlled by local criteria, attitudes, and perceptions. In some countries such intervention aims at assisting and rehabilitating adolescents, in others it is often punitive.

Consent

By way of preface here, some space must be devoted to a discussion of the legal capacity of minors and, in particular, of how this affects the issue of consent. The law generally takes a protective view of minors—those under the age of legal majority—designed both to insulate them from the supposed flightiness of their own decisions and from outside

pressure or coercion. The theory is that minors lack the capacity to give legally valid consent, where such is required, because their physical, mental, and moral development is incomplete (*11*), and they are "too vulnerable to exploitation by the rapacious and too exposed to the unscrupulous" (*12*). For this reason, they do not have the same basic legal rights as adults. Of this essentially paternalistic view, it has been said (*13*):

> The disabilities are really privileges, which the law gives them, and which they may exercise for their own benefit, the object of the law being to secure infants from damaging themselves or their property by their own improvident acts or prevent them from being imposed on by others.

Privileges perhaps, constraints possibly; the special legal status of minors cuts two ways. On the one hand, it reflects an attitude that gives minors special protection that is not available to adults, but on the other, many of the benefits available to adults through the exercise of choice are not available to minors without parental consent. Nowhere is this more evident than in the area of medical treatment, where the concerns for the welfare of the minor and the standards governing the tort liability of medical personnel (*14*) come together generally to bar medical treatment without parental consent. In the absence of such consent, the actions of a medical practitioner in treating a minor may, in fact, constitute assault and battery (*15*). The vindication of parental rights, given parents' liabilities for support of, and responsibility for the child, and the protection of health care providers have thus been recurring legal themes. To a certain extent, then, minors are held hostage to the will of adults, either that of their parents or guardians, or of health care providers.

It is the law concerning consent to medical treatment of minors that most directly affects the question of whether health care services are, in fact, available to youth. Consent is the key to access. While requiring parental or spousal consent arguably tends to safeguard adolescents from irrational decisions and poor, if not dangerous, care, in the minds of many observers, it pragmatically limits the options for health care available to adolescents, particularly where such thorny issues as reproductive health care or drug abuse are concerned (see Chapters 6 and 10 respectively). It overlooks, as well, the process of intellectual development which occurs as the adolescent progresses towards maturity.

Under historic common law, children were considered chattels—property, possessions—of their parents, and therefore no interference was countenanced in the way in which the parents dealt with the child's interests, including deciding what services were made available (*14*). Until recently, the near-universal rule has been that minors must have the consent of their parents, or if married and female, the consent of