Overview


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Government uses big language - comprehensive and lifelong holistic care to each citizen - but doesn't do what it says
Quality of care is benchmarked locally and internationally
Child Health definition is very broad, covering emotional, intellectual and social well-being which fits well with education missions
Holistic care that embraces an integration of physical, psychological and social well-being is more of a concept than a practice
Lack of guiding principles and values in the promulgation of child health policy and service delivery model
Current services are not child friendly and children have not been involved in their design
Health education activities for children are not comprehensive and lack a continuous programme
Legislation for SEN students (as in UK, Australia, US) should be enacted to ensure access to services
Children's Rights are neither appreciated nor respected
Government is signatory to UNCRC and should uphold its requirements
No statutory or regulatory framework on the healthy development of children
The % of GDP spent on overall health care is low. the proportion spent on children and adolescents is not transparent.
There is a mismatch between opportunities (which are many) and investment (which is small)
Child-related legislation should be systematically subject to evidence-based scrutiny from a well-being perspective
There is an opportunity to enhance partnership - intersectoral and transdisciplinary collaboration - in transitional care, including clinical condition needs, psychosocial, educational, vocational issues and health behaviours
Children's Rights should be legislated as the foundation for a Child Health Policy, driven by a set of over-arching values
Goal-driven, evidence-based, realistic and specific investment in infrastructure, service and human resource development to enhance child health in a forward-planning manner
Enhance the partnership between the government, NGOs, business sector and the public sector
Government has to commit to promoting, measuring and monitoring children's health, well-being and development
Policy alignment through a 'Health in All Policies' approach based on rights and obligations
Children/Parents/Patients are more aware of their rights. This has promoted family involvement
Parents and carers are becoming more actively involved in treatment programmes
Parents, and parents-to-be are becoming more assertive in striving for their own entitlements
Parents are better-educated and aware of 'well-being' needs
There is more awareness on the need to address the well-being of children with disabilities
Public awareness of children's physical and motor developmental issues is increasing (e.g. Special Olympics)
Stakeholders are becoming more empowered and involved in the healthcare system
Complaints or grievances by parents for the rights of children are always unsolved or neglected by the government
There is scope to help children to become more aware of their rights and therefore more empowered
It's time to enforce children's rights and entitlements
Most parents understand the rights of children. Their voices are becoming the momentum for social or political change
Because parents are more educated, then given the right kind of social culture and values they would be motivated to nurture their children in a more holistic manner
Need for a state-of-the-art health education curriculum that empasises a) teaching functional health information (essential knowledge); b) shaping personal values and beliefs that support healthy behaviours; c) shaping group norms that value a healthy lifestyle; and d) developing the essential health skills necessary to adopt, practice and maintain health-enhancing behaviours
Parents are more concerned with academic performance than with children's health
Young parents are more aware of the importance of balanced health and development for children and the need for improvements in the education system in HK
Traditional emphasis on academic achievement remains the major trend in most schools and the expectation of parents
Schools emphasize academic training rather than balanced life skills
curriculum too packed with academic subjects with inadequate health education
Teaching methods are not focused on developmental milestones
Although education is free, there is inadequate funding for children with learning disabilities/SEN
Inadequate funding and support for students and teachers
Help is not rarely immediate and often inappropriate
Poor understanding from government and community of the need for support and equity for this group
Inequity exists in higher education and job hunting for children with different cultures and disabilities
Children with SEN are not well protected or entitled by an IEP to a tailor-made learning curriculum. Only 5% of SEN students are reported to have IEPs in mainstream schools
Stigmatisation and discrimination in mental health through lack of public education
ASD, ADHD, AN sufferers may be deprived of appropriate treatment
Poor transition and continuity care for post secondary students with intellectual deficiencies, chronic medical problems or other disabilities
Teenagers with special learning needs are facing great difficulty
IT has improved public access to healthcare information
HK is technologically advanced. People can access health information easily
Internet and social networking help public know more about children's health and developmental issues
Online resources: smartphone, Facebook, SMS and tele care. iPad are useful as platforms to provide health advice and symptom assessment for adolescent patients with chronic disease
Web information is fragmented, misleading and inaccurate. It is not monitored or filtered. Misinformation on issues such as nutrition for example propagates rapidly
Poverty and unequal wealth distribution
High Gini coefficient. Significant poverty impacts health and well-being for a significant proportion of HK children
This leads to a reduction in social mobility and all the associated social determinants of health
Role of the business sector?
Family-friendly employment practices e.g. paternity leave
Family-friendly workplace
Overseas Child Health Policies can be used as a benchmark for Hong Kong
Increasing amount of research on education worldwide and guidelines from other countries that can supply more evidence-based information to hep in formulation of our own policy
Technology enables better outcomes
Technology facilitates learning for children with disabilities
Technological developments change lifestyle. New media devices will lead to new health problems (iPad will cause neck pain). More schools will adopt these new devices in teaching
HK could be a leader in using technology to develop and promote healthy lifestyle choices
Health indicators and data are ineffective or inadequate. This restricts the ability to identify service gaps and needs, identify at-risk populations, and engage in planning across the various domains
Research data is fragmented, uncoordinated and has little impact on policy development
Indicators under-developed
Currently there is an emphasis on quantitative outcome as opposed to qualitative evaluation
High literacy rate and relatively low school drop-out rate
maternal, perinatal and neonatal mortality and morbidity, low infant mortality perceived as indicators of an international standard of child health
No data on psychological well-being of children
Demographic trends are disrupting population structure - younger generation prefers to keep pets
The education system discourages parenting
Increasing evidence and worldwide trend of investment in early childhood
International trends moving towards emphasis on early intervention programmes
Research is needed on outcomes to identify areas for improvement and to establish clinical pathways for special needs children
Research into the use and effectiveness of health services
Academic institutions need to collaborate on research into key issues to guide policy direction
Establish a cross-sectoral and cross-jurisdictional research agenda to improve outcomes for children
Fragmentation and poor coordination
Over dominance of medical sector
Accountability spread among Bureaux
Even within health, further fragmentation exists between DH (public health, CAC, MCHC, SHS, Dental) primary, secondary, terry paediatrics, FM, A&E, psychiatry, public, private and NGO sectors
Problems facing families are often interlinked. Services equally need to work closely together to be most effective. Sometimes the planning element seems divorced from the operations
A child health policy can serve as a reference to harmonise partners' actions and create a supportive environment for child health care
Promoting the well-being of children to ensure their optimal outcomes requires integration at all levels: joined-up government - in respect both of policy-making and of service delivery
Links could be developed through existing local political frameworks - District Councils - for improved sectoral coordination. This links with the WHO Healthy Cities initiative
Evidence-based indicators and data can be collected on a district basis - to create an 'atlas' of health and well-being
Uneven distribution of resources e.g. geriatrics vs paediatrics
Policy focus on the ageing population - prioritising investment in the old instead of the young
There are competing demands for government funding and private donations from other groups, such as geriatrics
Closer cooperation between HA and NGOs on psychosocial interventions
There should be formal partnership schemes with NGOs to establish multidisciplinary resource centres
CEP has a role to play in leading and advocating
Children are dependent on others for advocacy and ineffective on their own
A platform should be established for communication among all the service providers across different settings
Children and youth must be involved in public policy development. When decisions must be made on behalf of a young, dependent child, he or she must be involved in making them
Government not concerned with importance of family structure and social determinants of child health
The health of young children is affected by a wide range of social, cultural, physical and economic environmental determinants. Many of these wider determinants are outside the direct control of the health sector
Inadequate psychosocial support
Private settings and NGOs fill some service gaps in after school programmes
Changing social values are leading to increased family conflict - ageing parents; compensated dating; teenage pregnancy; abandoned, neglected, abused children; hidden youth at home
Rising number of adverse social determinants - single parent; cross border family; working parents; new immigrants; ethnic minorities
There is increased concern among the public on child health issues - obesity, anxiety, stress etc
Lack of mid/long-term planning to tackle obesity rates, deteriorating air quality, mental health services. Providers not incentivised to set or achieve targets
Escalating working hours and poor income contribute to poor parenting
Due to the economic crisis, more families are living in poverty. This will jeopardise the development of their children
There is a growing awareness in the community that early childhood problems may have long term influence on problems in later life
Lifestyle awareness in a highly-urbanised and networked society is changing the model of learning how to become a valued member of society
There is a dedicated group of professionals interested in taking on child health in a broader perspective beyond health care boundaries, e.g. injury prevention, including bullying, self-harm, cyber bullying, resiliency programmes, anti-drug programmes, healthy school programmes, exercise and health, nutrition and wellness
Policies are Chinese ethnocentric. Minorities are marginalised or presumed to use private sector
Society is changing. We need to change how we respond to children
NGOs, charitable groups, funds, foundations and professionals in the community are valuable agents for innovative change
The first priority is to enhance public understanding of the determinants of healthy child development
Establish a risk and resilience framework for child, youth and family
Timely interventions and continuity of care are needed regardless of who is responsible for funding, delivering and administering services
Inadequate training for professionals
Large demand for and shortage of trained manpower in specialised care; community paediatrics; undergraduate paediatric training; integrated education; ICDC; SCDC teachers; social workers; GPs; how to identify mental health problems; parenting; handling chronically/terminally ill; paediatric psychotherapy; paediatric pharmacy; research; public health etc
Inadequate support from government on training
Child health should be developed as a distinct public health specialty at tertiary institutions
Curriculum for healthcare professionals should be revised
Provision of special training and enhancement programmes for school teachers who take care of special needs students
Professional training opportunities abound (HKAM/HKAN) but little opportunity to maximise exposure in work setting
There is a need for competency-based training programmes; development of career pathways; development of skills necessary for working in multidisciplinary teams
Gen-Y looks for work/life balance and not committed to work
Paediatrics is unattractive as a career choice - this will impact future leadership and the need for political skills in policy making
Disease focus, not public health/prevention/early detection oriented
The concept of preventive healthcare and a healthy lifestyle is still not widely understood or implemented in the community
As a society we are weak in the public awareness of risky behaviour and their effects on a healthy lifestyle
Attention focus on the management of health problems rather than building up resilience
Most adult disorders are extensions of juvenile disorders with onset in childhood/adolescence
The need to identify and enhance protective factors is not well-recognised
Government is unaware of the importance of early intervention in childhood problems and diverts more resources to elderly services
Limited resource allocation and professional development to preventive and community-based care
NGO services filling in gaps in public services are increasingly self-financed (social enterprise model, and the introduction of the lump sum grant), raising issues of accessibility
Develop standardised screening/assessment tools for local children
There is a need for standardised practices, protocols and guidelines across sectors
There are not sufficient locally-validated assessment and screening tools

I. Health indicators and data are ineffective or inadequate. This restricts the ability to identify service gaps and needs, identify at-risk populations, and engage in planning across the various domains

A. Research data is fragmented, uncoordinated and has little impact on policy development

B. Indicators under-developed

C. Currently there is an emphasis on quantitative outcome as opposed to qualitative evaluation

D. High literacy rate and relatively low school drop-out rate

E. maternal, perinatal and neonatal mortality and morbidity, low infant mortality perceived as indicators of an international standard of child health

F. No data on psychological well-being of children

G. Demographic trends are disrupting population structure - younger generation prefers to keep pets

H. The education system discourages parenting

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K. Research is needed on outcomes to identify areas for improvement and to establish clinical pathways for special needs children

L. Research into the use and effectiveness of health services

M. Academic institutions need to collaborate on research into key issues to guide policy direction

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II. Fragmentation and poor coordination

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C. Even within health, further fragmentation exists between DH (public health, CAC, MCHC, SHS, Dental) primary, secondary, terry paediatrics, FM, A&E, psychiatry, public, private and NGO sectors

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III. Uneven distribution of resources e.g. geriatrics vs paediatrics

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C. Teenagers with special learning needs are facing great difficulty

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XXI. H1

A. H2

1. H3

H4

H5

H6