Health, Education and Wellbeing in Hong Kong: British Legacy and New Challenges since the Handover to China

Santé, éducation et bien-être à Hong Kong : héritage britannique et nouveaux défis depuis la rétrocession à la Chine

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1. Introduction

Hong Kong lies on the eastern side of the Pearl River estuary in the Guangdong Province of Southern China. The territory is one of the most densely populated in the world, with a population of nearly 7.5 million living in an area of 1,104 per square kilometre (426 sq. mi.), in other words, the density of 6,300 people per square kilometre (World Population Review, 2019). According to the 2016 by-census, 93.6% of the population are ethnically Chinese and there are three official languages spoken (Cantonese, Mandarin and English).

As a British colony from 1842 to 1997, Hong Kong was set apart from neighbouring China and ruled by a Governor who headed an executive-led government with advisory and consultative bodies. The system aimed at business efficiency through laissez-faire policies, administrative legality and social order. As specified in the 1984 Sino-British Joint Declaration and the Basic Law which is the meaningful constitution post 1997 establishing the structure and responsibility of the local government, Hong Kong is now a Special Administrative Region (SAR) of the People’s Republic of China. The territory has a high degree of autonomy with full power over internal affairs. The purpose of these Sino-British constitutional arrangements was that the Hong Kong legal, economic and social systems would remain intact and distinct from those of Mainland China, under the “one
country, two systems” principle which guarantees the territory's capitalist economic system and autonomous government for 50 years after the transfer of sovereignty.

While wellbeing has only been put forward as important for citizens over the last decades, it is worth recalling that growth and wellbeing are not necessarily in opposition to each other. Richard Easterlin in a series of influential papers published between 1973 and 2005 “found no statistically significant evidence of a link between a country's GDP and the subjective well-being of its citizens” (Sacks et al., 2010: 1). However, later studies argue that absolute income still has a role in shaping wellbeing (Sacks et al., 2010: 3). Sacks, Stevenson and Wolfers from The Wharton School hold that within a given country, wealthier citizens have higher levels of life satisfaction and as a result, economic growth which brings wealth and happiness improves both individual and overall life satisfaction (Sacks et al., 2010: 1). Even if GDP is still considered to be an indicator of a society's standard of living, it is only a rough indicator because it does not directly account for leisure, environmental quality, levels of health and education, activities conducted outside the market, increases in technology, or the value that society may place on certain types of output (Khan Academy, 2016).

Wellbeing started being considered per se only recently in Hong Kong, through the concept of “quality of life”. This concept became a topic of discussion for academics worldwide and developed as a major concern for the public and the government in the 1960s. Indicators of quality of life have been used as “measures of social wellbeing, its achieved level and changes over time” (Chan et al., 2005: 260). Quality of life usually differs from standards of living which rely more on material satisfaction. In addition to life opportunities and satisfaction in basic needs, quality of life also includes “satisfaction in emotional needs, such as being satisfied with freedom, justice, and opportunities for the complete development of individual capabilities” (Chan et al., 2005: 260). Quality of life research deals with topics as varied as health, wellbeing, satisfaction, family, work, housing, social networks, political life amongst others (Chan et al., 2005).

Researchers from the Hong Kong Institute of Asia-Pacific studies at the Chinese University of Hong Kong have been studying quality of life in projects every two years since 1988, to help contribute to the enhancement of people's wellbeing. But it was only in 2000 that the Hong Kong Council of Social Service developed a Social Development (SDI) index to measure social development in Hong Kong. Released once every two years, the Index aims “to record and keep track of the progress of social development of Hong Kong and assess the social and economic needs of the entire society” (Social Indicators of Hong Kong, 2018), which shows an interest in both material and subjective wellbeing. In 2007, a territory-wide survey led by Xiaogang Wu’s team at the Centre for Applied Social and Economic Research from University of Science and Technology studied subjective wellbeing specifically. It revealed a lower level of subjective wellbeing of the post-1980’s generation with implications for the social and political environments (Wu, 2010).

This article will focus on policy inputs especially in health and education, in the context of the historical transfer from a British colony to a Special Administrative region of China and attempt to link them to the assessment of wellbeing in Hong Kong. These fields are major areas of concern for families due to pressures from changes in the labour market, upward mobility, integration with the mainland and an ageing population in the face of what some referred to as a “silver tsunami” where almost one in three Hong Kong residents will be aged 65 or above by 2041 (The 2015 Policy Address, Hong Kong). Wellbeing obviously does not limit itself to those two policy fields. Nevertheless,
according to statistics from Measuring What Matters, a survey report which was part of a reflection on a debate on National Wellbeing (ONS, 2011), health is one of the top things people say matter for them. The World Health Organisation (WHO), for its part, states that “wellbeing exists in two dimensions, subjective and objective. It comprises an individual’s experience of their life as well as a comparison of life circumstances with social norms and values.” The British Department of Health ranks health and education at the top of its list of examples of life circumstances (HM Department of Health, 2014).

From a Hong Kong point of view, the fields of health and education also seem worth studying as they were among the most impacted by the evolution from a colony to a Special Administrative Region of China. Hong Kong has had to compress nearly a century of healthcare and educational development in the West into the last three decades (The Harvard Team, 1999). This situation has been further exacerbated by the fact that colonial powers commonly ruled through a local elite, originating mainly from the business sector and decided on policies and programs; the general public therefore depended on the good intentions of this elite for provision of such services (Goodstadt, 2007).

This article will first examine the areas of health and education in turn, insisting on the contexts in Hong Kong with reference to the colonial legacy and Chinese cultural environment and exploring more recent developments in both areas since the Handover. It will then assess how specific factors (geography, history, politics such as an authoritative form of local government and a special status in China) may have influenced policy. And finally, it will conclude on challenges which lay ahead to measure wellbeing with reference to those sectors in Hong Kong.

2. Health context during the colonial period

Wellbeing is a term which was adopted in the second half of the 20th century. Yet it is not easy to define (Dodge et al., 2012: 222) and welfare seems more relevant to evoke the earlier individual or state efforts concerning caring for citizens. Welfare in Hong Kong finds its origins through 19th-century charities set up by successful Chinese and western missionary bodies, which delivered many support and educational programs for communities in need. Although we cannot really equate one term for the other, welfare has been more narrowly construed in economic terms to encompass the idea that wealthier individuals generally enjoy a better overall condition. Welfare economics concentrates on the income of individuals and their assumed preferences whereas wellbeing contains more variables. As a consequence, wellbeing is gradually replacing welfare as a central political goal for social and public policy. Academics in the field of social policy have encouraged a focus on wellbeing so as to allow for a “fully rounded humanity” instead of welfare which is more concerned with the economic utility (Taylor, 2011: 778-779). International research findings from Layard to Heinz and Deeming (2015) clearly show that welfare policies and wellbeing outcomes remain inextricably linked (Taylor, 2011: 785). Research continues to offer a broad justification for the principles of social welfare as a means for promoting wellbeing and happiness in the population (Heins et al., 2015).

Until the late 1970s, the colonial government was little interested in regulating matters concerning the Chinese population’s health as long as no diseases threatened the social and economic order of Hong Kong (Tse, 2008). It was only concerned about promoting sanitary conditions and preventing the spread of infectious diseases in a congested area
(Department of Health, Hong Kong SAR), thus maintaining basic order to guarantee economic stability. In the 19th century, segregation measures barring Chinese access to some areas and use of troops to dislodge families and bring patients by force to charitable hospitals during epidemics were frequent. For instance, the government intervened during the 1894 plague to maintain a healthy workforce, thereby ensuring peace in the colony and avoiding being put into quarantine as an “infected port” (Yip et al., 2016: 5-6). Attempts were then made to regulate the local population by promulgating anti-spitting laws to prevent the spread of tuberculosis, and mandatory vaccination of infants was ordained to combat smallpox (Yip et al., 2016: 6). Environmental and sanitary improvement was gradual but there was no comprehensive infrastructure or long-term planning from the start of the colony (Yip et al., 2016: 5; Tse, 2008). It was only in the 1950s that the government ‘involved itself in the provision of welfare without developing a formal welfare policy’ and established a basic universal health system (Tsang, 1995: 8).

Achievements in the field of health intensified in the 1970s as Hong Kong was undergoing rapid economic growth and enjoyed increasing levels of prosperity which enabled such developments (Tsang, 1995: 9).

On the Chinese side, some local magnates set up the Tung Wah Hospital in 1869 which provided free medical care and charitable services for the Chinese population of Hong Kong (Sinn, 1989). It is thus wealthy Chinese who were instrumental in addressing some of the early health issues of the Chinese population. In the 1930s, the Tung Wah group of hospitals had developed into the largest charity organization in Hong Kong, running hospitals and schools.

The Tung Wah Group, the city’s oldest and largest charity organization, originated from the Kwung Fook Temple founded by local Chinese in 1851 (Tung Wah Group of Hospitals website). To help those in need, a hospital using Chinese medicine which had always been widespread among the ethnically Chinese population of Hong Kong was founded on the same spot. However, the popularity of traditional medicine was severely affected by the introduction of antibiotics in the 1940s. It remained without any official recognition in the colonial system (Yip et al., 2016) since there were no laws governing practitioners and its knowledge continued to be acquired through apprenticeships (Zanzanaini, 2016).

It was not until the return of Hong Kong to mainland China in 1997 that the role of traditional Chinese medicine was acknowledged and incorporated as part of the Hong Kong healthcare system (Chung et al., 2007). The Basic Law required the Hong Kong government to regulate Traditional Chinese Medicine and the Chinese Medecine Council of Hong Kong was established in 1999.

On the British side, several medical facilities were implemented throughout the duration of the colonial period with one of the earliest being the Royal Naval Hospital founded in 1841 and the British Military Hospital built in 1907 for the use of garrisons and their dependents. Civil hospitals were also established in 1849 for troops, convicts, civil servants but only wealthy Chinese were able to pay for established practitioners in Western medicine (Yip et al., 2016: 17; Hutcheon, 1999). Among major hospitals founded during the colonial era, the Queen Elizabeth (1963) once stood out as the largest district general hospital in the Commonwealth.

Following the end of the Second World War, while in the UK the NHS was established in 1948 on the principle of free healthcare “from cradle to grave”, Hong Kong developed public hospital services for the community to compensate for the low economic capacity of the public to pay for private healthcare services and to curb the recurrence of
communicable diseases such as cholera and tuberculosis (Yip et al., 2016). Most public hospitals were thus built in the second half of the 20th century either with the help of charity or government funds to cater to the needs of a population which had more than tripled in the fifteen years which followed the end of the Second World War (Tang, 1998; Census and Statistics Department Website, 2015).

During the Post-war period, the government became more proactive in disease reduction and control measures as the population grew and the economic situation improved. To maintain a sustained rate of economic growth, the success of disease control became a priority in the mid-1960s. The post-colonial government had in fact inherited the system of the past known for its disease prevention measures. However, throughout the colonial rule, the government continued to place the economy first and rejected the idea of welfare in health policy formulation while maintaining a basic public health service to guarantee social peace and stability by covering all residents’ health needs and thereby ensuring acceptable levels of physical and mental wellbeing.

Before and after the Second World War, in the absence of state welfare services, charities and voluntary agencies became in fact the major providers of social needs in a society that was still poor. In this context, the introduction of legislation under public assistance in 1971 was a big turning point. A first public assistance scheme modelled on the British National Assistance Act was introduced as the foundation of Hong Kong’s social security system. This suddenly revealed the willingness of the government to take care of the basic needs of vulnerable members of society (Wong, 2008). The scheme allowed voluntary agencies, later called NGOs, “to transform their mission from dispensing relief to running professional social work services” (Wong, 2008: 5). Over 70% of their funding came from the government, augmented by fee charges and donations (Wong, 2008: 6). The subvention policy in effect incorporated NGOs in a kind of “statist-corporatist framework, turning them into agents of the state to deliver needed programs under service contracts” (Lee, 2005: 9-10). The responsibility for building and running hospitals came to be shared between government and charities, including religious orders (Tse, 2008). Since the 1970s, the government’s role in welfare matters has thus become more important regarding health policy formulation and review with the introduction of the first public assistance scheme (Chan et al., 2004).

In Hong Kong, social protection relies more on direct service support like free access to public hospitals than safety net provisions for the poor. Throughout the 1980s, the total spending on social welfare was between 4.5% and 6.5% of Hong Kong’s government’s budget (Tang, 1998: 76). At the same time, public social expenditure was over 15% of GDP on average across the OECD 4 (OECD, stats).

In order to foster self-reliance among citizens and deter long-term dependency, the government has deliberately set assistance scales at a very low level and thus limited the number of recipients. As a consequence, welfare recipients struggle with social stigma as it is perceived as a last resource and sign of inadequacy to conform to society’s expectations. Hong Kong citizens value hard work, self-reliance, family duty, and thrift in individual and public spending which is at the core of Confucian ethics (Wong, 2008: 3). These elements all have positive aspects for economic and societal development as is shown by Hong Kong’s economic success. Tu Wei-ming, professor of Chinese History and Philosophy at Harvard, underlines “the paradox of criticising Confucian ethics with its emphasis on traditional communities rather than innovative individuals as the main reason for East Asian backwardness” (Tu Wei-ming, 1989: 87) whilst stating that the very
same values (faith in the perfectibility of human condition, the importance of education, the centrality of the family in social harmony, the importance of hard work and discipline, the necessity for a strong government) are today deemed conducive to economic development. Tu Wei-ming reminds us that Confucian values which may foster a certain climate have nevertheless evolved through the encounter with the West and been adapted by those in power to meet the new challenges of the time (Tu Wei-ming, 1989: 91).

Welfare, which creates some of the conditions for economic, physical and social wellbeing, is gradually improved through self-effort which is better accepted in a traditional Confucian setting without creating the sort of dependency culture that has emerged in some industrial societies (Wong, 2008: 2). Hong Kong’s adherence to a low taxation system (ceiling of 15% for salary tax and 16.5% for profit tax) means that only one third of residents pay salary tax and this might appear as a compensation for lower scales of assistance (Wong, 2008: 5). Coupled with a high savings rate (about 35%)\(^{10}\), a stress on family obligation, and the ethic of self-reliance, private efforts have become the key to personal wellbeing and success just like in the liberal Anglo-Saxon model (Wong, 2008: 5).

### 3. Health policy since the Handover

The government undertook democratic reforms in Hong Kong from the mid-1980s to the late 1990s as the sovereignty of Hong Kong was going to be returned to China marking the end of British administration in Hong Kong. The implementation and effects of these reforms mostly dealt with the post-Handover period so as to preserve the nature of the Hong Kong government (Tsang, 1995: 10). Great Britain had not really been interested in extending democracy to Hong Kong until the return to China approached (The Guardian, 2017). The British and Chinese government signed a Joint Declaration in 1984 setting up a “one country, two systems” framework allowing a high degree of autonomy for the region for fifty years after the Handover.\(^{11}\)

The different compartments in the health sector were finally integrated in 1990 under the Hospital Authority and Health Department (Goodstadt, 2007). The establishment of the Hospital Authority (HA) which took place before Hong Kong was returned to China\(^{12}\) has brought steady improvement to specific aspects of quality and efficiency. As early as 1997, a study revealed that from the patients’ perspective, everyone had access to essential healthcare regardless of their financial means. Furthermore, the services were readily available in all communities so most residents did not need to travel more than thirty minutes to reach a provider. (The Harvard Team, 1999)

The following declaration from the introduction of the Yearbook 2006 of Hong Kong Government outlines the mission of the healthcare system. “The Government aims to ensure no one in Hong Kong is deprived of medical care because of lack of means. It provides a wide range of public services and facilities to meet the healthcare needs of the community. It also works endlessly to safeguard public health – combating infectious diseases and promoting health education.” This definition of a universal public healthcare system is akin to that of the National Health Service NHS in the UK which claims that services should be comprehensive, universal and free at the point of delivery (Grosios et al., 2010) although officially there is a higher emphasis on fighting infectious diseases in Hong Kong.
But a patient-centered approach is slow to be adopted. It started well when in November 1997, the Health and Welfare Bureau of the Government of Hong Kong SAR commissioned a team of economists, physicians, epidemiologists, and public health specialists from Harvard University to conduct a study on Hong Kong’s healthcare system based on a patient-centered approach. The first patient-centered healthcare survey was held in Hong Kong only in 2012 and by a non-governmental organization, the Alliance for Patients’ Mutual Help Organization (APMHO). The APMHO, which became a member of the International Alliance of Patients’ Organization (IAPO) in 2005, focuses on policy advocacy and closer networking with patients’ organization, and has been actively advocating for patient-centered health (PCH) since 2008. The report concludes that although there has been a growing awareness among patients and patient organizations, in reality little progress has been made in this field. Despite the scale of this exploratory survey, it has not yet had the expected outcome on policy-makers nor have patients’ perspectives been seriously taken into account other than in a fragmented way and on a very small number of issues.

According to the 1997 Harvard report, “hospitals are the dominant institutions providing healthcare in Hong Kong and priority is given to hospital-based services”, which constitutes the majority of the healthcare system. There are more than fifty public hospitals and twelve private ones (Lewis, 2008). Healthcare is therefore available for all at nominal charge in government hospitals and clinics (HK$100 (about US$13) for hospital treatment, HK$68 (about US$9) for outpatient treatment Hong Kong’s welfare system) (Wong, 2008: 6). Considering those minimal registration costs, it is clear that the Hong Kong government has basically achieved the goal that every resident can receive lifelong healthcare, and no one will be denied adequate medical treatment due to lack of means (Kong et al., 2015).

But, in Hong Kong, a continued lack of coordination in the health sector with an excessive reliance on public hospitals which have reached overcapacity adversely affects patients’ health and healthcare and unnecessarily increases the expenditures for health services as family and community medicine is underdeveloped and traditional Chinese medicine, which many chronically ill patients find beneficial, is excluded from the organized medical system. Most traditional Chinese practitioners are in private clinics and some operate in their own clinic. Over 40% of Hong Kong residents rely on Chinese medicine as an alternative option when they have a health problem, whilst 22% of medical consultations are provided by traditional Chinese practitioners (Who/ Department of Health, 2012) who are believed to offer a more holistic approach. Western-style pharmacy chain Watsons has introduced Chinese medicine services in some of its stores to bring traditions within a more modern setting (South China Morning Post, 2014), whilst offering elderly patients a 10% discount on the regular price of treatments. This is how private practice and initiative compensate for the public sector’s inability to fully take into account the patient’s cultural need.

In the mainstream health field, the public sector is taking care of 90 per cent of the city’s patients, while employing only 40 per cent of the doctors; whereas the lucrative private sector is taking care of only 10 per cent of patients while employing 60 per cent of doctors (South China Morning Post, 2016). The private system, on the other hand, takes on about 70% of all fee-for-service outpatient services compared to public outpatient clinics (Schoebe, 2016: 54).
Public hospitals, according to the Hospital Authority, currently operate with a shortage of 700 nurses and 250 doctors. New recruits in the profession are routinely lost to the more lucrative and relaxed private sector. It is projected that public hospitals will require an additional 6,200 medical doctor by 2041 in order to maintain the same level of service as today. Among measures to address the current staffing crisis in public hospitals, the Hong Kong government is increasing the number of medical graduates each year: from 250 to 320 last year, and to 420 in 2018 (Schoebe, 2016: 56). Meanwhile, the quality gap between treatments in a private clinic and public ones which have been struggling with large numbers and limited resources has increased over the years (South China Morning Post, 2016). As the superior medical service and treatment mode, private medical institutions are often particularly attractive for patients who have sufficient economic capability (Kong, 2014). The private sector medical care system which was gradually regulated in the 1990s parallels the laissez-faire development of the rest of the economy (Hay, 1995). And the local doctors’ union maintains that “the real issue is the inequitable resource allocation between the private and public sectors, and among different public hospitals” (South China Morning Post, 2016).

There is therefore some concern that the fragmentation between private and public health systems will accelerate and that only wealthy residents will be able to obtain quality treatment without delay (Schoebe, 2016: 54; Wong, 2008: 10). When needs are not catered for as well as in the past, one might experience stress and frustration, so an alteration of their wellbeing. The Willis Towers Watson 2017-18 Global Benefits Attitudes Survey (the third largest insurance broker in the world health surveys) reported that managing their health is a top priority for two thirds of employees (67%) in Asia and that over half (56%) say that they suffer from elevated levels of stress. As good health is correlated with higher life satisfaction (Department of Health, 2014), one’s health might in turn be altered, confirming that health and wellbeing are clearly interrelated (health influences wellbeing and vice versa). The provision of medical care for the whole population, welfare programs and some labour regulations are policies which make citizens happier. Mental wellbeing can guide people’s behaviour in terms of consumption and investments and at the same time, it improves their life spans (Li et al., 2008: 15).

Despite the persistent lack of coordination in the health sector, Hong Kong’s healthcare system has often been praised for achieving a better health outcome and being less costly in resources compared to European countries (The Harvard Team, 1999). The health outcome is good, no doubt. In Hong Kong, the ratio of healthcare professionals to the population has increased steadily in the past decade. Every 552 population was served by 1 doctor in 2012, a decrease by 12% compared to 2002 which is in fact an improvement of the situation (Wang, 2013: 1008). According to Healthy Hong Kong, Department of Health, compared with a few decades ago, Hong Kong people nowadays suffer less from infectious diseases (HK Department of Health, 2017). Hong Kong’s 7 million inhabitants are one of the healthiest populations in the world. Life expectancy is 84 for women and 78 for men, the second-highest worldwide (Lewis, 2008). Hong Kong’s Human Development Index (2003) ranked 22nd in the world, respectable among industrial economies, just behind Japan in Asia and on par with Singapore (Wong, 2008: 5).

Hong Kong’s health system was established within the framework of a perfect market-oriented economic matrix, where there are wide ranging social security and medical service systems (Kong et al., 2014). This system of government-operated hospitals, open to all citizens, costs the Hong Kong government about 3% of GDP (6% including private
hospitals) which is less than half of the 7.5% of GDP that is already being spent by US
governments on healthcare (Lewis, 2008). Within the next two decades, public healthcare
expenditure is due to increase up to 23% of the total government budget, a significant
increase from its current 14%. Given the Basic Law, which states that, over time, the
increase in total government expenditure should be kept in line with growth in GDP,
funding for other public programs, such as education, housing and infrastructure, will
have to be reduced when public health expenditure takes a larger share of the total
budget (The Harvard Team, 1999). This seems to be preparing for an era in which not all
aspects of public policy pertaining to individual and societal wellbeing will be covered,
especially as demand for healthcare increases. Per capita expenditure on health grew
from US$1,289 in 1999-00 to US$1,641 in 2009-10, an increase of 27.4%. The ratio of total
expenditure on health to Gross Domestic Product stood at 5.2% in 2009-10 (Wang, 2009: 2).

Some believe that healthcare must be rationed to patients. The policy of rationing
healthcare in Hong Kong amounts to examining which existing medical interventions
provided by public hospitals should be subsidised and leaving out those that are not as
effective (Yuen et al., 2006). Economists, since Adam Smith, have argued that “the
invisible hand of free market prices is a superior rationing system […] to the iron fist of
government”, or in other words, that “competitive markets provide the greatest good to
the greatest number of people” (Hay, 1992: 65). Colonial authorities have always defended
the free market and ultra-liberal system as a model for Hong Kong (Chan, 1996: 14).
However economic freedom and legal rights have not always been protected and laissez-
faire might have instead been an excuse for the government of Hong Kong to avoid any
responsibility towards its people. It was only after the 1967 riots that the Hong Kong
government began to adopt a more responsive social policy through social legislation and
provision of social services such as labour law, welfare programs, and mass education
entitlement (Chan, 1996:15). Besides Hong Kong is far from a free market as official
patronage and special preferences have always dominated in key personnel appointments
and major decision-making process, concerning public works contracts, real estate,
monetary and financial measures (BBC News, Hong Kong, 2012).

During the mainland immigration flows of the 1930s, the need for public housing was
already acknowledged by the government. Since 2006, private ownership has been going
up slowly from 49% whereas public rental and subsidised sectors have gone down from
48.8%. As of the 2016 Population By-census, 45% of the population lived in public rental
housing or subsidised home ownership housing compared to 53% in the private
permanent housing. This shows that authorities have not just relied on market allocation
but have instead controlled some key institutions which are essential to people’s
wellbeing.

Healthcare like housing appears crucial to survival and to maintaining decent standards
of quality of life. But it is less easy to obtain through a free capitalist market than
thorough public administration. As healthcare is vital for one to remain in good physical
and mental condition, some economists understandably argue otherwise that its quality
and availability must be guaranteed by the government (Hay, 1995).
4. Challenges ahead for the wellbeing of an ageing population

According to the Asian Urban Wellbeing Indicators Comparative Report, Hong Kong has assigned a high level of priority to medical care (Civic Exchange, 2016). Hong Kong has to face up to the ageing of its population but unlike developed countries, its population is confined to a very small territory. Crowded urban lodging increases the sanitary risk as the elderly form a vulnerable part of the population. Due to its unique geopolitical location, Hong Kong remains constantly on the lookout for new emerging diseases. Besides, wealthy families are still able to rely on paid labour to care for their seniors but that is not the case for the majority of the population.

It is predicted that the elderly population (aged 65 and above) will double to over 2 million by 2029. The elderly tend to visit medical facilities more often (in fact, 4.7 times more often) than younger patients, and they make up 42% of all inpatients in public hospitals (Localizz, 2017).

Satisfaction with medical care in Hong Kong is currently high: among those selecting this domain, 56% were satisfied with how fast and easy it is to see a doctor; 64% were satisfied with the availability of affordable care; and 74% were satisfied with the quality of care they received. But inevitably as the population ages, medical care will rise as a priority for Hong Kong residents, and the government will find it more difficult to maintain current levels of satisfaction (Civic Exchange, 2016).

As a result, healthcare for elderly people and their conditions such as dementia in primary care or in a community setting has become important priorities like in most developed countries. In 2014, Professor Lord Darzi, who led a delegation of UK companies to the Hospital Authority Convention in Hong Kong, concluded that they shared many similar healthcare challenges particularly that of a larger and ageing population and the increasing importance of improving primary care to reduce reliance on hospital care. According to him, the redesign of buildings and services to tackle this is simultaneously happening in Hong Kong and the UK and both could cooperate in sharing experience as they adjust to meet the challenges which lay ahead (Foreign and Commonwealth Office, 2014). On 15 October 2015, the UK and Hong Kong signed a Memorandum of Understanding (MOU) for a period of five years on health co-operation, including healthcare policy and protection, technology and redevelopment of existing hospital facilities (Foreign and Commonwealth Office, 2015).

Some pilot schemes like cross-residential border care projects have been backed by charitable organizations in Hong Kong. Care homes on the Chinese mainland border where space is more readily accessible, the environment of better quality and costs of living generally lower once appeared as the solution for ordinary people. But this no longer seems to be a desirable option since the yuan appreciated against the Hong Kong dollar thereby rising living expenses and the new generation of elderly born in Hong Kong are less keen to move up north to the mainland where they have no connections (China Daily, 2017).

Handling healthcare challenges and assessing levels of satisfaction in the field remain as relevant as it is for education which will be developed in the next part.
5. Educational context during the colonial period

There were initially twenty Chinese village schools in the 1860s but wealthy Chinese preferred to send their children to Canton for private education (Tang, 2006: 8). In 1862, the first government school, Queen's College (then Government Central School) was set up and based itself upon voluntary and philanthropic work. Educational initiatives tended to have a unique Chinese and British influence because of the region's proximity to China and its position as a British colony, although a western education style including Christian beliefs remained key features.

By the turn of the 20th century, Hong Kong families had started to value the British education system as trade levels increased in the colony and the number of wealthy Chinese grew with more opportunities and influential networks outside. Besides, as a cosmopolitan city, it attracted diverse nationalities and remained a window to the outside world. British-style education proved to better prepare students for higher education, professional training, or further study abroad, all prerequisites to form part of the new westernized and modern elite. English was thus regarded as part of elite culture and gave access to a good career in government, education, academia and law and this is still true today (Cheng, 2014).

In addition, government funding was only offered to British and Chinese schools being administered through western models and not to the traditional Chinese institutions with a curriculum often based on teaching ancient texts of little relevance to the modern world. Hong Kong's first university was founded in 1912 as an English-medium tertiary institution. The university supported the community by enabling those involved in education studies to combine their coursework with teaching experiences in the local communities, thereby raising educational standards for those previously devoid of such an opportunity and as a consequence, increase the attractiveness of the residential area in the vicinity (Martinez, 2013).

In the 1960s, government spending on schools was not seen as a priority. Government officials became increasingly committed to education in general, and as an investment in the workforce of the future and its productivity, most noticeably in the 1970s due to demographic changes in the population (Government Secretariat, Hong Kong, 1981). With a young and rapidly increasing population, it became clear that a massive school building program was needed and that the main priority was the development of primary education and teacher training. Nine years of free and compulsory schooling was thus adopted for all pupils in 1978 (extended to 12 years of subsidized education in 2008-2009) (Wong, 2008: 6). Another policy was the establishment of engineering, science, and business evening classes for students as well as evening training for teachers.

By contrast, two decades later, Hong Kong had developed from a manufacturing country in the 1970s and 1980s and evolved into a regional hub of business and service in the 1990s, thus witnessing a decline in employment opportunities in the secondary sector and a growth in the tertiary. Education then expanded as part of a government effort to develop Hong Kong into a knowledge-based economy and enrolments in higher education tripled from 1989 (Wu, 2010: 5-6). According to Wu, the young post-80s generation is the major beneficiary of the education expansion in the 1990s, and they have enjoyed more educational opportunities than those of the same age groups in earlier years. However
young people remain frustrated in terms of opportunities and hopes for the future as the pro-democracy “Umbrella” protests showed in 2014 (Wu, 2010: i-ii).

6. Education policy after the Handover

Since the post-colonial period, changing the medium of instruction in secondary schools has been one of the most controversial policies in Hong Kong’s education. Prior to the 1970s, English was still the only official language and it remains highly regarded today as an international language (Tang, 2006: 2). Most local schools used English for teaching different subjects although some classes were taught in Cantonese. Mandarin which is considered as standard Chinese started being introduced in schools as early as the 1980s but it was not until 1998 that it became an essential part of the local curriculum (Liu, 2017). Indeed, in April 1997, three months before the Handover, the new government published a document regarding compulsory Chinese medium instruction policy. It suggested that enhanced fluency in Mandarin would help students whose mother tongue is Cantonese and who use full-form characters instead of the simplified version widespread on Mainland China understand content better. However, in September 2007, the government retreated to give more freedom to schools to be exempt from this policy. As a result, only 25% of the secondary schools were approved to continue EMI (English as a Medium of Instruction) education, whereas the rest of the secondary schools must use CMI (Chinese as a Medium of Instruction) in teaching most subjects (Cheng, 2014). Furthermore, the new language policy required teachers to enhance their language proficiency. Thus, there was the emergence of Language Proficiency Assessment for Teachers in 2008 to mainly assess the Mandarin and English skills both of which are not mother tongues in Hong Kong, a Cantonese stronghold (Cheng, 2014).

In 2012, another drastic reform was the application of the Chinese educational system, which follows the American model of “three-three-four” (middle school/ high school/ tertiary education) thereby extending university education from three to four years. This has affected all levels of local students and educators. Students end up having only one public examination, the Hong Kong Diploma of Secondary Education (DSE). Another particularly controversial area was the introduction of civic education in 2012, perceived as a political step which caused a series of radical protests initiated by political parties and youth. Changing language policy in education was only the first wave of reforms that the Hong Kong government has recently initiated to gradually decrease British influence. The reactions of parents, students and teachers were very strong, reflecting not only how attached they are to English as a medium of instruction, but also how entrenched British educational values adopted during the colonial period remain today (Cheng, 2014).

According to the OECD (OECD, 2014), between 2003 and 2011, Hong Kong implemented top innovations in pedagogic and organisational practices. One of these top innovations in primary and secondary schools was the increased use of teachers’ peer review. Hong Kong also scored the highest in text interpretation and progress has been made in relating school lessons to everyday life. In 2009, Liberal Studies was a new curriculum introduced at senior secondary level to encourage Hong Kong students to develop skills in critical thinking.

More resources have been allocated to education. The total government expenditure on education amounted to US$10,031 million in 2012-13, an increase of 40.7% compared to US$7,128 million in 2002-03 (Wang, 2013: 1008). For 2017-18, the total government expenditure on education amounted to US$13,137 million, a further increase of 31.7% compared to 2016-17.
expenditure on education is estimated at US$11 million. The recurrent education spending is about 21.3% of the overall government spending (Lee, 2017). In 2015-16, about 3.3% of GDP was spent on education. This is, however, lower than other high-income economies and well beneath the OECD average of 5.9% a year (OECD, 2014). Furthermore, education in Hong Kong was largely modelled on that of the United Kingdom and is overseen by the Education Bureau and the Social Welfare Department which outlines the administration policies of government and aided schools. University education is subsidized for some 20% of relevant age cohorts (Wong, 2008: 6).

Education remains one of the most important public policy areas for the new leader of Hong Kong, Carrie Lam, whose five-year term of Chief Executive began on 1 July 2017. She had promised in her election manifesto to increase financial resources to the education sector (Lee, 2017). In early July 2017, she announced in her first question-and-answer session in the Legislative Council that the government would be spending an extra HK$3.6 billion (US$450 million) for local undergraduate programs, to increase the ratio of classes to teachers in public primary and secondary schools with the creation of 3,200 permanent teacher posts within a year (2017-2018). Lam’s education policy direction is largely agreed to by different stakeholders in the education sector (Lee, 2017) and is part of a policy to transform Hong Kong into a regional education hub for higher education (Lee, 2014).

The outcome of these post-Handover education policies is that among population aged 15 and above, the proportion of those having attained secondary and post-secondary levels increased from 71.1% in 2001 to 77.3% in 2011. There has been a continued improvement in the quality of education in terms of pupil-teacher ratios. For primary level, it improved considerably from 19.8 in the 2002-03 school year to 13.9 in the 2012-13 school year; while that for secondary level also improved from 17.6 to 13.7 over the same period (Wang, 2013: 1008). Though pupils over 15 in Hong Kong perform very well in terms of mathematics and reading, student wellbeing (life satisfaction and sense of belonging at school) remains well beneath OECD average whereas schoolwork-related anxiety is higher than average (OECD, 2017). Policies aimed at encouraging higher education should not only target the young, but also enhance positive valuation of education throughout one’s life. Awareness campaigns promoting the benefits of education, including practical or vocational skills, can help better promote the intrinsic value of education at all levels (ESRC, 2014).

Higher levels of education are associated with a wide range of positive outcomes - including better health and wellbeing, higher social trust, greater political interest, lower political cynicism, and less hostile attitudes towards immigrants (ESRC, 2014). Yet the emphasis on education today affects people with lower levels of education who may suffer from low self-esteem and as a consequence enjoy less personal wellbeing (ESRC, 2014).

Hong Kong has been the heir to the social welfare and educational traditions from her colonial past (missionary and charity works) as well as Confucian values of self-reliance and family duty. The integration of the two legacies produced a special mix of welfare values and educational practices from east and west. The legacy of a highly centralized and executive-led governance regime continues in Hong Kong today where there is little public input over education. In terms of education, the Chinese population in Hong Kong has always adopted a practical attitude in order to guarantee the success of its youth. Faith schools which enabled the best schooling in English were favoured over others because they either helped achieve a professional career in Hong Kong or enabled them
to pursue higher education abroad in English-speaking countries. Parents continue to view schools as a path to upward social mobility (Postiglione et al., 1998: preface) especially since under the British colonial framework and up until the signing of the Sino-British declaration in 1984, the schools of Hong Kong have catered to the elite (Postiglione, 1992: introduction).

7. Wellbeing, health and education in Hong Kong

Education has become one of the clearest indicators of life outcomes such as employment, income and social status, and is a strong predictor of attitudes and wellbeing. Education is often used by people to shape their ‘social identity’, sketching out their understanding of themselves and their relationships with other people. A positive, affirming social identity is associated with a range of positive outcomes in life, such as increased wellbeing, health, social trust and political engagement (ESRC, 2014).

Since the delivery of both education and healthcare are closely related to the public and has an influence on citizens' wellbeing, the government should provide an opportunity for them to express their opinion and let them have constructive discussion (Tse, 2008). The importance of public debate and effective mobilisation and communication of research has been developed by Christine Loh, (LSE Cities, 2011) who suggested that political and business elites in Hong Kong were uncomfortable about opening up a dialogue around the sharing of wealth and resources, worrying that it might lead to conflict. As Deputy-Minister for the Environment (2012-2017), Loh was interested in exploring how productive conversations might be initiated and sustained between citizens and city leaders and especially how new technologies could be used to improve the wellbeing of the citizens. According to the first Asian Urban Wellbeing Indicators Comparative Report (2016) which took into account people’s subjective attitudes and experiences rather than only policy inputs (educational spending) and outputs (graduation rates), 70% of people in Hong Kong felt their city had become worse or much worse to live in than when they first moved in. Whilst housing was by far the top priority of government action, quality of government came in second with education. Loh also worried about growing public discontent towards the government and how negative perceptions could affect the overall wellbeing of citizens (Le Monde, 2017).

Throughout the 20th century, Hong Kong was prone to a colonial culture which believed that it had little to benefit from a western welfare system, where the level of wellbeing is often deemed to be higher and its distribution more equitable (Veenhoven, 2000). In a discussion on wellbeing and the welfare state, Veenhoven concedes that individual and collective meanings tend to become confused. “Social welfare” contains both the notion that a strong welfare state is good for society (it strengthens “social cohesion”) and the idea that people who live in a welfare state “fare well”. It is thus commonly assumed that what is good for society will also be good for individuals who belong to it.

Hong Kong has developed a unique social and economic model which has contributed to its economic success and is highly regarded in the world. Its position has been confirmed over time by one of the highest HDI among developed countries (Hong Kong ranked 7th in the 2018 UN Human Development Indicator, before the US and Great Britain). The efficiency of its administration, an extremely well-developed transport and communication network, sound education, health and public housing infrastructure, all

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contribute to this ranking. Besides English as a business and education language, together with Cantonese and Mandarin as official languages are assets on the world stage.

57 During the colonial period, while the British preferred to let the Chinese community solve their own problems without interfering in social policy (Goodstadt, 2007: 23), neither the colonial authorities nor the business sector, which supported them, had understood that economic growth would not be sufficient to solve Hong Kong’s social, political and environmental problems. Until very recently, the contrast between a thriving society and institutions, which were incompletely developed, remained stark. For instance, healthcare was fragmented until the creation of a Hospital Authority in 1990 with Chinese clinics being the most widespread offer for the local population until the 1960s (Goodstadt, 2007: 24). Health had been left at the mercy of citizens but with an ageing population (about 27% will reach the age of 65 by 2030), families who mostly lack time, space and finances to provide adequate care for their elder relatives have seen their burden increase. Another illustration of Hong Kong’s lagging behind other developed countries is that the workforce was not entitled to a statutory retirement pension scheme until December 2000 (Information Services Department, Hong Kong, 2015).

58 Since 2003, the Centre for the Quality of Life at the Chinese University of Hong Kong (CUHK) has conducted surveys and published comprehensive indices on wellbeing (Chan et al., 2004: 265). The Hong Kong Quality of Life Index measures 21 indicators across Social, Economic and Environmental sub-indices (Chan et al., 2004: 266-267; Social and Economic Mobility, 2015). It also asks participants to self-report stress levels and life satisfaction. It came out that Hong Kong people considered good health, peace of mind and money as key to happiness and desired a better living environment, placing education as a key to success (Chan et al., 2004).

59 Professor Angus Deaton claims that it is also important to monitor more subjective social factors, such as “physical and psychological wellbeing, education, and the ability to participate in civil society” in order to address the wellbeing of all nations (Deaton, 2013). These last two concerns are especially relevant for the citizens of Hong Kong who expected gradual implementation of the political reforms promised in the Basic Law.

60 In 2012, the Centre for the Quality of Life began to survey youth quality of life in Hong Kong; its July 2015 report concluded that the youth quality of life had declined over the past 12 months. In particular, the physical health, psychological wellbeing, and political engagement of youth were found to have diminished. Of the 28 indicators, “government performance evaluation” was the most noticeable factor in decline, followed by “satisfaction with youth policy” and “perceived impact on policy” (Social and Economic Mobility, 2015).

61 These findings seem to confirm the feeling that there is a growing disappointment from a Cantonese-speaking youth which has lost hope in a political and social system which no longer matches expectations. They feel stranded in between their family’s local expectations and social pressure for them to play a greater role in People’s Republic of China’s society (Ford, 1996: 80).

62 The conflict between the desire to have government ensured healthcare and education for all and the recognition that private markets provide goods and services more effectively than the government is nothing new (Hay, 1995). Veenhoven believes that the amount and extent of welfare are negotiable but he insists that it should not be written off altogether. Whilst they do not necessarily help much in producing more or less
wellbeing, welfare systems nevertheless provide a neutral framework in which to develop wellbeing (Veenhoven, 2000).

63 The Happiness Index used for the Youth Quality of Life Report also demonstrates that many young people are unhappy with their lives as compared to previous years. But it does not help the government clearly identify the actual causes behind fluctuations in wellbeing which would also enable it to adopt more suitable policies. This report assesses a state without enquiring about the aspects of government performance that are creating dissatisfaction and trying to establish a connection between the deteriorating wellbeing of Hong Kong people to tensions with Mainland China and the Occupy Movement (Social and Economic Mobility, 2015).

64 These indices are insufficient in themselves to have any impact on government policy because they fail to fully take into consideration subjective social indicators like satisfaction, worries or trust usually determined through self-ratings (Rammstedt, 2009: 2). More research needs to be undertaken for the government to be able to enact the right policy if it is to rely on specific index relevant to the Hong Kong context. A diversified set of indicators may enable them to measure improvements resulting from social and economic policies but without an official incentive, it would be difficult to adopt local statistical indicators enabling them to evaluate progress. Due to current uncertainty about the extent to which the Quality of Life Index may be used to make concrete policy proposals, the OECD’s Framework for Measuring Wellbeing and Progress has so far remained widespread in political discourse.

65 In 2011, the OECD launched the Better Life Initiative, which aimed to measure wellbeing by looking at material conditions and quality of life through eleven dimensions ranging from income and health to work-life balance, civic engagement, and subjective wellbeing. The initiative was itself inspired by the Stiglitz 2009 Report following the Commission on the Measurement of Economic Performance and Social Progress, which was created to identify the limits of GDP as an indicator of economic performance and social progress. It is likely that Hong Kong will follow the UK and Canada’s lead and find inspiration in the Better Life Initiative to formulate wellbeing indices (Social and Economic Mobility, 2015).

8. Conclusion

66 After over a century of colonial rule and twenty years under a special status within China, Hong Kong has reached a state of economic development which makes it one of the most advanced places in terms of health and education. However, the population has mostly benefited from its newly-found wealth through the top down directives to improve overall wellbeing without any direct public consultation on citizens’ life expectations. Moreover, Hong Kong’s short-term future could be greatly affected by two main challenges: the Chinese government’s growing tendency to interpret and rely on the Basic Law to reaffirm full control over the most Southern part of its territory inhabited by a Cantonese-speaking population which has partly lost trust in their local political institutions and an ageing population with limited land resources. This demographic evolution is common to all Western and Asian economically advanced nations but Hong Kong will be particularly affected by old age and dependency due to its tight manoeuvring space, and it could thus develop as a platform to experiment with new ideas and concepts regarding forms of social organisations like cross-border care on the mainland.
Recently Hong Kong has adopted international criteria to assess wellbeing. Yet some questions remain as to how to use the wellbeing assessments, which overall reflect favourably on the government as Hong Kong’s GDP per capita ranks seventh based on purchasing power parity rates (Social and Economic Mobility, 2015). The Hong Kong Quality of Life Index asks participants to report stress levels and life satisfaction but it does not necessarily establish a causal connection. The Happiness Index used for the Youth Quality of Life Report also fails to guide policy makers on how to improve the lives of citizens as it does provide in-depth insight but only speculates over some of the possible causes affecting levels of wellbeing (Social and Economic Mobility, 2015).

Surveying institutions “should ask more in-depth questions when assessing subjective social indicators” in order to uncover not only how but also “why respondents feel more content or less content with their lives as compared to previous years” (Social and Economic Mobility, 2015). The Hong Kong government is currently proposing to implement a family impact assessment in any policy formulation. This latest improvement in the wellbeing index could be used to measure the government’s performance in some domains (Elliot et al., 2016).

In measuring the wellbeing fluctuations of a population, political aspects should also be explored on top of economic and social components and included in any assessment of health and education. The study case of Hong Kong with its unique geopolitical setting and top down approach to policy-making may be as interesting for China as it is for economically advanced nations.

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NOTES

1. The GDP has been used as a measure of economic wellbeing since the 1940s: it measures the total economic output by individuals, businesses, and the government and is a tangible way to quantify the state of the economy.

2. The Stiglitz Commission (2009) describes the different aspects of Subjective Wellbeing (SWB) as “cognitive evaluations of one’s life, happiness, satisfaction, positive emotions such as joy and pride, and negative emotions such as pain and worry” and insists that “each of them should be measured separately to derive a more comprehensive appreciation of people’s lives … [and that SWB] should be included in larger scale surveys undertaken by official statistical offices.”

3. According to the ONS paper on Measuring Subjective Wellbeing for Public Policy (February 2011), there is increasing interest in the measurement and use of subjective wellbeing (SWB) for policy purposes.

4. According to the Cambridge dictionary, welfare is either defined as the provision of financial support for citizens without the means to provide for their basic needs or as the physical and mental health and happiness, especially of a person.
5. Layard argued in *Happiness: Lessons from a New Science* (London: Penguin Books, 2005) that funding by the Department of Health to develop psychological therapies in the treatment of depression and anxiety, would positively impact on the number of people who are fit to work and thus help reduce the number of Incapacity Benefit recipients.

6. Poor Chinese quarters were established in Taipingshan and the peak with a slightly better climate was strictly reserved for European settlers to protect themselves from disease and spare them the unhealthy and unsanitary living quarters of the Chinese.

7. The Social Welfare Department had come into existence in 1958 but its function had remained limited while the government stressed the role of the family in social welfare. Long-term plans for social welfare were only introduced in the 1970s with double in social spending per capita between 1971 and 1974 (Wong, 2008: 6). Two thirds of the welfare budget was attributed to social security which includes Public Assistance Scheme and Old Age and Disability allowances (Hong Kong government, 1991).

8. In 2018, public social expenditure is 20% of GDP on average across the OCDE with 8% of GDP on average being spent on pensions. Over the last decade, such spending has increased by 1% a year (OECD, 2019).

9. The Social Allowance Scheme (known as Social Security Allowance Scheme since 1993) introduced in 1973 is one of the major components of Hong Kong’s social security system which is noteworthy for its low benefit level and generates social stigma.

10. In the UK, household savings rate averaged 8% between 2008 and 2010 whilst in France the rate was higher at about 15% (ONS, Trading Economics).

11. The foreign ministry in Beijing recently described the Joint Declaration as “a historical document which no longer has any practical significance” (*The Guardian*, 2017), leaving a lot of uncertainty floating as to the long-term future of Hong Kong.

12. The 1997 Handover of Hong Kong from the United Kingdom to the People’s Republic of China represents one of the major political transformations of the twentieth century.

13. The APMHO was established in 1992 with the support of key organizations (such as the Hong Kong Medical Association and the Hong Kong Council of Social Services) and 16 patients mutual help organizations serving patients with diabetes, renal failure, cancer, rheumatoid arthritis, lupus, asthma, etc. By 2012, it had become a network of 44 patients-led organizations with approximately 40,000 patients in Hong Kong, representing more than 20 disease areas of which most can be classified as chronic illness or currently named under the UN and WHO as Non Communicable Diseases (NCDs). There are currently more representations of APMHO participating on healthcare issues and related committees and working groups in Hong Kong SAR Government and Hospital Authority. (APMHO, CRN HKSR, 2012: 12)

14. It is believed that by promoting great patient responsibility and optimal usage, PCH leads to improved health outcomes, quality of life, and optimal value of healthcare investment. In 2006, all IAPO members signed a Declaration on PCH which supports the following principles: Respect, Choice and empowerment, Patient involvement in healthcare policy, Access and support, Information. (APMHO, CRN HKSR, 2012: 11-12)

15. The APMHO instigated three rounds of data collection with individual questionnaires to patients and caregivers (862 respondents), followed by telephone interviews with 20 Self help Organization’s (SHO), Executive Committee representatives and finally, two focus group meetings with 18 SHO’s representatives from the second round.

16. “The ability to measure innovation is essential to an improvement strategy in education. Knowing whether, and how much, practices are changing within classrooms and educational organizations, how teachers develop and use their pedagogical resources, and to what extent, change can be linked to improvements would provide a substantial increase in the international education knowledge base”. (OECD, 2014)
17. In 2012, Civic Exchange launched the project that would become the Asian Urban-Wellbeing Indicators. The Asian Urban-Wellbeing Indicators is a public opinion survey designed to measure public attitudes towards urban life. It measures how much people care about and are satisfied with 10 different policy domains—housing, medical care, education, work and business opportunities, transportation and utilities, environmental protection, community and belonging, public safety and crime control, recreation and personal time, and quality of government.

18. Veenhoven shows that this widely shared belief is not necessarily true as there may be no link between the size of the welfare state and the level of wellbeing within it. In countries with generous social security schemes people are not healthier or better off than in countries where the state is less generous. There also appears to be no connection between the size of state welfare and equality in wellbeing between its citizens. In countries with high levels of social security expenditure, the dispersion of health and happiness is as remarkable as in countries with less public sector spending (2000).

19. The largest sub-group, the sociocultural sub-index (10 indicators) encompasses health statistics, press freedom statistics, political statistics, and crime statistics. The economic sub-index (seven indicators) covers statistics on employment, wages, the property market, public attitudes towards economic conditions, and education (Chan et al., 2004: 266).

20. Professor at Princeton who was awarded the 2015 Nobel Memorial Prize in Economic Sciences for his analysis of consumption, poverty and welfare. In The Great Escape (2013), Angus Deaton describes how economic growth has eradicated the vicious circle of poverty and disease mainly thanks to improvements in health and living standards.

21. They are grouped into eight domains: Physical Health, Psychological Wellbeing, Society, Economics, Education, Politics, Living Environment, and Overall Wellbeing.

22. It is based on the recommendations made in 2009 by the Commission on the Measurement of Economic Performance and Social Progress – also known as the Stiglitz-Sen-Fitoussi Commission – to which the OECD contributed significantly. This framework is built around three distinct domains: material conditions, quality of life and sustainability.

**ABSTRACTS**

For over half a century of British rule (1842-1997), Hong Kong was run by a colonial and business elite who focused on economic development and political stability through a laissez-faire policy, except during the Second World War Japanese occupation and the last years of colonial rule when democracy was being gradually introduced. After the Handover which took place on the 1st of July 1997, the government of Hong Kong had to adapt to an unprecedented geopolitical context which combined an economic, legal and social structure inherited from its colonial past and a Chinese institutional framework, known as “one country, two systems” within which the liberal economy and political autonomy of Hong Kong would coexist with the interventionism of the communist regime in Beijing. This article will focus on policy inputs especially in health and education, in the context of the historical transfer of the territory of Hong Kong from a British colony to a Special Administrative Region of the Chinese People’s Republic and will integrate the analysis of these inputs into the wider framework of the assessment of wellbeing issues in Hong Kong. These are indeed two key sectors concerning the wellbeing of the population. Besides they are major sources of concern for families in Hong Kong due to pressures from demography and structural changes in the labour market, integration with the mainland (pushing for adaptation
of programs and use of standard Chinese) as well as cultural factors. The Chinese have always valued good health and perceived education as particularly important for upward social mobility and economic success. This article will first examine the areas of health and education in turn in the context of British colonial rule, and move on to explore the most recent developments in those areas since the Handover. It will then assess how specific factors (geography, history, politics) may have influenced policy and finally, it will conclude on the main challenges in terms of public policies which lay ahead to measure wellbeing in these fields.

Hong Kong a été durant les quelque cent cinquante années de souveraineté britannique (1842 à 1997) un territoire gouverné par une élite coloniale et d’hommes d’affaires menant une politique de laissez-faire axée principalement sur le développement économique et la stabilité sociale, à l’exception de la période d’occupation japonaise durant la Deuxième Guerre mondiale et des dernières années où la représentation démocratique des institutions a été introduite. Après son retour à la Chine, le 1er juillet 1997, le gouvernement local a dû s’adapter à un nouveau contexte géopolitique combinant une structure économique, juridique et sociale héritée de son passé colonial britannique et un cadre institutionnel chinois sans antécédent, celui « d’un pays, deux systèmes », dans lequel le système libéral et autonome de Hong Kong coexiste avec le système interventionniste du régime communiste de Pékin. L’objet de cet article est d’examiner les apports politiques en matière de santé et d’éducation, dans le contexte de l’évolution historique du territoire de Hong Kong passé de colonie britannique à « Région Administrative Spéciale » de la République populaire de Chine et en intégrant l’analyse de ces apports dans la problématique plus large de l’appréciation du bien-être de la population. Ce sont en effet deux secteurs clés du bien-être d’une population. En outre, ils sont au cœur des préoccupations des familles de Hong Kong du fait notamment de facteurs liés aux changements structurels de la démographie et du marché de l’emploi, du retour du territoire dans le giron chinois, ainsi que de facteurs culturels : la tradition chinoise accorde une grande valeur à la préservation de la santé et à l’éducation, pour la longévité et la réussite qu’elles procurent aux plans économique et social. Cet article examine d’abord la santé, l’éducation et le bien-être à Hong Kong dans le contexte colonial des années de souveraineté britannique, puis les évolutions marquantes sur ces questions depuis la rétrocession du territoire à la Chine. Il s’efforce ensuite de cerner les facteurs pouvant expliquer ces évolutions, ainsi que les principaux défis des politiques publiques du gouvernement local dans ces domaines.

INDEX

Mots-clés: éducation, santé, bien-être, Hong Kong, héritage britannique
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