# Welfare Attitudes and Health Care Financing Reform in a Dual-Track Medical System: The Case of the Voluntary Health Insurance Scheme in Hong Kong

by

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## Statement of Originality

I, WONG, Sin Man Mandy, hereby declare that I am the sole author of the thesis and the material presented in this thesis is my original work except those indicated in the acknowledgement. I further declare that I have followed the University's policies and regulations on Academic Honesty, Copyright and Plagiarism in writing the thesis and no material in this thesis has been submitted for a degree in this or other universities.

## Abstract

Health policy and health care reforms all over the world have attracted substantial scholarly attention. Healthcare financing reform represents a major rebalancing effort to redistribute financial responsibilities between the state and its citizens. It is therefore a politically sensitive undertaking that must be built on strong popular support if it is to succeed. Unfortunately, the widely witnessed decline of public trust in the state and the rise of populism and anti-retrenchment sentiments have narrowed the political window for structural reforms, making health care financing reforms even more difficult to implement. Political trust is essential for welfare reforms; the failure of many health care reforms worldwide was at least partially attributable to the lack of political trust, which may obstruct necessary retrenchment efforts.

How does public opinion react to a proposal for health care financing reform in a society characterized by low political trust? What are the policy implications of popular attitudes for the legitimacy of welfare reforms? The Hong Kong Special Administrative Region (SAR) offers an ideal backdrop for investigating these issues. This research seized the great opportunity when the SAR Government was about to launch a major health care financing reform, i.e. the Voluntary Health Insurance Scheme (VHIS) in 2014 that was intended to rebalance private-private mix in Hong Kong's health care financing. Adopting a mixed-method design in empirical investigation, this study collected quantitative data from a telephone survey of Hong Kong citizens in 2014 while in-depth interview was extensively employed to collect qualitative data.

Broadly, this study has yielded four significant conclusions. First, reinforcing some recent studies in the international literature, the thesis reveals the multi-dimensionality of welfare

attitudes through quantitative analysis. The latent attitudinal structure encompasses three dimensions: nominal support for the reform, willingness to purchase the regulated private health insurance, the expectation for government responsibility in health care. People's attitudinal patterns varied considerably across the three dimensions. While their nominal support and intention to purchase were both moderately low, people's expectation for government involvement in health care was polarized. Taken as a whole, there was no overwhelming evidence showing that a welfare reform emphasizing private financing responsibility is destined to be drawn in massive social opposition.

Second, the influence of the self-interest explanations dominated people's intention to purchase the proposed insurance, a practical behavioural decision, whereas ideological leaning, egalitarianism in particular, played a significant role in shaping their normative views in the other two dimensions (i.e., public support for the health care financing reform and expectation regarding government responsibility in health care). Remarkably, trust turned out to be the fundamental motive behind people's welfare opinions. More important, trust included not only the general political trust in policy-making institutions, but also how citizens perceived government responsiveness, its citizen participation, and policy competency. If citizens trust in policy-makers' capability to undertake reforms and maintain good institutional competence, they tend to be more receptive of welfare reforms that do not materially benefit themselves.

Third, a tricky but salient phenomenon warrants close attention and is very illustrative of the dynamics of health care reform in Hong Kong: individuals typically associated with higher health risks did not favour the alternative financing instrument, nor did they seem to be desperately concerned with health care, because the highly equitable government-funded health system always provides a reliable safety net for all in Hong Kong. As a result, policy-

makers are trapped in a situation in which only marginal reforms are politically possible.

Fourth, this thesis, particularly its qualitative phase, has discovered a battery of nuanced attitudinal dynamics that are peculiar to Hong Kong and hardly documented in the existing literature. For example, the traditional principles of self-reliance and self-sufficient seem to be upheld by the current generation of older adults too, in part limiting their expectation for extensive government responsibility in health care, something that I was not expected prior to the interviews. Moreover, some people did not necessarily expect the government to extensively engage in direct provision of health services but instead, preferred the government to tackle more fundamental issues such as strengthening health regulation. In addition, Hong Kong's public health care system appears to be built on the strong value of social solidarity and positive attitudinal feedback, but the ideological framework goes beyond the linear depiction of egalitarianism and should be further unpacked in future studies.

This study also draws policy implications. First, the revealed intent to purchase VHIS plans was not low given the scheme's voluntary nature. Second, most of the empirical evidence suggests the population's continued reliance on the public medical system. Hence, to what extent this moderate health care financing reform is able to achieve its stated goals is doubtful. Third, more high-powered policy instruments on the financing side and more concerted reforms on the provision side are necessary to address the long-standing health policy problems in Hong Kong. Fourth but importantly, the government must revisit its citizen engagement strategies and pay sincere efforts to rebuild political trust in the Hong Kong society, which is critically important for social welfare reforms.

*Keywords:* welfare attitudes, health policy, health care financing reform, Hong Kong, political trust

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Financing reform has been at the centre of health policy debates in Hong Kong in recent decades. Popular attitudes towards such reform are one of the issues in which I—as an ordinary citizen—am most interested. It has been a long journey with The Education University of Hong Kong (EdUHK), and I am proud to have been part of it. While studying at EdUHK for my undergraduate degree, I was inspired by professors of the Department of Asian and Policy Studies (APS) and found my interest in social policy research. The many opportunities offered by the Centre for Greater China Studies (CGCS) at EdUHK further enriched my knowledge and broadened my horizons. All these inspirations eventually encouraged me to start my research journey.

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## List of Abbreviations

| | |
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| DH | The Department of Health, HKSAR |
| FHB | The Food and Health Bureau, HKSAR |
| GDP | Gross Domestic Product |
| GHI | Group Health Insurance |
| HA | The Hospital Authority, HKSAR |
| HPS | The Health Protection Scheme |
| MRs | Minimum Requirements |
| OECD | The Organisation for Economic Co-operation and Development |
| PHI | Private Health Insurance |
| SAR | Special Administrative Region |
| VHI | Voluntary Health Insurance |
| VHIS | The Voluntary Health Insurance Scheme |

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# Chapter 1: Introduction

## 1.1. Welfare attitudes and health policy reforms

Public support is fundamental for upholding the legitimacy and stability of a welfare system and ensuring the success of social policy reforms (Jæger, 2006; Svallfors, 2013; Chung, Taylor-Gooby & Leruth, 2018). Welfare attitudes have been a key area of research interest for social policy scholars in recent decades (Kulin & Svallfors, 2013; Van Oorschot & Meuleman, 2012; Muuri, 2010). The global economic uncertainty in recent years has led to a continuous rise in public demand for government intervention in social welfare, triggering concerns about the financial sustainability of welfare systems (Missinne, Meuleman & Bracke, 2013; Jordan, 2011; World Health Organization, 2009). The structural tension between welfare austerity and the proliferation of new social risks has intensified, and will inevitably become even more so in the aftermath of the devastating Covid-19 pandemic.

Health care is a central social policy domain given its universal nature. Public demand for quality health services has been on the upward trend as a result of rising expectations, ageing population, and advancement in medical technologies (Figueras, Saltman & Sakellarides, 1998; Taylor-Gooby, 2006). Yet, a few peculiar characteristics, such as asymmetric information, moral hazards, supplier-induced demands, and adverse selection, render health care intrinsically different from other welfare domains and lead to possible market failures that necessitate government intervention (Arrow, 1968; Newhouse, 1993; Breyer, Bundorf & Pauly, 2012). Over the past decades, a series of sweeping health care reforms have been carried out worldwide, most of which were intended to curb the rapid growth of health expenditure, with some inevitably leading to retrenchment measures (Jordan, 2011; Naumann, 2014).

Health care financing reform represents a major rebalancing effort to redistribute the financial responsibilities between the state and its citizens. It is therefore a politically sensitive undertaking that must be built on strong popular support if it is to succeed. Unfortunately, the widely witnessed decline of public trust in the state and the rise of populism and anti-retrenchment sentiments have narrowed the political window for structural reforms, making health care financing reforms even more difficult to implement (Hacker, 2004; Pavolini et al., 2018). Political trust is essential for welfare reforms; the failure of many health care reforms worldwide was at least partially attributable to the lack of political trust (Hetherington, 2005; Taylor-Gooby, 2006), which may obstruct necessary retrenchment efforts. *How does public opinion react to a proposal for health care financing reform in a society characterized by low political trust? What are the policy implications of popular attitudes for the legitimacy of welfare reforms?* The Hong Kong Special Administrative Region (SAR) offers an ideal backdrop for investigating these issues.

### 1.2. Hong Kong, its health care reforms and political environment

Hong Kong, one of the former Asian Tigers, has long been characterized as a residual welfare society, one that has historically prioritized economic growth over income redistribution (Chan, 1998; Walker & Wong, 2005; Lee, 2012). This productivist, also variably coined as developmental, social policy approach is further entrenched by its long-held laissez-faire philosophy and free market doctrine (Holliday 2000). Yet, Hong Kong's social policy has been distinctive in that it encompasses both conservative welfare provision in the general and a highly equitable government-funded health care system that provides universal access to all citizens. This highly revered system, however, has been confronting critical challenges in its long-term financial sustainability in light of cost escalation and growing fiscal burden on the part of the government. To examine these inherent challenges and implications for welfare policy reforms, this doctoral thesis has been grounded on a major health care financing

reform was initiated in the past ten years.

Described as a dual-track system, health care in Hong Kong is financed and provided by both public and private sectors. The Hong Kong's public system has inherited from the British National Health Service (NHS) model and honours high equity and universal coverage (Wong, Chau & Wong, 2002; Yin & He, 2018). Lauded as one of the least expensive in the world, the health care system of Hong Kong has garnered outstanding public health achievements. Since the system offers services of decent quality at nominal charges, citizens in general give high endorsement and adhere to the universal public health care system, even though it is perceived by some as being inefficient. Yet, rising expenditure on health care, ageing population, and epidemiological transition have imposed financial strains on Hong Kong's health care system, prompting the SAR Government to contemplate reforms in order to safeguard fiscal sustainability (Ramesh, 2012). After several rounds of reform setbacks, the government eventually decided to adopt private health insurance (PHI) as a supplementary financing instrument to reduce the mounting pressure on the public medical system. However, it soon had to revise its decision and switch to a voluntary insurance program instead after citizens demonstrated strong resistance to health care schemes requiring mandatory contribution. Named as the Voluntary Health Insurance Scheme (VHIS), the initiative is intended to rebalance the public-private mix of Hong Kong's health care system by encouraging the middle- and upper-class population to subscribe to private insurance on a voluntary basis (He, 2017).

Since the reform inevitably entails an increase in private expenditure, in both relative and real terms, an adequate level of popular support is of critical importance for its success. The reform in itself, manifests discernible characteristics of welfare retrenchment. Unfortunately, the political environment in Hong Kong has been particularly turbulent in the past twenty

years. Since the handover of Hong Kong's sovereignty to China in 1997, expectations for greater democratic space have soared among in the Hong Kong society (Cheung, 2009, 2012). However, the absence of universal suffrage has significantly undermined the political legitimacy of the SAR Government, and several attempts of political reform have all failed (Lam, 2013; Cheung, 2007). The large-scale protest movement in September 2014, commonly referred to as Occupy Central, and the recent massive social unrest in 2019 have heightened the tension between the SAR Government and many citizens, leading to a severe legitimacy crisis for the political system (Lam, 2015; Ortmann, 2015; Ni et al., 2020).

Against this grave backdrop, the introduction of major public policy reforms has become increasingly difficult given the mounting public distrust in the government (Cheung, 2013). In liberal democratic societies, political mandate allows the state to introduce unpopular social policies, if necessary. Although the citizenry may stage defiance or "punish" the government for advancing welfare retrenchment through the election, high political trust may serve to mitigate the tension and pave the way for imperative reforms (Trüdinger & Bollow, 2013; Stensöta & Bendz, 2020). In authoritarian (or semi-authoritarian) states, although organized defiance is less likely due to rigid social control, governments are not necessarily indifferent to public opinion. The relatively high levels of political trust enjoyed by the state, as demonstrated by the cases of China and Singapore, also offer an alternative source of legitimacy for reforms that may undermine material interests of the populace (George, 2007; Wong, Wan & Hsiao, 2011). In either scenario, political mandate or paternalistic coercion is largely sufficient to justify and enact difficult reforms. However, since Hong Kong belongs to neither category, it offers an intriguing case for examining welfare retrenchment reforms in a liberal society where the government suffers from remarkably deep political distrust. How do citizens respond to a health care financing reform that increases individual financing responsibilities? Do they accept the political narratives put forward by the government to

justify the reform? This empirical study as supported by an extensive literature review into welfare attitudes is intended to shed light on these questions.

### 1.3. Theoretical background and contribution

This doctoral thesis conducts literature reviews into two prominent bodies of research on welfare attitudes and health care financing reforms and seeks to establish a unique theoretical contribution by launching an empirical study on Hong Kong. The study of welfare attitudes has occupied centre stage in the social policy scholarship. Many previous studies tended to measure public opinion towards social policy based on a composite index and have largely neglected the inherent multi-dimensionality of welfare attitudes (Van Oorschot & Meuleman, 2012; Svallfors, 2011; Muuri, 2010; Andreß & Heien, 2001; Gelissen, 2000). People may endorse the principle of government responsibility in welfare but expect less government-provided services due to their perceived poor quality. By the same token, they may demonstrate strong redistributive preference but are reluctant to shoulder more tax burden. Therefore, the formation of welfare attitudes, which is an essential popular basis of social policy reforms, is highly contingent and multi-dimensional. If people's attitudes indeed vary across dimensions, that "discrepancy" may exactly offer the key to unveiling the complex mechanisms through which attitudes are formed with a specific socio-political context.

Health care, a unique domain of social policy, is associated with several salient characteristics that distinguish it from other welfare domains (Del Pino & Ramos, 2018; Wendt et al., 2010; Jordan, 2010). It can thus be reasonably hypothesized that there are noticeable differences in people's welfare attitudes towards health care financing reform. Since the sustainability of any welfare system ultimately depends on citizens' willingness to pay tax and social security contributions, it is crucial to understand their attitudes towards the welfare policy-making.

Two prominent theoretical frameworks are commonly used to explain the formation of welfare attitudes: self-interest and ideology. The self-interest thesis argues that individuals' attitudes towards social policy are primarily determined by self-interest considerations. Those who are welfare recipients or at risk of becoming recipients tend to show greater support for welfare policies and oppose retrenchment due to their greater dependency (Owens & Pedulla, 2014; Jæger, 2006; Andreß & Heien, 2001; Gevers et al., 2000). However, this argument is contested by the ideology thesis, which maintains that an individual's attitude towards welfare is not solely driven by material interests but is rather profoundly embedded in his or her value framework and ideological beliefs as well (Azar et al., 2018; Pacheco & Maltby, 2017; Guo & Gilbert, 2014; Missinne et al., 2013; Lynch & Gollust, 2010).

Empirical evidence pertaining to the welfare attitudes scholarship predominantly originates from Western welfare states, whereas scholarly understanding of the patterns and determinants of welfare attitudes in East Asia remains rather limited (Yang, Peng & Chen, 2019; Kim et al., 2018). It is widely believed that the paradigmatic differences between mature welfare states and their East Asian counterparts in terms of welfare tradition and institutional set-up may lead to considerably different attitudinal patterns (Li & He, 2019; Yeh & Ku, 2020). Hong Kong's distinctive welfare system, a mix of exceptional equity standards in the public medical system and a long-standing residual capitalist tradition in the broad welfare realm, renders a study of welfare attitudes in Hong Kong highly intriguing.

This doctoral thesis not only examines Hong Kong citizens' static view on the health care system but also investigates their level of support for a concrete health care financing reform proposal put forward by the government. The occasion where the SAR Government was about to roll out a major health care financing reform amidst an unfavourable political climate presented a valuable research opportunity and enabled this study to gauge citizens'

viewpoints with regard to the reform. More importantly, political trust is included in the conceptual framework and empirical analysis as a key mechanism on top of self-interest and ideology to explain people's support for the reform which carries retrenchment implications. This study's results reinforce the compelling argument that general trust in policy-making institutions and competence-based political trust is fundamental for social policy reforms because popular support for reforms is more likely to be garnered when the state is believed to be trustworthy than when citizens' experiences with the state are largely negative (Rothstein & Steinmo, 2002; Rose, 1994; Gilson, 2003). It is crucial to note that political trust is of great importance for maintaining social policy legitimacy in not only liberal democracies, but also in nondemocratic societies because it vigorously underpins citizens' willingness to pay for the reform costs. In the meantime, this thesis also illustrates that citizen participation and government responsiveness powerfully alter trust that in turn shape citizens' popular support to welfare reforms.

In addition to the literature on welfare attitudes, this thesis also alludes to health policy literature, particularly the literature stream concerning financing reforms. The global escalation of health care costs has not only strained the financing systems of many countries but has also prompted governments to conceive effective ways to "bend the sharp curve" while not frustrating people's rising expectations. While social health insurance and taxation remain as the most dominant financing mechanisms in most high-income societies, there has been a revival of interest in private health insurance among policy-makers and scholars (Liaropoulos & Goranitis, 2015; Mossialos & Thomson, 2002; Hurley, Vaithianathana & Crossley, 2001). It is increasingly believed that despite its conceived supplementary nature, private insurance can play a much more active role in health care financing (Laugesen, 2005; Colombo & Tapay, 2004; Mossialos & Thomson, 2002). In Hong Kong, the VHIS, a flagship program promoted by the SAR Government, has been introduced to achieve a range of health

policies. This thesis attempts to discuss the potential benefits and drawbacks of private health insurance in financing reforms in Hong Kong, a society with a dual-track health system. Consequently, the practical insight drawn by the thesis is intended to evoke policy implications for health care reforms not only in Hong Kong but also in other jurisdictions that are contemplating the option of expanding the coverage of private health insurance.

### 1.4. Research questions

In light of the theoretical and contextual background outlined above, this doctoral thesis seeks to answer the following central research question: What shapes the public attitudes towards the health care financing reform, that is, the Voluntary Health Insurance Scheme (VHIS), initiated by the Hong Kong SAR Government? The investigation is specifically guided by three sets of sub-questions:

1. Are Hong Kong citizens' attitudes towards the health care financing reform multi-dimensional? What is the underlying structure of such attitudes? What are the implications of this attitudinal multi-dimensionality?
2. How do citizens—in a liberal society of low political trust—respond to a health care reform introducing moderate retrenchment?
3. What are the practical policy implications that this opinion study can offer to health care financing reforms in Hong Kong and beyond?

### 1.5. Methodological plan

This thesis adopted a mixed-methods strategy in empirical investigation. Specifically, sequential explanatory design consisting of two interconnected phases, was adopted (Creswell & Clark, 2011). The first phase involved the collection of quantitative data through a telephone survey conducted in September 2014 and subsequent analysis of the data to

provide statistical evidence to answer the research questions. In the second phase, qualitative data were collected and analysed to further interpret and explore the quantitative results derived in the first phase. Purposeful and convenience sampling methods were employed in selecting informants. An interview guide was designed with reference to the quantitative findings in order to reinforce the arguments generated in the first phase.

The strength of this design lies in its ability to interpret the "plain" statistical results in a real-life context, yield richer insights, and resolve possible ambiguities that can hardly be addressed by quantitative analysis alone. The overall interpretation was achieved by synthesizing the results of both phases. Hence, the combination of large-N quantitative analysis and an in-depth qualitative analysis strengthens the analytical power put forward by this thesis (Jogulu & Pansiri, 2011) and validate, thus increasing both internal and external reliability. Details of the methodological roadmap are presented in Chapter 4.

### 1.6. Structure of the thesis

This thesis comprises seven chapters. The current chapter introduces the research motivation, theoretical background, research questions, and methodological road map. Chapter 2 systematically reviews the literature related to welfare attitudes and health care financing reforms and identifies the research gaps. Chapter 3 describes the social policy system of Hong Kong and its welfare tradition. It particularly contextualizes the financing reform within the broad development of Hong Kong's health system and the health policy challenges faced by Hong Kong, setting the scene for the empirical investigation. The research design and methodology of the thesis are explained in Chapter 4, and the quantitative and qualitative research results are presented in Chapter 5 and Chapter 6, respectively. Chapter 7 concludes the thesis by summarizing the key arguments, and discussing the policy implications and limitations of this study.

# Chapter 2: Literature Review

This chapter reviews two major bodies of research literature, one on public attitudes towards social policy and the other on health care financing and its reform. Section 2.1. clarifies key terminologies. Section 2.2. discusses the concept of multi-dimensional welfare attitudes and its significance. Section 2.3. and Section 2.4. review the theoretical arguments on general welfare attitudes and their predictors, and public perceptions of health policy and the determinants, respectively. The challenges of health care financing and the niche of private health insurance in health care financing reforms are discussed in Section 2.5. Welfare retrenchment reforms are characterized in Section 2.6. that situates the health care financing reform in Hong Kong in the broad social policy debates. Based on an overview of the related scholarly sources, Section 2.7. concludes this chapter and identifies the research gaps that the thesis intends to fulfil, and formulates the research hypotheses.

## 2.1. Terminological clarifications

Before proceeding to the literature review, it is necessary to clarify some of the key terminologies due to the existence of several conflated terms that are occasionally used in an interchangeable manner, in particular, those related to welfare, social welfare, and social policy. First, a *welfare system* refers to a series of policies and arrangements that are organized by the state to provide social safety nets for citizens through redistributing income and providing public goods and services (Jæger, 2006; Daly & Giertz, 1972). A welfare system often operates in the form of national social insurance, mitigating the diversified social risks faced by citizens and protecting their rights to obtain social benefits against potential risks arising from sickness, unemployment, old-age, disability, and so forth (Palier, 1997).

*Social policy* is generally defined as the deliberate use of power by the state through political and administrative means to intervene market processes and adjust outcomes of market forces in an attempt to: 1) ensure a minimum income for citizens, 2) provide social safety nets against risks and adversity throughout life, and 3) provide basic social security for all citizens regardless of socio-economic status (Briggs, 1961). Concisely put, social policy is "an institutionalized response to social and economic problems, ranging from economic insecurity to inequality and poverty" (Béland, 2010, p. 9). Social policies define a range of social rights and address citizens' needs for protection against market uncertainties (Svallfors, 2012). Typical social policy domains include health care, old-age pensions, education, public housing, and social assistance for older adults and the unemployed. From the public administration point of view, social policy is often presented in the form of welfare programs to deliver services and provide benefits to citizens (Abramovitz, 2004). In this case, *welfare policies* and *social policies* are often used largely interchangeably.

Terms such as *public opinion*, *attitude*, and *values* are also widely used in the welfare attitude literature. *Public opinion* refers to a non-singular piece of opinion among the mass that is accumulated at the aggregate level, reflecting interests of social groups rather than a single individual (Steele & Breznau, 2019). Public opinion exerts profound influence on politics, policy-making, and social movements through various mechanisms such as norm-shaping, emotional mobilization, and so on. In the social policy literature, public opinion has been conceptualized as attitudes, preferences, perceptions or values (Zimmermann, Heuer & Mau, 2018). *Attitude* represents a series of normative opinions about a particular object, indicating their perceptions or preferences (Sundberg, 2014). It loads an individual's evaluation of a particular object that can be captured by categorical dimensions such as good or bad, agree or disagree, like or dislike (Ajzen, 2001; Kumlin, 2007, 2011; Goerres & Prinzen, 2012).

In their very nature, *preference* and *perceptions* are expected to convey *attitudes.* Welfare attitudes can be demonstrated in the form of support for government-funded welfare (Azar et al., 2018; Missinne et al., 2013), welfare reforms (Shue et al., 2014; Knoll & Shewmaker, 2015; Taylor-Gooby, 2006) or certain welfare principles (Kim et al., 2018; Wu & Chou, 2017; Lee & Park, 2015). To distinguish attitudes from values, a conceptual distinction can be made from a cognitive-affective perspective. *Values* are cognitive orientations that guide an individual towards an evaluation of a certain object (Williams, 1979), whereas attitudes pertain to one's affective preferences towards an object (Oskamp & Schultz, 2005). In simple words, values should be regarded as criteria for an individual's choice-making, preference, and judgement (Kumlin, 2007; Schwartz, 1992; Rokeach, 1973). Throughout this thesis, values are assumed to constitute a relatively stable normative cognitive template that is exogenous to the formation of welfare attitudes.

## 2.2. Welfare attitudes: concepts and significance

### 2.2.1. Welfare attitudes and policy legitimacy

Legitimacy refers to the capacity of the state to obtain public support for its governance (Beetham, 1991). Because the operation and sustainability of modern welfare systems ultimately depend on citizens' willingness to pay tax and social security contributions, it is critical to understand their attitudes towards social policy. Public endorsement of income redistribution and popular satisfaction with actual welfare arrangements fundamentally underpin the legitimacy of welfare systems (Rothstein, 2001; Muuri, 2010; Kohl & Wendt, 2004; He, Ratigan & Qian 2020).

In liberal democratic societies, citizens' attitudes towards the state's welfare responsibility exert considerable influence on social policy-making. Page and Shapiro (1983) noted a substantial association between citizens' welfare attitudes and changes in social policies since

the early 20th century. Because the changes in people's attitudinal patterns often accelerate social policy reforms through the electoral pressure, policy-makers need to include welfare attitudes as one of the key functional parameters in the decision-making process (Svallfors, 2012; Konisky, 2007; Pacheco & Maltby, 2017; Graham, 2002). Practically, securing public support is essential for pre-empting a legitimacy crisis in regard to welfare reforms, especially in light of the general decline of trust in the state. Social policy, by its very nature, conducts income redistribution that inevitably creates "winners" and "losers"; it is therefore vital to gain endorsement from different population groups by appreciating the rationale behind their various views.

Even in authoritarian states, it would be erroneous to assume that public opinions are inconsequential in actual policy-making. Rather, as Thornton (2011) has rightly pointed out in the case of China, the absence of a multi-party electoral system leads Chinese political leaders to extensively and earnestly seek attitudinal feedback across the population to understand trends in popular attitudes and make necessary policy adjustments. Therefore, studies on popular welfare attitudes matter even in authoritarian states (He, Qian & Ratigan, 2020). More importantly, the growing literature on policy feedback has revealed that existing social policies can be strengthened or undermined by themselves through a battery of attitudinal feedback mechanisms in both liberal democracies and authoritarian systems (He, Ratigan & Qian, 2020; Campbell, 2020; Jordan, 2013).

Empirical evidence suggests that most societies—in both the East and the West—have witnessed an increasing level of popular support for the social policy (Hasenfeld & Rafferty, 1989; Brooks & Manza, 2007; Park, 2010; Van Oorschot & Meuleman, 2012; Lee & Park, 2015; Li & He, 2019). People in most societies demonstrate a high expectation for stronger collective responsibility on the part of the state in providing and financing social welfare

(Svallfors, 1997; Muuri, 2010; Rantanen, McLaughlin & Toikko, 2015; Wu & Chou 2017; He, Qian & Ratigan, 2020).

2.2.2. The multi-dimensionality of welfare attitudes

The welfare state itself is a complex institution that consolidates social solidarity through a range of welfare policy domains to cater for the different welfare needs of citizens (Gelissen, 2000; Cheng & Ngok, 2020). There is a profound isomorphism between welfare system and popular attitudes towards it, as welfare attitudes are also intrinsically multi-dimensional, varying in degree and across domains (Gelissen, 2000; Kumlin, 2007; Muuri, 2010). Most early studies focused on people's expectations regarding state responsibility in social service provision (Gelissen, 2000; Blekesaune & Quadagno, 2003; Svallfors, 2003). It is argued that this normative support for government intervention in welfare constitutes the most fundamental component of citizens' welfare attitudes, establishing the legitimacy of the welfare system (Pereira & Van Ryzin, 1998; Van Oorschot & Meuleman, 2012).

Yet, this conception has been recognized as too simplistic because the general support for state intervention is insufficient to capture the complexity and multi-dimensionality of public opinions (Van Oorschot & Meuleman, 2012; Svallfors, 2011; Roosma, Van Oorschot & Gelissen, 2014). Welfare systems are associated with remarkable internal complexity and variations that not only vary across regimes but also across welfare programs in different policy domains. Therefore, individuals are very likely to hold varying views with regard to different welfare policies depending on their materials needs and ideological disposition. For example, a person may favour greater state involvement in health care but disapprove of such involvement in education. Many empirical studies have found that welfare programs with a universal nature or those that benefit wider portion of the society, such as health care and old-age pension, tend to enjoy greater public endorsement (Edlund 2006; Muuri, 2010; Rantanen

et al., 2015), while a lower level of support is typically found on welfare programs that target specific groups of the population, such as social assistance for the unemployed (Edlund, 2009; Park, 2010; Petersen et al., 2011; Van Oorschot & Meuleman, 2012). In brief, it would be erroneous to assume that people's expectation regarding government responsibility is necessarily identical across various social policy arenas (Gelissen, 2000; Jordan, 2010). As a matter of fact, these inconsistencies and discrepancies are often reflective of the highly contingent dynamics and contextual mechanisms of how welfare attitudes are formed in a particular society.

Roller (1995) offered a popular theorization of multi-dimensional welfare attitudes. In her widely referenced bi-dimensional conception, commonly known as "the role of government," she distinguished two aspects of individuals' expectations regarding government responsibility in welfare provision, namely, the *range* and the *degree* of intervention. Range refers to the policy arenas in which government should intervene, while degree refers to the intensity of government intervention in specific social policy areas. The latter is usually represented by the public perception of the level of public spending on specific welfare policy areas or programs.

Roller's bi-dimensional model has been applied in several studies (Baute, Meuleman & Abts, 2019; Roosma, Gelissen & Van Oorschot, 2013; Park, 2010). Following this line of reasoning, welfare attitudes have been analysed from various angles, such as expected level of social spending, preferred level of welfare benefits, and public satisfaction with the actual services rendered (Hills, 2002; Van Oorschot, 1998; Wendt et al., 2010; Footman et al., 2013; Li & He, 2019). Due to reduced fiscal space and rising expenditure, social policy reforms in many societies often encounters pressure to increase private payments; this is particularly the case in the health policy arena. Since financing reforms often entail greater responsibility on

the part of citizens to contribute to the welfare system, popular support would, to a large degree, predict the reform outcomes (Feldman & Steenbergen, 2001).

Another prominent conception of welfare attitudes pertains to the variety of roles that individuals play in the welfare system as welfare recipients versus taxpayers (Kangas, 1997; Andreß & Heien, 2001), ordinary citizens versus financial contributors (Li & He, 2019; He, Ratigan & Qian 2020), and so on. It is argued that individuals' attitudes towards social policy may diverge according to the various roles they play (Gelissen, 2000). For example, an individual may prefer extensive government provision of welfare services as a beneficiary but may be less willing to see its expansion because of his or her role as a taxpayer. An individual's poor experience with welfare services as an end user may also undermine his or her support for government intervention as a citizen (Muuri, 2010). Similarly, normative values may prompt a person to support a social policy reform proposal as a citizen, but his or her role as a social security contributor may create a sense of hesitation due to possible financial burdens incurred. This doctoral thesis is built on a multi-dimensional conception of welfare attitudes in the context of health care financing reform in Hong Kong and this will be illustrated by the conceptual framework this research study shall establish in later sessions.

## 2.3. Theoretical frameworks explaining welfare attitudes

### 2.3.1. The self-interest thesis

The theory of self-interest is the first prominent theoretical framework used to explain welfare attitudes, indicating how individuals' material interests determine their welfare preferences. Intertwined with the paradigm of rational choice, the self-interest thesis assume that individuals are guided by economic individualism and instrumental rationality, and hence, their decision-making is driven by the pursuit of utility maximization (Sears & Funk, 1991; Missinne et al., 2013; Brooks & Manza, 2007). In stating that people will make choices

in their own self-interest, the theory argues that individuals first calculate the gains they expect to receive from a welfare policy and tend to support it only if the net benefit is deemed to be positive. As a result, the poor tend to favour welfare policy since they are more likely to benefit from redistributive programs than the rich. This thesis argues that public perception of social welfare is rooted in the so-called *pocketbook* perspective on redistribution: people who are the recipients of welfare or at risk of become recipients are more likely to hold positive views of the welfare system (Jæger, 2006; Owens & Pedulla, 2014, Geliseen, 2000; Mau, 2004). This pocketbook perspective has been endorsed by many empirical studies (Hasenfeld & Rafferty, 1989; Andreß & Heien, 2001; Blekesaune, 2007; Li & He, 2019).

An individual's self-interest in the welfare system is primarily represented by his or her social position in society (Svallfors, 2011; Yang & Barrett, 2006). A welfare system provides social services and mitigates income inequality, but also serves as an agent of social stratification (Esping-Andersen, 1990). As a result, variations in welfare perceptions are understood as the outcomes of negotiation or conflict between social groups of different class interests (Naumann, 2018). One's socio-economic position is found to be the key factor that determines people's attitudes towards social policy (Kangas, 1997; Svallfors, 1997; Chong, Citrin & Conley, 2001; Hall & Soskice, 2001; Li & He, 2019). People of lower socio-economic status tend to demand more government intervention because of their lower material status and reduced competitiveness in the labor market. In contrast, those from higher socio-economic status tend to have less interest in generous welfare provision due to their lower dependency on the welfare system (Korpi & Palme, 2003; Svallfors, 2006; Kumlin & Svallfors, 2007; Van Oorschot & Meuleman, 2012).

As an indicator of one's material circumstances and social position, income is found to be a strong determinant of welfare attitudes. The key argument is that most welfare states rely on

progressive tax to finance the entire welfare system, and therefore, a higher level of state intervention imposes a heavier tax burden on the high-income segments of society (Baslevent & Kirmanoglu, 2011). As they are more likely to rely on welfare benefits than their wealthy peers, low-income individuals are typically associated with more favourable attitudes towards redistribution (Murri, 2010; Wendt et al., 2010; Azar et al., 2018; Feldman & Steenbergen, 2001). High-income groups tend to offer less support for redistributive policies and state involvement in welfare provision, presumably due to the possibility of higher tax burdens (Hasenfeld & Rafferty, 1989; Jæger, 2009; Van Oorschot & Meuleman, 2012; Missinne et al., 2013).

Another significant socio-demographic factor in measuring one's social position is educational attainment, but the effect appears mixed. One argument is that higher education is often associated with greater income and higher positions in the social structure, and therefore, the lower support for redistributive policies from better-educated people is predominantly due to their lower reliance on social welfare (Yang & Barrett, 2006; Bailey et al., 2013). However, a counterargument maintains that education is a socialization process that is able to provoke and enrich an individual's recognition of essential social values such as solidarity and equality (Hasenfeld & Rafferty, 1989; Gelissen, 2000; Linos & West, 2003). Education also provides knowledge about the practical functions of social policy in pre-empting social instability to which middle- and higher-class individuals typically attach great importance, and hence, better educated people may actually be more supportive of social policies. The empirical evidence collected thus far varies, with the causal arrow pointing to both directions. Social context and the operationalization of education in the actual survey may explain the discrepancies.

Self-interest explanations also manifest in the theory of risk aversion, which suggests that

individuals support welfare policies because of foreseeable need for protection against unexpected risks, such as negative income shocks, illness, and unemployment (Alt & Iversen, 2017; Iversen & Goplerud, 2018). A higher level of welfare support should be found among people who are exposed to greater risks such as the elderly and the sick. This theory implies that individuals consider their self-interests from future perspective instead of merely looking at current circumstances (Barber, Beramendi & Wibbels, 2013; Moene & Wallerstein, 2001). Specifically, older adults usually hold stronger positive perceptions of government responsibility for welfare, given their greater health risk and welfare dependency (Svallfors, 2006; Staerklé, Likki & Scheidegger, 2012; Wendt et al., 2010; Yang & Barrett, 2006). Interestingly, self-interest considerations also shape seniors' differential attitudes across other welfare domains. For example, older adults tend to favour fiscal spending on universal welfare programs that benefit them most, such as old-age pension and health care, rather than those benefiting other groups of the population, such as education and public housing (Christian, 2008; Ponza et al., 1988). Employment status is also underlined in many research studies as a crucial factor in shaping people's perceptions of social welfare. Bearing greater vulnerability and social risks, the unemployed are typically found to be more supportive of redistribution and social welfare, particularly social security programs (Linos & West, 2003; Andreß & Heien, 2001; Pfeifer, 2009; Muuri, 2010).

Other demographic factors—gender and marital status in particular—are also found to exert considerable influence on people's welfare attitudes. Typically, women tend to be more supportive of redistribution than men (Edlund, 1999; Andreß & Heien, 2001; Linos & West, 2003; Jæger, 2009), since they are more likely to be associated with a lower participation rate in the labour market that makes them more reliant on government-funded welfare (Svallfors, 1997; Blekesaune & Quadagno, 2003; Yang & Barrett, 2006). Another explanation pertaining to psychological disposition proposes that women are more likely than men to adhere to the

principles of needs and social equality, which create favourable attitudes towards welfare policies (Arts & Gelissen, 2001). The effect of marital status is mixed. One may argue that married individuals should favour less redistribution since family may function as a safety net to reduce social risks (Yang & Barrett, 2006; Linos & West, 2003). Yet, it may also be argued that when marriage leads to larger family size, especially more children, the need for social security rises substantially and this can be translated into favourable attitudes (Jæger, 2006).

### 2.3.2. The ideology thesis

The second theoretical framework of relevance underscores the importance of the ideological dispositions in shaping welfare attitudes. Ideology defines sets of enduring beliefs that are socially preferred (Schwartz, 1994). In contrast to self-interest-based models, the ideology thesis maintains that an individual's attitudes towards social welfare are not simply determined by his or her material circumstances but are rather ingrained in one's value frameworks and normative beliefs (Brooks & Manza, 2007; Quadagno & Pederson, 2012; Chung & Meuleman, 2017). Moreover, while an individual's economic conditions may be subject to drastic changes as a result of unemployment and sickness, ideology is usually more stable and thus provides a stronger prediction of one's attitudinal orientation. Specifically, two constellations of factors are pertinent: social ideology and political ideology.

Social ideology refers to the fixed sets of beliefs and goals that guide one's life or behaviour within and in relation to a societal system and offer a broad explanation of how a society should work (Schwartz, 1992). People's welfare perceptions are found to be rooted in more generalized value systems; such systems cover a series of contradictory social cognitive views about the appropriate relationship between individuals, state, and welfare providers (Blekesaune & Quadagno, 2003; Feldman & Zaller, 1992). Social rights and economic individualism are regarded as two central principles of social ideologies. Citizens who

emphasize basic social rights usually expect the state to provide acceptable levels of welfare benefits and social security whereas economic individualism suggests that people should be financially self-sufficient through their own hard work, instead of depending on welfare benefits.

Against the aforementioned debate, Schwartz (1992) conceptualizes social ideology into two dimensions: the values of self-transcendence and self-enhancement. The value of self-transcendence emphasizes the capacity of promoting equality, social justice, and fairness in the society under the notion of caring for others, highlighting the basic social rights of every citizen. On the contrary, self-enhancement emphasizes the value of personal efforts and success based upon the principle of economic individualism. Both types of values exert influence on the formation of people's attitudes towards redistribution (Kulin & Meuleman, 2015; Kulin & Svallfors, 2013).

Individuals holding stronger self-transcendent values would wish to see the attainment of the ultimate goals of welfare states, such as social equality and justice, and are thus expected to show greater support for redistribution. In comparison, individuals who believe in the values of self-enhancement tend to offer less support to social policies that may undermine personal efforts and success. In other words, stronger ideological commitment towards the common good is positively linked to preferences for redistribution and government responsibility in welfare (Hasenfeld & Rafferty, 1989; McClosky & Zaller, 1984; Staerklé et al., 2012). The principle of equality emphasizes social equality and avoids large economic differences between individuals. There have been abundant empirical studies on the positive impact of social ideological commitments on preference for stronger government responsibility in social policy (Gilessen 2000; Muuri, 2010; Kulin & Svallfors, 2013; Arikan & Bloom, 2015; He, 2018).

Another social ideological predictor of welfare attitudes is an individual's perception of the causes of poverty. It is argued that people who attribute the cause of poverty to social injustice as opposed to individual failures are more likely to have sympathy for the underprivileged and therefore show support for redistribution (Fong, 2001; Ng, 2015; Wu & Chou, 2015; Li & He, 2019).

Political ideologies also frame people's perceptions of redistribution and guide them to decide to what extent they support or oppose welfare policies (Yang & Barrett, 2006; Muuri, 2010; Blekesaune & Quadagno, 2003). Empirical studies reveal that individuals who position themselves as leftist or closer to the left-wing ideological orientation are more likely to favour greater government responsibility for providing social welfare and developing an extensive welfare system (Hasenfeld & Rafferty, 1989; Andreß & Heien, 2001; Jæger, 2006; Naumann, 2014).

### 2.3.3. The trust thesis

The third theoretical framework of relevance points to the critical importance of political trust in the formation of welfare attitudes. Trust broadly refers to social ties based on trustworthiness (Gilson, 2003; Fukuyama, 1995). As a particular form of trust, political trust[1] represents citizens' level of confidence in the political institutions (Levi & Stoker, 2000; Gilson, 2003; Su et al., 2016). Trust not only entails one's positive expectations of political institutions, but also his or her willingness to act on these beliefs (Luhmann, 1979).

Political trust is also found to shape public preferences with regard to the role of the state in

[1] Throughout the thesis, the terms "political trust", "trust in political institutions" and "trust in policy-making institutions" are used interchangeably.

social policy. Citizens' acceptance of social policies depends on their trust in the policy-making institutions before making judgments about the acceptability of new policies or reforms (Bronfman, Vázquez & Dorantes, 2009; He & Ma 2020). Hetherington and Globetti (2002) contend that even if people do not understand the complexity of government policies and strategies, they do have a general impression of government responsibilities, and this impression serves as a guiding rule to judge the desirability of these policies.

Hetherington (2005) has developed a "trust theory" to explain under what conditions political trust may affect one's expectations of state involvement in welfare. First, trust in political institutions provides a heuristic framework for citizens to decide whether to support or oppose higher government responsibility for welfare. Second, trustworthiness is the fundamental factor for gaining citizens' support for service expansion in the welfare system. The underlying assumption is that citizens believe the government is able to deliver welfare services properly. Third, the implications of the trust heuristic on welfare preferences vary across different types of welfare policy. Hetherington highlights that political trust is more prominent in stimulating perceptions of redistributive government spending rather than distributive government spending, since redistributive government spending is generally activated by trade-offs associated with different welfare policies (Hetherington, 2005).

Steinmo (1994) suggests that citizens who have more trust in political institutions are more likely to expect greater state intervention in the welfare system. However, several comparative studies have reported inconsistent results, indicating that distrust in political institutions may actually lead to stronger preferences for state involvement in welfare provision and public welfare spending (Edlund, 1999; Svallfors, 2002). People who do not trust the state may still prefer its involvement in social welfare because they may perceive welfare provision as a moral responsibility of the state (Craig, Niemi & Silver, 1990; Niemi,

Craig & Mattei, 1991; Edlund, 1999). As such, while political trust is a powerful factor in framing people's attitudes towards government's role in social welfare, the exact direction and mechanism are highly contingent and must be investigated with reference to the actual socio-political context as well as the dynamics of their respective state-society relations.

## 2.4. Welfare attitudes towards health care system

### 2.4.1. Centrality of health care in social policy

Health care constitutes a key pillar of the welfare system. Health policy not only has a direct impact on people's quality of life but is also vital for social investment as a healthy population provides essential human capital for economic growth. The universal nature of health care has caused citizens in many societies view it as a basic welfare necessity (Rothstein, 2002; Lim, 2012; Ward & Johnson, 2013). Despite a general decline of public satisfaction with health care services in most societies, Jordan (2011) has noted that health policy remains to be characterized by broad popular support.

Across all social policy domains, health policy has long been found to receive the most popular support, and therefore, retrenchment in health care usually triggers considerable social resistance, which is risky in electoral terms (Pettersen, 1995; Giger, 2011). The centrality of health care in social policy has also made it a politically contested avenue prone to ideological debates, as evidenced by the well-known controversies related to Barack Obama's ambitious health care reform program in the United States (Shue et al., 2014; Bulanda, 2016; Pacheco & Maltby, 2017). The debates between the proponents of market-oriented reform and their state-dominant counterparts in China's health care reform are also a vindication of competing ideologies in this policy domain (Yu, 2006; Wagstaff, 2007; Wang et al., 2014).

In most societies, the public shows strong support for government intervention in the health care arena. Even in the United States, where right-wing liberal market capitalism has long dominated national health policy ideologies, there has been a discernible shift towards pro-intervention ideologies for the federal government to overcome the vast equity deficit in the country's health care system (Shue et al., 2014; Azar et al., 2018). The general pattern observed in the West and the East is the tension between rising support for increasing public health care expenditure and citizens' remarkable reluctance to shoulder more tax and premium contributions (Nam & Woo, 2015; Ng, 2015; Svallfors, 2011; Mossialos, 1997). In the health policy literature, three prominent frameworks have been used to explain popular support for health policy; these frameworks are discussed below.

### 2.4.2. Self-interest explanations

Individuals' attitudes towards health policy are shaped by their material circumstances (Gelissen, 2002; Pfeifer, 2009, He, 2018). Income, age, gender, education, and self-reported health status are found to be important factors associated with a person's attitudes towards health policy. Consistent with the findings on general welfare attitudes, the concept of social position is extensively employed in empirical studies on health policy support.

Many prior studies reported negative effects of income on public support for a government-funded health system and state responsibility (Missinne et al., 2013; Wendt et al., 2010; Gelman, Lee & Ghitza, 2010). Yet, the explanatory power of income is far more ambiguous in health care. Diseases represent one of most catastrophic risks for individuals, irrespective of income. The inclination to be risk averse tends to be higher for the rich than for the poor. Thus, having a higher income and a higher socio-economic position may reasonably lead to a positive expectation for state-organised health care. A recent study set in 29 countries, including China and Japan, noted that higher income status evidently contributes to

motivation for paying more taxes to finance health care (Azar et al., 2018). A similar result has been reported in South Korea (Lee & Park, 2015), Taiwan (Kim et al., 2018) and Hong Kong (Wong, Wong & Mok, 2006).

Health status powerfully explains individuals' attitudes toward health policy. People in poor health are found to show stronger support for state provision of health services that protect them against unintended health risks (Gevers et al., 2000; Naumann, 2014; Lee & Park, 2015; He, 2018). Age exerts an ambivalent impact, however. It has been widely examined that older adults generally prefer more state responsibility in health care (Wendt et al., 2010; Missinne et al., 2013; Nagayoshi & Sato, 2014) but tend to hold contradictory attitudes towards health care reform at the same time (Nixon & Aruguete, 2010; Gelman et al., 2010). The underlying logic of this attitudinal conflict is that older adults generally enjoy access to universal government-funded health programs, but they are worried about potential cutbacks of current benefits likely to be brought about by potential reforms (Gelman et al., 2010; Wong, Wan & Law, 2010; Ku et al., 2011). A similar conservative stance of the elderly towards health care reforms is also reported by Kessler and Brady (2009) and Bendz (2017). Clearly, the elderly population is more sensitive to health care reforms that may possibly alter the status quo and introduce unexpected threat to their interests.

The explanatory patterns of education in health policy attitudes are very similar to those in general welfare attitudes. Individuals with higher educational attainment are likely to oppose government-funded health care arrangements and public health spending (Park, 2010; Iida & Matsubayashi, 2010; Naumann, 2014). Interestingly, Missinne et al. (2013) defy this line of argument with the finding that lower-educated groups in their sample actually demanded less in terms of public health care arrangements, largely owing to their dissatisfaction with the actual services provided. Individuals with a lower educational level are expected to have

lower expectations on health care as consideration for their experiences is usually limited. Lee and Park (2015) suggest that better educated South Koreans largely appear to have a positive attitude towards state responsibility for egalitarian health arrangements; this can be explained by shared public views superseding self-interest considerations. A similar pattern is also observed in Hong Kong (Wong et al., 2006) and China (Kim et al., 2018).

Gender exerts the same impact on people's attitudes towards health policy as it does on their general welfare attitudes. Most studies report that women have a stronger desire for more government provision of health services and opposition to pay more taxes in Singapore (Ng, 2015), South Korea and Taiwan (Nam & Wo, 2015). This can be explained by their longer life expectancy and greater health risks in older age (He & Chou, 2020; He, 2018).

### 2.4.3. Ideological explanations

Since public health care as a form of mutual support is grounded in solidarity, it is therefore underpinned egalitarian norms and values (Missinne et al., 2013). Egalitarianism considers health care as one of the basic social rights, and thus people holding this view usually support stronger state intervention in health care through universal coverage (Feldman & Steenbergen, 2001). Missinne et al.'s (2013) study in 24 European countries revealed a positive link between an individual's egalitarian ideology and preference for stronger government responsibility in health care; the effect is particularly strong among low-income groups. This finding is endorsed by several empirical studies based in East Asian societies which found that citizens in support for a higher level of government responsibility for service provision and public health spending were deeply influenced by egalitarian values (Lee & Park, 2015; Azar et al., 2018; Kim et al., 2018). In particular, Azar et al. (2018) reported that egalitarian views have strengthened the willingness to make a monetary contribution to the health care system among high-income groups. In brief, health care

appears to be a social policy domain characterized by high social solidarity in most welfare states.

2.4.4. Political trust-related explanations

The essential role of political trust in shaping health policy legitimacy has become increasingly prominent. A substantial body of empirical research has endorsed the argument that political trust is the fundamental driving force behind successful health care reform. Health policy reforms often imply trade-offs, and political trust is essential for reassuring citizens that the government has the ability to undertake redistributive health reforms in a fair and effective manner, even though they may have to accept potential material loss resulting from such reforms (Hetherington, 2005; Rudolph & Evans, 2005; Mau, 2004; Gabriel & Trüdinger, 2011). Yet, Gainous, Craig and Martinez (2008) challenged the traditional positive argument of the trust theory. The empirical evidence from the United States shows that Americans with a lower level of trust in government demonstrate a stronger preference for government-funded health care programs.

The importance of public evaluation of health care services has attracted scholarly attention, and it serves as an alternative heuristic in shaping people's health policy attitudes (Kumlin, 2007). A high level of public support for public-financed programs stems from people's positive evaluation of the system's efficiency and fairness (Kumlin, 2004). Similarly, stronger motivation for making private financial contributions to health care is also fostered by satisfaction with current health care services, a mechanism described by He, Ratigan and Qian (2020) as an individual learning effect.

## 2.5. Health care financing and its reforms

### 2.5.1. Health care financing: an overview

Health care financing refers to "the function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system" (World Health Organization, 2008, p. 2). Financing is fundamental to a health system as the allocation and pooling of financial resources enable the system to deliver services and optimize population health outcomes (Langenbrunner & Somanathan, 2011).

In reality, all health care systems are financed through both public and private resources, although the mix varies. In theory, health care can be financed from three sources: public, private, and social channels. In health care systems dominated by public financing, health expenditure primarily comes from the government's general revenue. Known as the Beveridge system, the British National Health Service (NHS) system is one of the most famous examples of public financing. This system is typically associated with universal health coverage, underpinned by the assumption that taxpayers who contribute to government revenues should no longer bear financing responsibilities when receiving care from state-run health facilities. Therefore, the state typically grants citizens equal and universal access to public-funded care regardless of their socio-economic status. Other financing mechanisms, such as private health insurance, still exist at the margins of the system, notwithstanding the dominance of taxation.

Public financing of health care has clear strengths. Since the delivery system is predominantly owned by the state, which acts as the single payer to health care providers, the state therefore has strong budgetary authority and capacity to control the behaviours of the providers in order to achieve social policy goals such as quality assurance and cost

containment (Culyer, 1989; Evans, 2002). More importantly, financing health care by general revenues favours equal access to health care services without a means test, and thus this system reduces social inequality by income redistribution (Rothstein, 1998). Furthermore, the universality of health care provision has the effect of muting class conflicts between lower classes and higher classes and therefore enhances social solidarity (Rothstein, 2002). Despite these strengths, public financing of health is associated with major weaknesses: for example, its high reliance on government revenue poses fiscal challenges to public finance. Economic recession, reduced fiscal capacity, and competition from other sectors may all introduce great threats to its sustainability.

In health care systems characterized by social financing, health expenditure mainly comes from social health insurance. Social health insurance is a statutory health insurance program typically co-paid by employers and employees through payroll taxes that may be semi-funded by the government (Normand & Weber, 2009). In this so-called Bismarckian system, although the state is not the key financing contributor, it implements regulations to provide broader coverage for citizens and to achieve broad health policy goals, especially universal health coverage (Palier & Martin, 2008; Wendt, Frisina & Rothgang, 2009). When a country's economic system is dominated by the formal sector and formal employment, a social health insurance system is very conducive to universal health coverage, practically because the enforcement of mandatory contribution is feasible. Wide risk pooling also achieves high systemic efficiency and equity as contribution is typically based on income, while utilization of services is based on needs. Social insurance has been the most popular health care financing instrument in industrialized societies, including Germany, France, Japan, South Korea, and Taiwan. The past two decades have also witnessed its rapid diffusion to developing countries, especially China.

Health care financing by means of social insurance tends to attract public support because of the relatively high transparency of resource flows and the direct link between users and providers, both of which help to enhance consumers' rights and the accountability of health care as a whole (Thomas, Foubister & Mossialos, 2009). However, both insurance-induced demands and supplier-induced demands may fuel the rapid escalation of health care costs, which will eventually threaten the financial sustainability of the entire financing system (Wagstaff, 2010; Saltman, 2004). Moreover, the strength of social health insurance as a form of financing and managing health care importantly relies chiefly on the professional capacity of the insurance agency to act as a prudent third-party purchaser and negotiate with providers for better- and high-quality care at lower costs, but this assumption does not always hold. Li and He (2018) have elucidated that the existence of multiple agency problems coupled with limited capacity on the part of the social insurance agency may actually aggravate some existing problems, such as cream-skimming and cost explosion.

Private financing refers to all types of private household spending on health care. It can be in the form of direct out-of-pocket payments, prepaid private health insurance, or medical saving accounts. Out-of-pocket payments are the payments households make to purchase medical services at the point of use (Langenbrunner & Somanathan, 2011). Prepaid private health insurance is provided by private or non-governmental organizations and may be mandatory or voluntary in nature (Colombo, 2007). Usually, voluntary private health insurance is provided by commercial insurers. However, the state can also organise voluntary health insurance programs; this is the case in Denmark and Ireland (Bassett & Kane, 2007).

Private health insurance offers consumers more choices and encourages competition among insurers that in turn improves the efficiency and quality of services (Colombo, 2007). However, there are also apparent disadvantages associated with this type of insurance

coverage, such as adverse selection and risk selection, both of which limit the scope of private health insurance protection in society, excluding people on a low income or in poor health and older adults from financial protection (Zweifel & Eisen, 2012; Langenbrunner & Somanathan, 2011).

First instituted nationwide in Singapore, medical savings account is a special type of private insurance instrument designed to finance individuals' healthcare expenses. Jointly contributed by both employers and employees, medical savings accounts operate with a similar logic as social health insurance but without risk pooling. The accumulated savings are restricted to the approved medical use of the employees only. A unique strength of medical savings accounts is that it allows the financial risks of illness to be spread out over time, ensuring that citizens have adequate savings to pay for unexpected and expensive medical bills (Jost, 2007). Medical savings accounts also encourage the prudent use of savings on the part of patients, enhance consumer choice, and allow price competition in the markets (Dixon, Greene & Hibbard, 2008). Yet, medical savings accounts do not have the function of income redistribution, and the tax-deductible savings available for paying medical expenses are widely found to be insufficient in reality (Wouters et al., 2016; Borda, 2011). The limited financial protection that medical savings accounts may offer means that this type of private financing cannot play a dominant role in health care financing in most health systems.

### 2.5.2. Health care financing reforms and the niche of private health insurance

Welfare states across the world are facing increasingly daunting challenges of financing their health care systems. First, longer life expectancy and rapidly ageing populations have led to increased use of health care resources, straining health budgets and operations (Williams et al., 2019; Liaropoulos & Goranitis, 2015; Chernew & May, 2011). Second, despite their enormous clinical value, the rapid advancement of medical technologies has also deepened

the financial strains on health care systems due to their high cost (Arentz, Eekhoff & Kochskämper, 2012; Varo, McGuire & Costa Font, 2011; Jordan, 2011; Costa Font & Sato, 2012). Third, the epidemiological transition from infectious diseases to chronic degenerative diseases observed in countries worldwide means there will be a further increase in prevalence of hypertension, diabetes, and cancers, and this shift will inevitably contribute to escalating health care costs (Liu, Vortherms & Hong, 2017; Chapel et al., 2017). Lastly yet importantly, failure to curb cost inflation in some health systems has further aggravated the financial stress. In health care systems predominantly financed through social insurance and taxation, long-term financial sustainability has become a key area of policy concern, prompting serious deliberations on health care financing reform (Hsiao, 2007; Thomson et al., 2009; Pencheon, 2013; Liaropoulos & Goranitis, 2015).

Against this backdrop, private health insurance has been gaining increasing prominence globally with growing discussion on health care financing reform as a potential mean of mitigating the various financing challenges (Organisation for Economic Co-operation and Development [OECD], 2004; Arentz et al., 2012; Preker, 2007). There are two major purposes behind promoting private insurance in health care financing reforms: (a) to strengthen its role as an alternative source of financing health care systems in order to enhance the system's financial robustness and (b) to achieve other health policy goals, such as emphasizing private responsibility (Colombo & Tapay, 2004).

In most East Asian societies, private health insurance plays a supplementary role in financing; nevertheless, it serves important purposes, such as enhancing market choices. For example, in Japan and South Korea, people insured by private insurance can enjoy greater flexibility in choosing health service providers, which are typically restricted in the public system. By 2018, private insurance expenditure constituted a considerable share of total health

expenditure as a supplementary financing source in certain economies (World Health Organization, 2020, see Table 2.1). In Hong Kong, its share in total health expenditure steadily climbed from 3.9% in 2000/01 to 9.1% in 2018/19.

Table 2.1. Share of private insurance expenditures in total health expenditures

| | Expenditure as % of total health expenditure | | |
|---|---|---|---|
| | 2000 | 2010 | 2018 |
| China | 0.4 | 2.1 | 5.4 |
| Japan | 2.5 | 2.4 | 2.3 |
| South Korea | 1.6 | 4.3 | 6.4 |
| Malaysia | 6.1 | 9.3 | 9.6 |
| Indonesia | 5.1 | 3.4 | 2.7 |
| Hong Kong | 3.9 | 7.3 | 9.1 |
| | [2000/01] | [2010/11] | [2018/19] |

Sources: Food and Health Bureau with further calculations, retrieved from https://www.fhb.gov.hk/statistics/download/dha/en/table2_1819.pdf;
World Health Organization, retrieved from https://apps.who.int/nha/database/ViewData/Indicators/en.

Health economics theories also pinpoint a myriad of problems associated with private insurance, including adverse selection, risk selection, and moral hazard (Arrow, 1968; Newhouse, 1993; McGuire et al., 2014;). The heterogeneity of insurance providers may induce high administrative costs, leading to technical inefficiency (Colombo & Tapay, 2004; Colombo, 2007). Ultimately, reliance on private health insurance may introduce a variety of unintended consequences if the free market reigns. A certain amount of regulation is therefore believed to be necessary in order to mitigate these negative consequences and reduce social inequality (Zweifel & Pauly, 2007; Hurley et al., 2001; Korpi & Palme, 1998).

**2.6. Characterizing welfare retrenchment reforms**

In the past decades, economic crises and continuous escalation of welfare spending have resulted in welfare retrenchment—in various forms—in many countries in order to sustain public financing (Ross, 2000; Bonoli, 2001; Green-Pedersen, 2001). Welfare retrenchment describes "policy changes that either cut social expenditure, restructure welfare state programs to conform more closely to the residual welfare state model, or alter the policy environment in ways that enhance the probability of such outcomes in the future" (Pierson, 1994). Traditionally, welfare retrenchment takes the form of budgetary changes through which the state becomes less generous to finance and provide welfare benefits to the population (Ross, 2000). However, conceptualizing retrenchment as mere budget cuts is criticized for being too narrow to reflect the variety of reforms (Pierson, 2001; Clasen & Van Oorschot, 2002; Hacker, 2004).

Green-Pedersen (2004) develops two new criteria to theorize about welfare retrenchment based on institutional changes which include: (a) an obvious increase in the adoption of means testing for administering welfare benefits, and (b) major shifts of responsibility of welfare provision or expenditure from the public sector to the private sector. In real-world policy practice, welfare retrenchment goes beyond direct cuts of public expenditure on welfare but encompasses most efforts intended to shift the financial responsibility away from the state to the private sector and individual citizens. These efforts may include stricter requirement on eligibility, shorter period of benefit provision, contracting out of provision of welfare services, re-commodifying or privatizing welfare services, cost containment, promoting private financing instruments, and so on (Chan, 2010; Pierson 1996, 2001; Frericks, 2013; Leisering, 2012; Mabbett, 2011).

Jacob Hacker (2004) puts forth a highly well-known typological framework that categorizes

welfare retrenchment into drift, conversion, layering, and revision. Layering refers to the creation of new policy without elimination of the old. The health care financing program investigated in this research study, namely, the Voluntary Health Insurance Scheme (VHIS) is a clear embodiment of welfare layering. As described in Chapter 3, the Hong Kong SAR Government was eager to rebalance the public-private mix of the health system by encouraging private sector participation and responsibility on the part of individuals. In particular, growing fiscal stress in financing the public health care system has prompted the government to seek alternative funding sources. The proposed solution was to induce citizens with the ability-to-pay to purchase private health insurance and seek care in private hospitals. Doing so, as the government reiterates, would enable it to maintain sustainable functioning of the public system, on which the lower-class people rely. Hence, this financing reform does not directly cut government spending, nor does it terminate or reduce public provision. In its very nature, this reform manifests welfare layering, a moderate retrenchment.

In this regard, Schattscheneider (1935) has insightfully observed: “a new policy creates a new politics”. Social policies, once enacted, construct new constituencies of beneficiaries that are organized to defend the material benefits provided to them by existing policies, hence frustrating retrenchment attempts (Pierson, 1994; Campbell, 2012; Larsen, 2018). For the same reason, anticipated material loss resulting from potential welfare reforms may not only trigger public opposition, but also lead to participatory reactions to these “policy threats” (Campbell, 2003; Pierson, 1996). Yet, on the other hand, welfare retrenchment does not necessarily lead to public opposition or loss of political popularity (Giger, 2011). Some studies have found that the public does not always blame policy-makers for welfare retrenchment since people’s attitudes are cushioned by normative values, consensual recognition of the problem, and other factors (Armingeon & Giger, 2008; Schumacher, Vis & Van Kersbergen, 2013; Giger & Nelson, 2013). As a result, initiating welfare retrenchment

demands policy-makers to lead and manage public opinion with tremendous political skill and astuteness. Constructing a clear vision and communicating it to the citizenry through various participatory mechanisms are essential for the political management of popular sentiments, especially in Hong Kong where the government does not enjoy electoral mandate (He, 2018; He & Ma, 2020).

### 2.7. Summary: research gaps and hypotheses

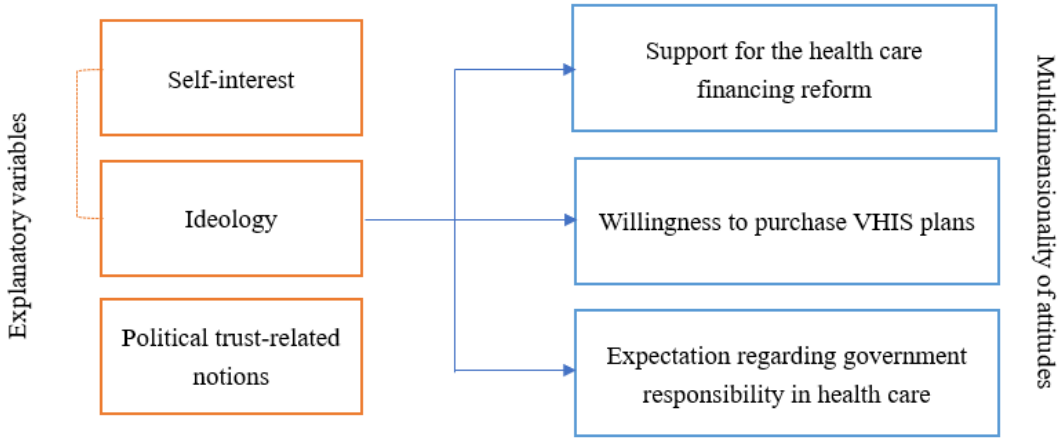
This chapter has reviewed the literature on welfare attitudes in general and in the health policy field in particular. Three prominent theoretical frameworks were reviewed: self-interest, ideology, and theoretical arguments related to political trust. The health policy and economics literature on health financing reforms and private health insurance are also summarized to inform the "applied" part of this research study with practical implications. It is argued that the health care financing reform of Hong Kong, which forms the subject of investigation for this study, pertains to layering which is a moderate form of welfare retrenchment. Overall, two research gaps are identified that necessitate a thorough investigation as undertaken by this research study.

First, many previous studies focused on general attitudes, while scholarly knowledge on the attitudinal patterns and determinants in the health policy field is very limited. Even less is known in the context of East Asia, where distinct social policy traditions, socio-political characteristics, and cultural factors may shape remarkably different opinions. The institutional and ideational legacies of the East Asian developmental welfare regime, notwithstanding its diminishing relevance in the recent years, may still profoundly shape the formation of welfare attitudes in the region. Furthermore, while most previous studies were set in the institutional context of either liberal democracies or authoritarian systems, we know very little about the popular attitudes towards social welfare, especially health care, in a

liberal semi-democracy. On the one hand, deeply entrenched liberal values and rising welfare needs may prompt citizens to voice their demands for more welfare provision but oppose possible retrenchment. Yet, on the other hand, we do not fully know to what extent the long-held principles of self-reliance and familial obligations still have explanatory power in these societies such as Hong Kong.

Secondly and relatedly, the unique nature of Hong Kong's political system prevents policy-makers from resorting to electoral mandate to pursue unpopular policy reforms like their counterparts in electoral democracies. At the same time, they are unable to impose the reforms in a sheer top-down manner irrespective of public opinion. More importantly, policy-making has been operating under an increasingly confrontational atmosphere in Hong Kong since 2013. This type of hostile social environment fuelled by low political trust has put the SAR Government in an awkward position and posed daunting challenges for political leaders to govern and implement legislation. How do citizens respond to a major health policy reform proposal in a low-trust environment? To what extent do they accept a government-initiated reform that carries moderate welfare retrenchment? As discussed earlier, welfare attitudes are innately multi-dimensional. The attitudinal patterns across dimensions may actually provide useful insights on the dynamics of welfare attitude formation in a liberal East Asian society with low political trust, a topic that has been scarcely discussed in existing literature.

Figure 2.1. Conceptual framework for this study




Source: the author.

Against this backdrop, this doctoral thesis is primarily built on the multi-dimensional conception of public attitudes towards health care financing reform. The three attitudinal dimensions of significance are: (a) citizens' general support for the reform, (b) citizens' willingness to purchase VHIS plans, and (c) citizens' expectation regarding government responsibility in health care. The three theoretical frameworks cited above will be tested in the context of the health care financing reform in Hong Kong. On the basis of the literature review summarized above, this study sets out to formulate an integrated conceptual framework, as diagrammed in Figure 2.1. In synthesizing the three theoretical frameworks, it intends to provide a comprehensive framework to examine people's attitudes towards health care reform in Hong Kong.

First, being multi-dimensional in nature, public attitudes towards the health care financing reform in Hong Kong not only include citizens' nominal support for the reform or perceptions of government responsibility in health care, but also encompass their willingness to shoulder additional financial responsibilities. In Hong Kong, citizens have long been enjoying low tax rates and a universal health system. As a result, they may become too "idealistic" in

expecting extensive government responsibility and stand against private financing (Wong, Wan & Law, 2009). Living in such a "pain-free" tax system, Hong Kong citizens may easily ignore the issue of private contribution when indicating welfare preferences (Wong et al., 2006). Given its voluntary nature, people's interest in purchasing VHIS plans directly reflects their willingness to shoulder individual responsibility for health care costs and ultimately determines the outcome of this reform initiative.

Second, this research study hypothesizes that self-interest, ideology and political trust-related mechanisms derived from related literature review explain welfare attitude formation across three attitudinal dimensions. The self-interest thesis leads me to the first sets of explanatory variables to be tested in the empirical part of this study. Gender, age, education, income, marital status, health status, and insurance enrollment status are selected to gauge one's self-interest consideration when indicating attitude towards a health financing reform. The self-interest thesis posits that individuals are utility maximizers, so people who receive higher net gains from the reform should hold a more favorable stance towards the reform. Since the VHIS is initiated to promote private financing through regulating hospital insurance products, greater financial protection and more alternative choices of care provision can be expected. Individuals on a higher socio-economic position, i.e. high income and better educated individuals, typically show desire for better quality of care and lower dependence on the public system (He, 2017). Hence, they can be expected to be more supportive of the reform and more willing to shoulder the costs incurred.

As the theory of risk aversion predicts, individuals with higher exposure levels of health risks tend to be opponents of reforms associated with private financing, and thus would prefer government-funded health arrangements against unintended catastrophic expenditure (Maldonado et al., 2019; Lee & Park, 2015; Wendt et al., 2010; Yang & Barrett, 2006). It is

thus expected that women and older adults, two major high-risk groups in the health care arena, are more supportive of greater government responsibility in health care financing, but reluctant to shoulder the responsibility on their part. This hypothesis is particularly relevant to Hong Kong given the extraordinarily high life expectancy, severe problem of elderly poverty, and their high dependence on public health care.

In addition, the sick and uninsured people can be classified as high-risk individuals, who may desire greater government involvement in health care. But in the meantime, the adverse selection effect predicts that these high-risk individuals are exactly keen to purchase private insurance to protect them against possible catastrophic spending. As a result, it is reasonable to assume that Hong Kong people in poor health and those uninsured will be more willing in general to purchase VHIS plans in order to obtain better coverage.

In East Asia, the role of family remains a salient factor in shaping public perceptions about welfare responsibilities (Yang, Miao & Wu, 2020; Guillaud, 2013; Lin & Yi, 2011). Marital status is the most common indicator to measure family influence. Due to low birth rate and ageing population, defamilization and structural changes in family structure have remarkably weakened families' role in welfare responsibilities in East Asian societies (Chow, 2007; Kim & Choi, 2011; Fleckenstein & Lee, 2017; Zeng & Wang, 2018). In this vein, it can be reasonably posited that, in Hong Kong, being married creates greater demand for government responsibility in health care, stronger opposition to private financing, and lower interest in purchasing VHIS plans.

The second set of explanatory variables is built upon the ideology thesis. Ideological orientation powerfully shapes people's welfare attitudes. Egalitarian values, in particular, lead to stronger support for government involvement in health care (Van Oorschot, 2006;

Blekesaune & Quadagno, 2003). These values also foster people's willingness to pay additional taxes to cover health care costs or pay contributions to insurance schemes in some East Asian societies (Wong et al., 2006; Lee & Park, 2015). Since the VHIS reform attempts to adjust the public-private-imbalance in Hong Kong's health system and reallocate more resources to the vulnerable groups, it is proposed that people who hold stronger egalitarian beliefs tend to offer greater support for the reform, demonstrate stronger desire to purchase VHIS plans, and expect stronger government commitment in health care.

Political trust-related factors serve as the third set of explanatory variables in the empirical investigation. These factors that measure one's past experience with political and welfare institutions are increasingly prominent in explaining welfare attitudes, including political trust, government responsiveness, and perceived efficiency of health care system. Trust in political institutions is fundamentally crucial for the legitimization of policies and acquisition of popular support from citizens, especially those who are adversely affected (Hetherington, 2005; Rudolph & Evans, 2005). It is reasonable to hypothesize a positive association between political trust, support for the reform, and willingness to purchase the VHIS plan because of the belief in the SAR Government's capability to regulate the insurance market.

Perceived responsiveness is found to be a critical indicator for measuring the quality of political institutions (Huang et al., 2020; Cheung, 2013), but such relevance has been hardly examined in health policy research. People who perceive that the government has taken their views into account are more likely to endorse welfare reforms even when private contribution is necessary (Nam & Woo, 2015; He & Ma, 2020). Health care financing reform in Hong Kong has been discussed for decades. A raft of reform proposals have all failed in part because citizens held low confidence in the government's responsiveness to public opinion (Ramesh, 2012). Hence, it is reasonable to expect that higher perceived responsiveness can

foster public support for private financing initiative in Hong Kong.

Public support for welfare reforms is also practically underpinned by people's perceived performance of the welfare system. Individuals with negative views on the efficiency of a health care system tend to be more supportive of corrective reforms that involve greater government effort to improve the status quo (Nixon & Aruguete, 2010). They may also wish to vote with their feet and prefer to purchase better alternatives by seeking more efficient health care service delivery in the private sector (Dowding & John, 2011; Bendz, 2017). In Hong Kong, although the overall health care system enjoys strong public endorsement, citizens still have grievances about its inefficiency (Wong et al., 2012; Leung et al., 2005). It can therefore be hypothesized that people who perceive the health care system as being inefficient tend to be more supportive of the reform and more willing to purchase VHIS plans. Both these measures are deemed to enable them to obtain faster access to care in the private system.

The final set of explanatory variables is the interplay between self-interest and ideology. Rather than being contradictory explanatory mechanisms, self-interest motivations and ideological orientations should be seen as being complementary to each other in terms of attitude formation (Gevers et al., 2000; Kumlin, 2007). The lower-income groups tend to be more supportive of government responsibility in health care because they are the major beneficiaries of public medical services, and expect the government to spend more effort to improve social protection and reduce social inequality (Gelissen, 2000). The VHIS reform promotes private financing and attempts to leave more resources to the poor. It is thus broadly expected that public resistance to private financing and higher expectation regarding government responsibility in health care are likely to hold true among egalitarians with lower income status. In short, the interplay between egalitarian ideology and socio-economic

determinant still necessitates further investigation in explaining attitudes towards the health care financing reform.

# Chapter 3: Health Care System of Hong Kong and Its Reforms

This chapter offers an overview of the current health care system of Hong Kong and the broad architecture of social policy in which it is embedded. Hong Kong's social policy system and welfare tradition are described in Section 3.1. Section 3.2. reviews the evolution of Hong Kong's health care system, while its current structure is elaborated in Section 3.3. The policy challenges faced by the Hong Kong SAR Government and the health care financing reforms of the past decades are discussed in Section 3.4., while Section 3.5. introduces the current health care financing reform initiated by the SAR Government, namely, the VHIS. Section 3.6. summarizes the chapter.

## 3.1. Social policy system of Hong Kong and welfare tradition

Hong Kong has been under British colonial rule from 1842 until its sovereignty was returned to China in 1997. It is one of the most densely populated cities in the world, with a population of more than 7.521 million within its 1,106.8 square kilometre boundary at the end of 2019 (Census and Statistics Department, 2020a). Well known as one of the former "Asian tigers," Hong Kong experienced an economic miracle from the 1960s to the 1990s, with its per capita gross domestic product (GDP) reaching US$48,713.5 by the end of 2019 (The World Bank, 2020).

### 3.1.1. Social welfare system of Hong Kong

Hong Kong's social welfare system is made up of four main pillars, namely, public housing, health care, education, and social security (Wong et al., 2002; Wong, 2012). More than half of public expenditure is spent on social welfare programs to provide a safety net for the population and to improve the living conditions of the poor (Chow, 2003; Tang, 2010). Hong Kong's social welfare system is a complex dual-track system reflecting a mixture of public

and private sector involvement in welfare provision. Specifically, the government extensively intervenes in public housing; by the end of 2019, it was providing 45% of residents with rented public housing (Transport and Housing Bureau, 2020). In education, the government takes an active role in providing and funding free basic education, although most schools are operated by non-governmental organization. In social security, social assistance programs are run by the government, providing limited provision to specific populations and vulnerable groups in a residual manner (Lee, 2012; Walker & Wong, 2005). The government provides heavy subsidies to the health care system and is responsible for the provision of inpatient services, while the bulk of outpatient services is provided by private facilities.

### 3.1.2. Welfare tradition of Hong Kong

Hong Kong has long been labelled as a "reluctant" welfare system (Midgley, 1986). The doctrines of self-sufficiency, low taxation, balanced budget, and minimum government intervention had dominated Hong Kong's economic and social welfare development in the last century (Miners, 1987; Chan, 1998). Since early British colonial rule period was grounded on the concept of noninterventionism, the colonial government had not altered its welfare approach to the Hong Kong society in the mid-1960s when it began to commit to social welfare considerably with concrete sets of policies in response to emerging trends and critical social needs (Wong et al., 2010; Hodge, 1973).

The end of the civil war in China in 1949 resulted in a large influx of Chinese refugees to Hong Kong that tremendously boosted public demand for social welfare to meet basic survival needs (Jones, 2003; Chan, 1998). The first White Paper on social welfare development was published by the colonial administration in 1965, which emphasized the government's role in allotting conditional welfare provision to meet basic needs of the underprivileged population (Hong Kong Government, 1965; Chow, 1996). The 1966 and

1967 labour riots compelled d the colonial government to initiate paradigmatic changes in its stance towards social welfare in an attempt to restore its popularity and legitimacy by answering pressing social needs (Chan, 2009; Scott, 1989). The colonial government eventually refined its welfare attitude from non-interventionism to "positive non-interventionism" from the early 1970s, leading to increasing government involvement in the financing and provision of welfare services (Lee, 2005; Morris & Scott, 2003; Wilding, 1997).

In the subsequent decade, the ideology of laissez-faire propagated by the government contributed to tremendous economic success of Hong Kong and cemented its position as one of the four Asian tigers. This unique development model was characterized by rapid but sustainable economic growth, full employment, and limited supply of social welfare (Goodman, White & Kwon, 1998; Wong et al., 2010). Several scholars described the welfare model of Hong Kong as a productivist/developmental welfare system under which economic growth takes precedence over redistribution and the state assumes very limited responsibility in social welfare (Holliday 2000; Wilding, 1997; McLaughlin, 1993; Lee, 2005; Chan, 2009). To some extent, the residual welfare tradition of Hong Kong was also influenced by the traditional Chinese Confucian values that emphasize strong reliance on individual and family responsibilities (Chan, 1998; Walker & Wong, 2005).

Along with the economic boom enjoyed by the city between the 1970s and 1990s, social development clearly lagged behind its staggering economic growth. Growing poverty and rapid income polarization raised widespread concerns among the Hong Kong society. This period witnessed a noticeable rise in public demand for government intervention in social welfare (Chow, 1994; Wong et al., 2002; Wong & Liu, 1994; Wong et al., 2009). Nevertheless, the colonial government refrained from prioritizing social welfare development

in its public policy-making and would only allocate one third of its fiscal revenue to support welfare services, restricting its role to merely facilitating welfare services and leaving the direct provision of services to community organizations instead (Hong Kong Government, 1991; Wilding, 1997). In the meantime, the colonial government started to initiate reforms and promote alternative forms of state intervention in social welfare that were found in the West, such as public-private partnership and privatization of welfare services (Ramesh, 2012).

The fundamental philosophy underlying Hong Kong's social policy did not change following the transfer of sovereignty from Britain to China in 1997. Traditional principles that had long governed Hong Kong's welfare approach, such as a low tax environment, fiscal prudence, and the notion of "big market, small government," as upheld by the first Chief Executive Tung Chee-hwa, have remained largely in force (Wong, 2012), although the past two decades have indeed witnessed a moderate expansion of social policy in Hong Kong (Cheng et al., 2013). In response to an aging population, rising social expectations, and increasing demand for better welfare, the SAR Government—since the handover—has strengthened its commitment in various social policy domains, such as public housing, poverty alleviation, free compulsory education, and public health care (Chow, 2003).

Nevertheless, the social policy paradigm of Hong Kong has yet to reach beyond residualism. The government's narrow tax base and self-perceived vulnerability to external economic shock have continued to cause it to frame its welfare orientation in a conservative stance. For example, the 1997 Asian financial crisis and the 2007-2008 global financial tsunami reinforced the SAR Government's long-held belief and self-assessment of its fiscal capability that has, in turn, hindered significant social policy investment in the foreseeable future.

### 3.2. Evolution of Hong Kong's health care system and public opinions

The philosophy of laissez-faire and the emphasis on self-financing that have served Hong Kong for the last half-century were deeply rooted in British colonial rule until the 1970s. There were a limited number of hospitals providing health care services during the early stage of colonial rule in Hong Kong since the government required hospitals to be financially and operationally self-sufficient (Gould, 2006; Gauld & Gould, 2002). Therefore, local people mainly relied on family to afford health care (Chau & Yu, 2003; Jones, 2003). Direct public provision of health care services was very limited, and most patients greatly relied on traditional Chinese medicine and charity hospitals operated by non-governmental organizations such as the Tung Wah Group of Hospitals (Scott, 2010; Jones, 2003; Porter, 1999). Similar to its colonial rule elsewhere, the British administration governed Hong Kong without a sense of long-term mission and primarily regarded it as a place for maximizing its own interests (Wong et al., 2009). Against this broad backdrop, the government's role in welfare was confined to minimal provision of public and welfare services for maintaining the basic operation of the society (Scott, 1989).

In the early post-war period, the colonial government remained reluctant to provide health care services well into the 1950s, when the influx of refugees from Mainland China prompted it to make a substantive investment in medical as well as public health services. These mainland immigrants formed a vast pool of cheap labour force for Hong Kong's mushrooming labour-intensive industries, and therefore, the government's investment in health care was seen as a developmental strategy to ensure a healthy workforce to sustain economic growth (Tang, 2000). By the end of 1965, public hospitals funded by the colonial government provided more than 9,000 beds to the public (Jones, 1990).

In 1964, the fact that the colonial government put forward an inaugural plan for health care

development by introducing the first White Paper on health policy, entitled *The Development of Medical Services in Hong Kong,* marked a paradigmatic shift in its social welfare approach. It was the first ever consolidated government plan to guide health policy development (Gauld & Gould, 2002). Well aware of many citizens' inability to afford health services by themselves, the government adopted a public-funded system on a universal basis to ensure equal access and nominal charges (Chau & Yu, 2003). Although this policy document and its subsequent implementation formed the fundamental basis of the current government-funded health care system in Hong Kong, the provision was still far from being sufficient both in terms of quantity and quality (Luk, 2014).

The subsequent 1967 Hong Kong riots would force the colonial government hasten and deepen its involvement in the health care system. To maintain socio-political stability, the second white paper on health care was released in 1974. Titled *The Further Development of Medical and Health Services in Hong Kong*, this white paper was a ten-year blueprint for expanding the public health care system with major investment in response to soaring social discontent with government's under-provision of basic health services.

The establishment of the Hospital Authority (HA) in 1990 and the reform of the Department of Health (DH) marked the cornerstone of the structural reform in the health system. By separating hospital governance from the traditional command-and-control mode of management, the restructuring of government-funded hospitals into a highly autonomous corporation (formally instituted as the HA) was considered a ground-breaking institutional innovation in Hong Kong's health care reforms (Shae, 2016; Yip & Hsiao, 2003; Gauld & Gould, 2002).

Over the following decades of the city's development towards a universal health care system,

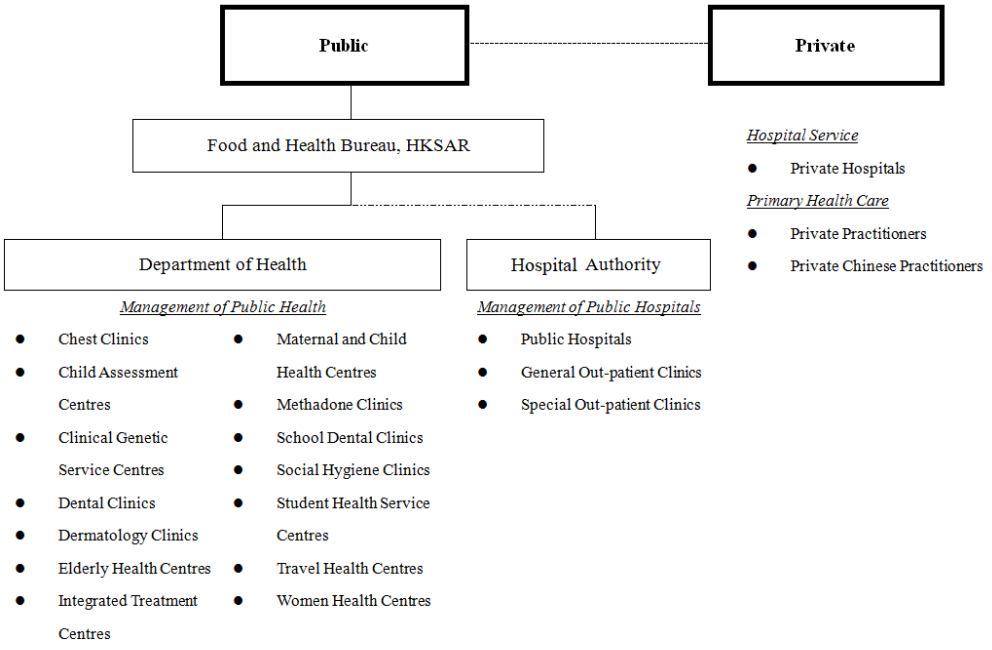
Hong Kong people have shown growing desires for greater government intervention than ever before (Wong et al., 2002; Schwartz, 2001). In addition, the awareness of welfare rights and democratic values has also reinforced popular attitudes towards extensive government responsibility in health care (Lau & Kuan, 1990). The pursuit of democratization in the past two decades has transformed the long-held norms of self-reliance and familial obligation into welfare entitlements and income redistribution (Lin & Wong, 2013; Walker, 2011; Tam & Yeung, 1994). Moreover, the steady weakening of traditional family structure has also amplified the demand for greater government responsibilities.

### 3.3. Current health care system of Hong Kong

#### 3.3.1. Governance

Hong Kong's health care system operates under a dual-track arrangement encompassing both the public and private sectors in funding and delivery. Figure 3.1 exhibits the current organizational structure of the system. The Food and Health Bureau (FHB) is the central authority responsible for health policy-making and resource allocation. While health policies are formulated and implemented by the FHB, the execution of these policies and the actual provision of services fall on the HA and the DH. The DH is responsible for safeguarding public health through the provision of a wide range of services, such as preventive and rehabilitative care, maternal and child care, to citizens via its community clinics and health centres.

Figure 3.1. Governance structure of Hong Kong's health system




Source: HKSAR Government, retrieved from http://www.gov.hk/en/residents/health/hosp/overview.htm.

The unique characteristic of health governance in Hong Kong is that all public hospitals and outpatient clinics are centrally managed by an independent statutory body, namely the HA. Established in 1990, the HA is given a high level of managerial autonomy in hospital operation and development and is lauded as a great model of hospital corporatization (Yip & Hsiao, 2003). All major decisions with regard to hospital management are made by the HA while hospital managers are responsible for routine administration. In Hong Kong, the private health care system runs in parallel to the public system. The private system enjoys extraordinary autonomy on account of minimal, if not non-existent, government regulation.

### 3.3.2. Provision

Under the principle of "no one should be denied medical care through lack of means," public hospitals in Hong Kong provide a wide range of health care services to all citizens at a very low level of nominal charge. Table 3.1 outlines the current fees and charges for selected

public medical services provided by hospitals and clinics managed by the HA. It costs only HK$120 per day for inpatient services; the all-inclusive charge covers treatment, diagnostic tests, pharmaceuticals, and even meals. The cost for general outpatient services is only $50 per attendance, which represents a large subsidy of approximately 90% of the actual costs (see Table 3.1).

Table 3.1. Fee structure of major public medical services provided by HA facilities

| Service | Charges |
|---|---|
| Accident & Emergency (A & E) | $180 /attendance |
| Inpatient (acute general beds) | $75 admission fee, $120 /day |
| Inpatient (convalescent / rehabilitation, infirmary & psychiatric beds) | $100 /day |
| Specialist outpatient (including allied health clinic) | $135 for the 1st attendance, $80 /subsequent attendance, $15 /drug item |
| General outpatient | $50 /attendance |
| Dressing or injection | $19 /attendance |
| Community nursing service (general) | $80 per visit |
| Community nursing service (psychiatric) | Free |

Note. The above new fees and charges for public hospital services provided by the HA are effective as of 18 June 2017. Source: Hospital Authority, retrieved from http://www.ha.org.hk/visitor/ha_visitor_index.asp?Content_ID=10045&Lang=ENG.

All public health care facilities are organised into seven clusters based on geographic proximity. Currently, there are 43 public hospitals and institutions managed by the HA. By the end of 2019, public hospitals provided 29,417 hospital beds in total (Department of Health, 2020) and nearly 90% of the territory's entire inpatient services (Hospital Authority, 2020a). The HA also provides outpatient services through its large network of specialist clinics and outreach services. The DH operates 49 specialist outpatient clinics and 73 general outpatient clinics to provide primary and preventive services (Hospital Authority, 2020b). The

public medical sector enjoys high levels of public satisfaction (He, 2018). Yet, most Hong Kong citizens have been accustomed to seeking outpatient care in private clinics for convenience due to longer waiting times in public clinics. Approximately 70% of outpatient services are provided by the private sector (Food and Health Bureau, 2020a; Kong et al., 2015).

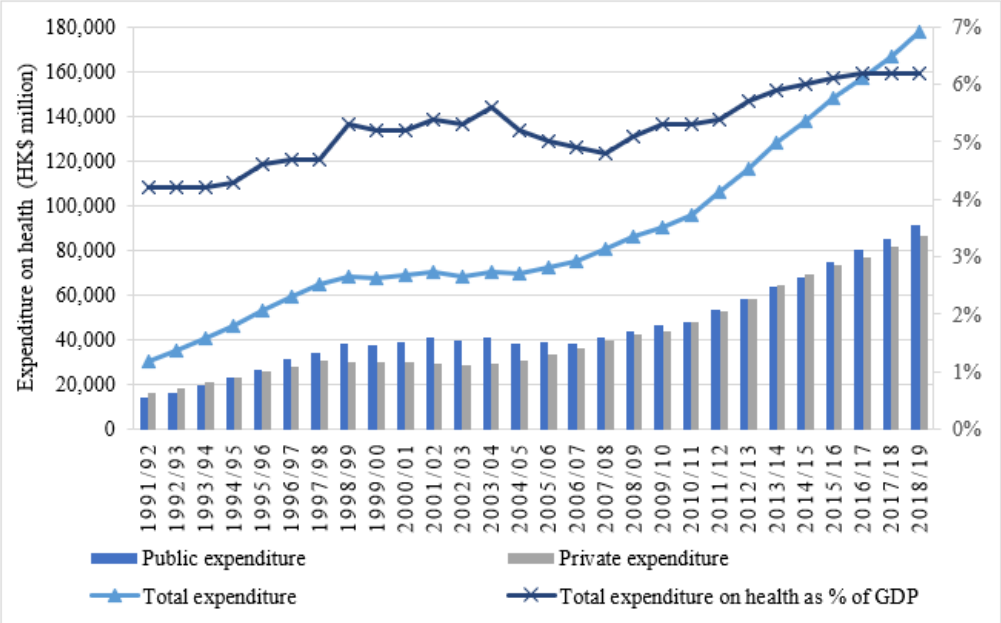
The provision of private inpatient services has been steadily increasing, fuelled by the rise in local demand and the influx of affluent patients from Mainland China (Kong et al., 2015). The private health care system currently consists of 12 hospitals, 66 nursing homes, and 20 correctional institutions providing a total of 12,057 beds by the end of 2019 (Department of Health, 2020). The service charge for private inpatient services usually ranges from HK$4,080 to HK$6,650 per bed day, depending on the type of ward and other conditions. It typically costs HK$790 to HK$2,210 per attendance for an initial general outpatient consultation and HK$640 to HK$1,990 per attendance for subsequent follow-up consultations (Hospital Authority, 2020c). Private specialist care is associated with even higher costs. Fee-for-service is the dominant payment method in Hong Kong's private medical system, which is well known for its cost-inflationary tendency. High hospital charges and low transparency in billing practices have been the major sources of public dissatisfaction with regard to the private health care system (Robinson, 2003). In other words, the biggest challenge of reducing public financing and promoting private care lies in conceiving ways to increase public confidence in the private sector.

### 3.3.3. Financing

Health care in Hong Kong is financed through both public and private sources. The public health care system is heavily dependent on tax revenue. Health spending represents the third biggest budgetary item (13.6%) for the SAR Government, following education (19.4%) and

social security (14.4%) (Legislative Council Secretariat, 2020). Approximately 95% of government expenditure on health is funded from general taxation (He, 2017; O'Donnell et al., 2008). According to the Domestic Health Accounts, Hong Kong's total expenditure on health has steadily increased from HK$30.069 billion in the financial year 1991/92 to HK$167.581 billion in the financial year 2018/19, a four-fold increase within two decades (Figure 3.2; Food and Health Bureau, 2020b, 2020c). The total health expenditure per capita tripled from HK$5,228 in the financial year 1991/92 to over HK$23,815 in the financial year 2018/19 (Food and Health Bureau, 2020b). In the same period, the share of total expenditure on health in GDP rose from 4.2% to 6.2%.

Figure 3.2. Total expenditure on health at current market prices, 1991/92–2018/19

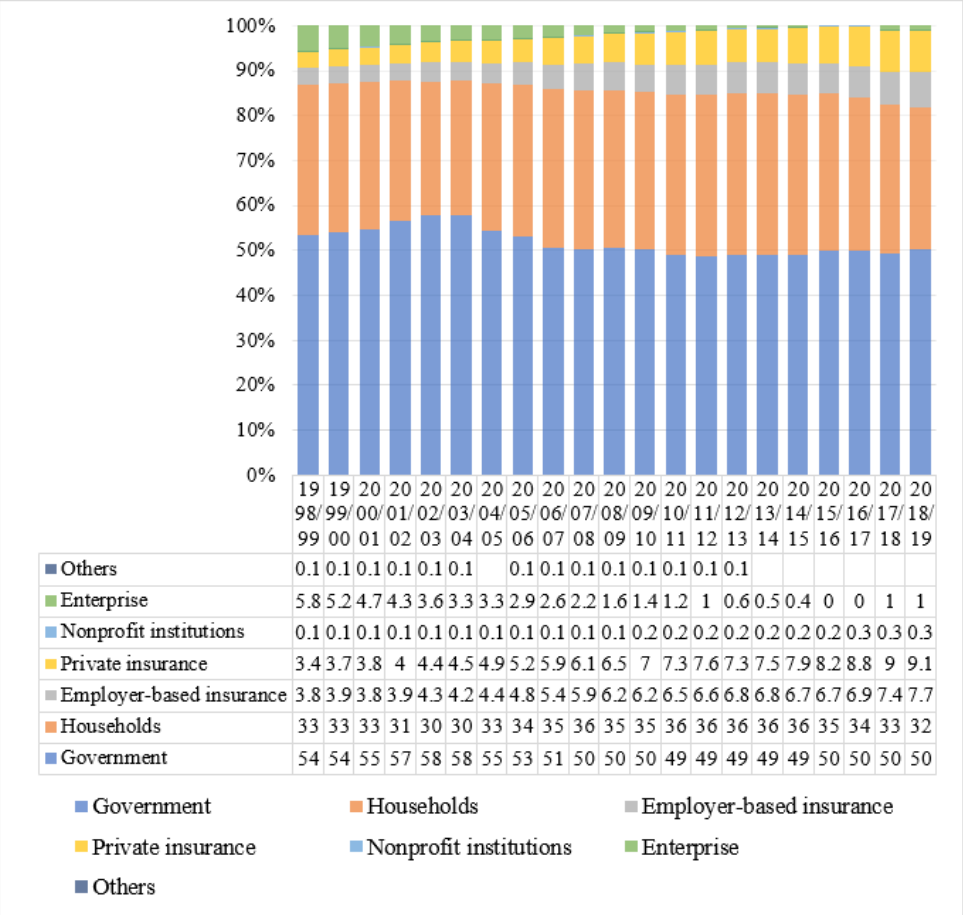



Source: Food and Health Bureau, retrieved from https://www.fhb.gov.hk/statistics/download/dha/en/table1_1819.pdf; https://www.fhb.gov.hk/statistics/download/dha/en/table2_1819.pdf.

Since the late 2000s, public and private sources have respectively financed about half of Hong Kong's total health expenditure (see Figure 3.3, Leung et al., 2005; He, 2017), but the

SAR Government has continued to play a dominant role compared with private financing sources. By the financial year 2018/19, government spending still accounted for the majority part, contributing to 50% of the total health expenditure. Table 3.3 displays the mix of financing sources of health care in Hong Kong in the recent decade. Although PHI still plays a supplementary role in financing, its contribution has steadily increased from 3.4% in 1998/99 to 9.1% in 2018/19. Employer-provided group health insurance also accounted for 7.7% of total expenditure on health in 2018/19. One third of the territory-wide health expenditure is paid out-of-pocket by local people (Food and Health Bureau, 2020c). There is no social health insurance or institutionalized medical savings accounts in Hong Kong.

Figure 3.3. Mix of health financing in Hong Kong at current prices, 1998/99–-2018/19

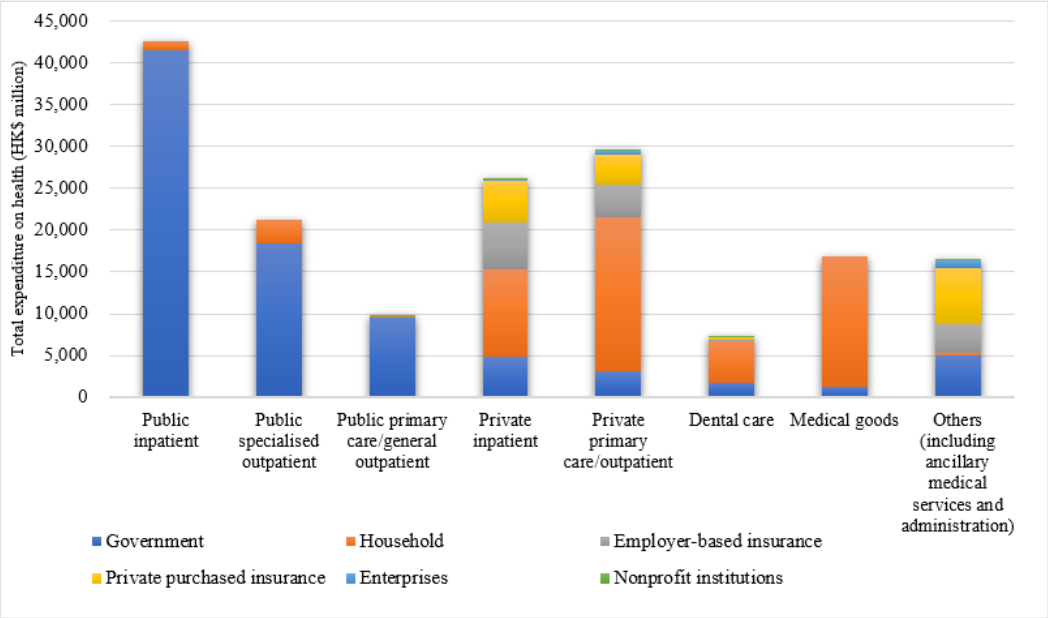



| | 1998/99 | 1999/00 | 2000/01 | 2001/02 | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Others | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | | | | | | | |
| Enterprise | 5.8 | 5.2 | 4.7 | 4.3 | 3.6 | 3.3 | 3.3 | 2.9 | 2.6 | 2.2 | 1.6 | 1.4 | 1.2 | 1 | 0.6 | 0.5 | 0.4 | 0 | 0 | 1 | 1 |
| Nonprofit institutions | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.3 | 0.3 | 0.3 |
| Private insurance | 3.4 | 3.7 | 3.8 | 4 | 4.4 | 4.5 | 4.9 | 5.2 | 5.9 | 6.1 | 6.5 | 7 | 7.3 | 7.6 | 7.3 | 7.5 | 7.9 | 8.2 | 8.8 | 9 | 9.1 |
| Employer-based insurance | 3.8 | 3.9 | 3.8 | 3.9 | 4.3 | 4.2 | 4.4 | 4.8 | 5.4 | 5.9 | 6.2 | 6.2 | 6.5 | 6.6 | 6.8 | 6.8 | 6.7 | 6.7 | 6.9 | 7.4 | 7.7 |
| Households | 33 | 33 | 33 | 31 | 30 | 30 | 33 | 34 | 35 | 36 | 35 | 35 | 36 | 36 | 36 | 36 | 36 | 35 | 34 | 33 | 32 |
| Government | 54 | 54 | 55 | 57 | 58 | 58 | 55 | 53 | 51 | 50 | 50 | 50 | 49 | 49 | 49 | 49 | 49 | 50 | 50 | 50 | 50 |

Source: Food and Health Bureau, retrieved from https://www.fhb.gov.hk/statistics/download/dha/en/table2_1819.pdf.

Figure 3.4 breaks down the total expenditure on health by financing sources in the financial year 2018/19. The SAR Government spent more than 80% of its total health budget on comprehensive public health care services. Approximately 60% of its subsidies/subventions were injected into the HA in the form of recurrent budget. These subsidies constitute primary source of income (approximately 94%) for public hospitals. In inpatient services alone, subsidies totalled HK$41,469 million in that financial year (Food and Health Bureau, 2020d). Being the principal funder of the HA, the SAR Government possesses a strong financial lever to seek compliance on the part of public hospitals.

Figure 3.4. Total expenditure on health by financing sources at current prices, 2018/19




Source: Food and Health Bureau, retrieved from https://www.fhb.gov.hk/statistics/download/dha/en/table6_1819.pdf.

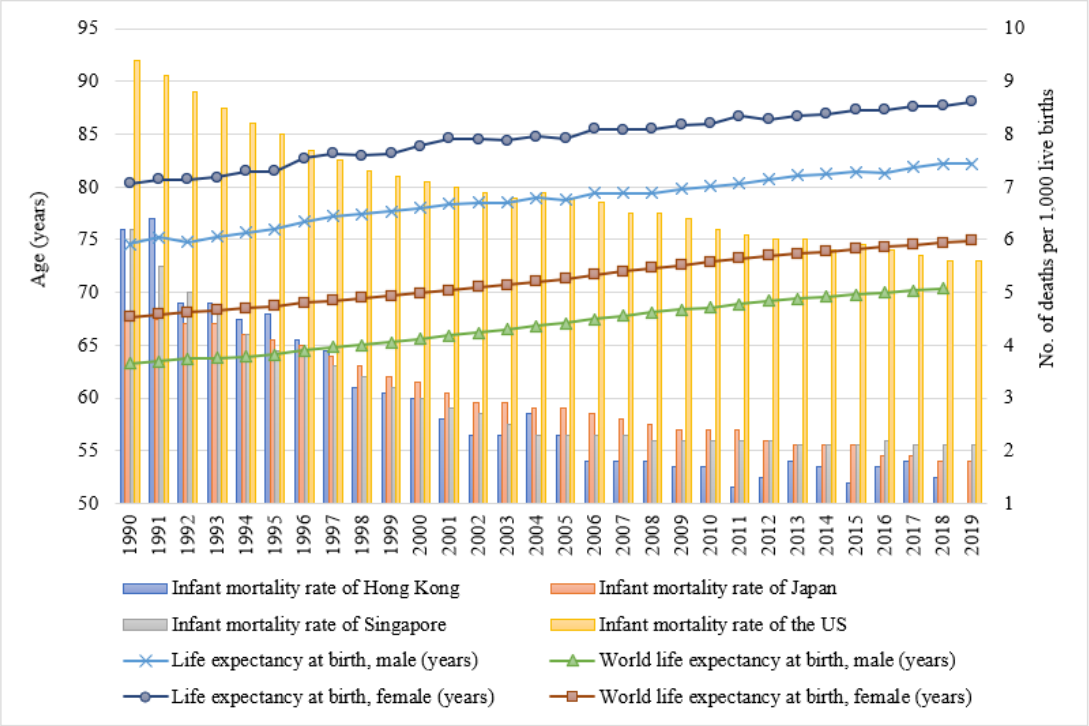
## 3.4. Health policy challenges and the history of financing reforms

### 3.4.1. Health policy challenges

Hong Kong's health care system enjoys a worldwide reputation for being one of the least

expensive in the world (Wagstaff, 2007). Relative to its low health care spending, currently set at 6.2% of its GDP, Hong Kong's population health achievement is outstanding, with the highest life expectancy at birth and one of the lowest infant mortality rates in the world (Figure 3.5). The life expectancies at birth for both sexes have steadily increased during the past three decades in Hong Kong, from 74.6 for men and 80.3 for women in 1990 to 82.2 and 88.1 in 2019, respectively (Census and Statistic Department, 2020b).

Figure 3.5. Life expectancy at birth and infant mortality rate of Hong Kong, 1990–2019

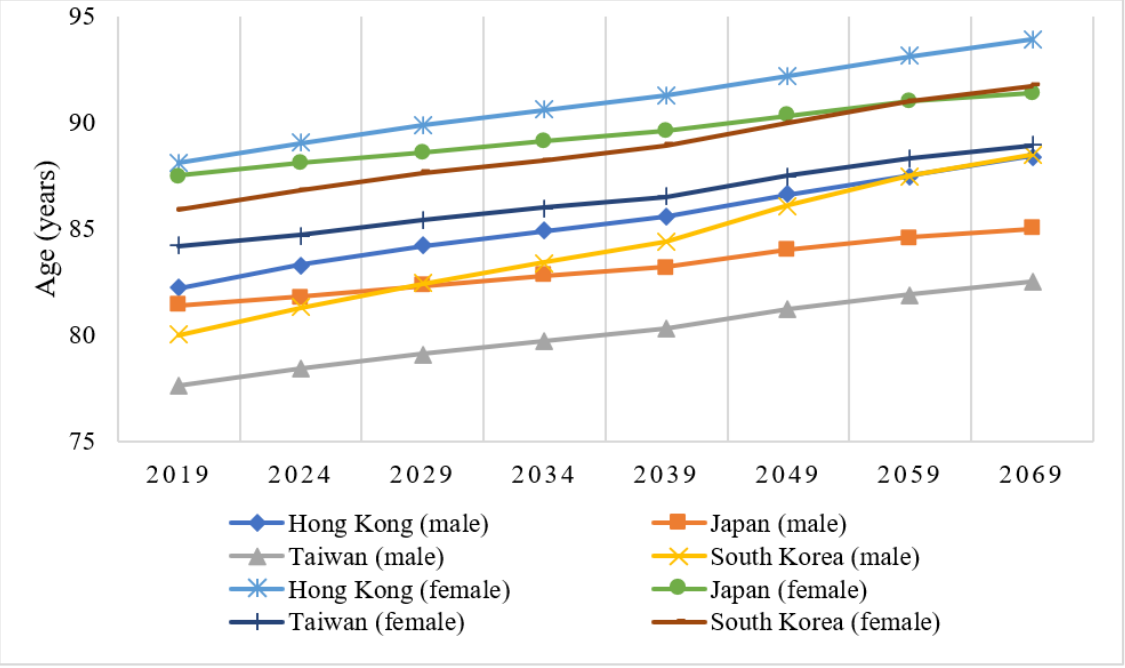



Note. Missing data are excluded.

Sources: Census and Statistics Department, The Word Bank, retrieved from https://www.censtatd.gov.hk/fd.jsp?file=B72003FB2020XXXXB0100.pdf&product_id=FA100108&lang=1; https://www.censtatd.gov.hk/fd.jsp?file=B11303032020AN20B0100.pdf&product_id=B1130303&lang=1; https://data.worldbank.org/indicator/SP.DYN.IMRT.IN; https://data.worldbank.org/indicator/SP.DYN.LE00.MA.IN; https://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN.

Despite the remarkable achievements, this internationally renowned health system has been confronting daunting challenges. First, a rapidly ageing population has dramatically increased health service utilization on the part of older adults, placing heavy pressure on the public hospital system. Increases in healthcare costs are strongly associated with increasing age (Yuen, 2014). According to population projections, the average life expectancy for men and women in Hong Kong will further increase to 88.4 and 93.9, respectively, by 2069 (Census and Statistics Department, 2020b; Figure 3.6). Foreseeably, public demand for health services will continue to soar in the coming years and health care costs for the elderly will account for an increasing proportion of Hong Kong's health budgets in the future.

Figure 3.6. Projected life expectancy at birth by sex for Hong Kong, 2019–2069




Source: Census Statistics Department, retrieved from https://www.censtatd.gov.hk/fd.jsp?file=B1120015082020XXXXB0100.pdf&product_id=B1120015&lang=1.

Second, in parallel to the demographic transition, Hong Kong's epidemiological pattern has been predominantly characterized by chronic degenerative diseases. Table 3.2 lists the ten

leading causes of death in Hong Kong in 2019. Such epidemiological transition will inevitably fuel cost escalation of health care in the long run. The prevalence of chronic diseases, compounded by the ageing population, will continue to heighten the demand on both curative and preventive care, and deepen pressure on already strained public finances.

Third, despite the existence of a sizable private medical system, the Hong Kong population still shows an overreliance on public facilities in general, especially when it comes to inpatient care (Leung et al., 2005; Chan & Beitez, 2006). Long waiting times have been the chief source of public discontent. As shown in Table 3.3, the median waiting time for many new cases at governmental specialist outpatient clinics was approximately one year (around 48 weeks). It is not uncommon for many patients to wait for more than two years for specialist consultation, medical imaging, and treatment. As shown in Table 3.4, on average, local patients had to wait for 8 to 22 months for a cataract surgery and 33 to 67 months for a joint replacement surgery in some clusters. Unfortunately, cross-cluster referral arrangement has been rare.

Table 3.2. Ten leading causes of death in Hong Kong, 2019

| Ranking | Cause of death | Number of deaths |
|---|---|---|
| 1st | Malignant neoplasms | 14,871 |
| 2nd | Pneumonia | 9,271 |
| 3rd | Diseases of heart | 6,096 |
| 4th | Cerebrovascular diseases | 2,970 |
| 5th | External causes of morbidity and mortality | 1,848 |
| 6th | Nephritis, nephrotic syndrome and nephrosis | 1,667 |
| 7th | Dementia | 1,490 |
| 8th | Chronic lower respiratory diseases | 1,373 |
| 9th | Septicemia | 1,065 |
| 10th | Diabetes | 493 |

Note: The figures in this table are based on the number of "registered" deaths.

Source: https://www.chp.gov.hk/en/statistics/data/10/27/380.html.

Table 3.3. Waiting time for stable new case booking at governmental specialist outpatient clinics by hospital cluster, 2020 (Unit: weeks)

| | HK East | | HK West | | Kowloon Central | | Kowloon East | | Kowloon West | | NT East | | NT West | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Median | Longest | Median | Longest | Median | Longest | Median | Longest | Median | Longest | Median | Longest | Median | Longest |
| **Ear, nose, throat** | 29 | 103 | 26 | 89 | 77 | 146 | 83 | 91 | 70 | 106 | 69 | 92 | 40 | 79 |
| **Eye** | 33 | 76 | 56 | 61 | 123 | 131 | 23 | 132 | 27 | 118 | 27 | 77 | 11 | 65 |
| **Gynaecology** | 28 | 42 | 41 | 61 | 20 | 36 | 40 | 94 | 29 | 70 | 49 | 84 | 71 | 75 |
| **Medicine** | 28 | 106 | 30 | 116 | 76 | 111 | 68 | 146 | 79 | 111 | 89 | 133 | 90 | 114 |
| **Orthopaedics & traumatology** | 35 | 116 | 19 | 74 | 51 | 139 | 66 | 114 | 54 | 83 | 59 | 121 | 79 | 97 |
| **Paediatrics** | 8 | 17 | 12 | 18 | 10 | 18 | 10 | 40 | 11 | 23 | 12 | 27 | 23 | 38 |
| **Psychiatry** | 15 | 33 | 18 | 72 | 14 | 38 | 46 | 99 | 16 | 78 | 57 | 100 | 29 | 64 |
| **Surgery** | 47 | 76 | 26 | 93 | 34 | 83 | 52 | 111 | 36 | 60 | 34 | 78 | 59 | 117 |

Note. The longest (90$^{th}$ percentile) waiting time implies that patients in 90% of new case bookings are able to make an appointment earlier than the indicated time.

Source: Hospital Authority, retrieved from https://www.ha.org.hk/haho/ho/sopc/dw_wait_ls_eng.pdf.

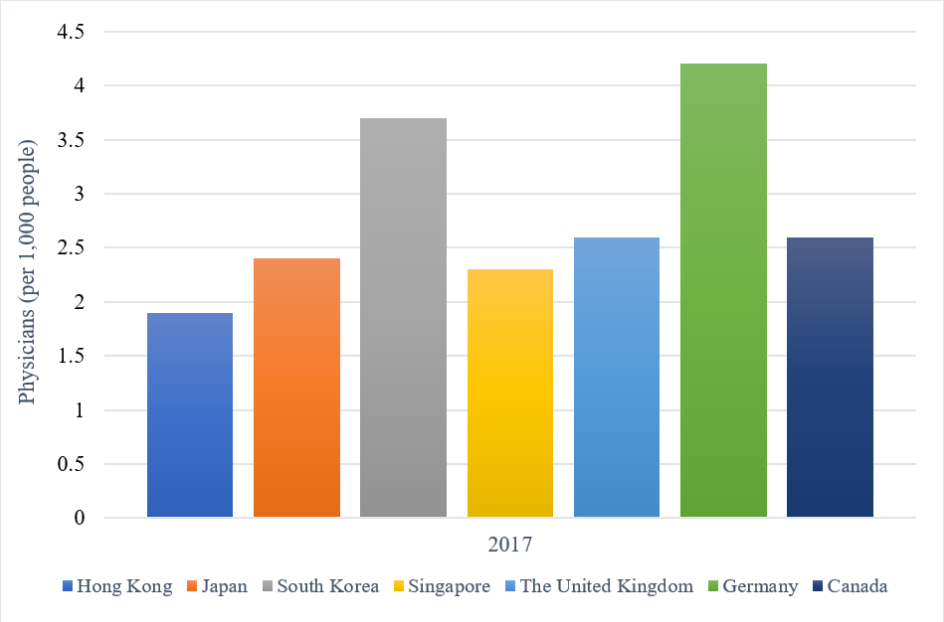
Table 3.4. Waiting time for selected surgeries in government hospitals by hospital cluster, 2020 (Unit: months)

| | Cataract surgery | | Total joint replacement surgery | |
|---|---|---|---|---|
| | Median | 90th Percentile | Median | 90th Percentile |
| HK East | 15 | 26 | 16 | 66 |
| HK West | 8 | 13 | 21 | 52 |
| Kowloon Central | 11 | 29 | 22 | 33 |
| Kowloon East | 8 | 15 | 17 | 49 |
| Kowloon West | 11 | 35 | 32 | 48 |
| NT East | 22 | 26 | 26 | 58 |
| NT West | 12 | 39 | 26 | 67 |

Note. The 90th percentile waiting time implies that 90% of the patients with surgeries performed could receive surgeries earlier than the indicated time.
Source: Hospital Authority, retrieved from http://www.ha.org.hk/visitor/ha_visitor_index.asp?Parent_ID=214172&Content_ID=214184; http://www.ha.org.hk/visitor/ha_visitor_index.asp?Content_ID=221223&Lang=ENG&Dimension=100&Parent_ID=214172.

Long waiting times eventually lead to non-attendance or to delays in receiving necessary medical attention for some low-income patients who do not have full access to alternative care in the private sector owing to financial reasons. The strained public health care resources are exacerbated by the shortage of manpower, particularly medical professionals. This brain drain issue has been worsening in the territory in the recent years while the local medical education system is unable to train more physicians in part due to the strong protectionism in the local medical sector (Chan, 2020). Compared with other societies, Hong Kong has a significantly low number of physicians per thousand people, a crucial indictor of medical manpower supply (Figure 3.7). The entrenched interest among organised medical professionals has vigorously thwarted any reform proposal that attempts to increase the supply of registered physicians in Hong Kong.

Figure 3.7. Number of physicians per thousand people in selected economies, 2017




Source: The World Bank; Food and Health Bureau, retrieved from https://data.worldbank.org/indicator/SH.MED.PHYS.ZS; https://www.fhb.gov.hk/statistics/en/health_statistics.htm.

Lastly and most fundamentally, policy-makers are most concerned with the notable imbalance of the public-private mix in Hong Kong's health system and the long-term sustainability of the public system. Given the escalating health expenditure and growing uncertainty in economic prospects and fiscal revenue, the burden on the government health budget and the public service delivery system is expected to heighten at an even faster rate. Some commentators have warned that the public hospital system is coming near a breaking point (Tsui & Fong, 2018). It is therefore imperative for the SAR Government to diversify the health care financing base towards greater private responsibility and alleviate the mounting pressure on the public hospital system by encouraging more utilization of private medical services on the part of its citizens (He, 2017).

3.4.2. History of health care reforms in Hong Kong

A series of health care reform efforts have been made by both the colonial government and the SAR successor since 1993. The first reform attempt was made in 1993 with the launch of a consultation paper entitled *Towards Better Health*, commonly known as the *Rainbow Report*. Five policy alternatives were suggested: (a) charging users 5 to 15 per cent more than the actual operational cost, (b) introducing semi-private beds and extra charges for items in public hospitals, (c) proposing private health insurance, (d) introducing compulsory universal health insurance, and (e) concentrating resources on the treatment of higher priority conditions. Unfortunately, this reform attempt failed due to strong public opposition to greater private responsibility (Ramesh, 2012; Shae, 2016).

The second reform proposal was announced in 1997. Entitled *Improving Hong Kong's Health Care System: Why and For Whom?*, the consultation document was known as the *Harvard Report* in which a team of health policy experts from Harvard University commissioned by the newly established SAR Government highlighted the need to secure long-term financial sustainability in order to reduce the government's budgetary burden. They estimated that 20 to 23 per cent of the total government budget would go to the health care sector by 2016 (Harvard Team, 1999). Two main financing schemes were therefore proposed, namely, the Hospital Security Plan (HSP) and MediSage. The former was a compulsory health insurance program that required joint contribution from both employers and employees, while the latter was a medical savings account resembling Singapore's famous Medisave system.

This reform effort, however, scrapped after less than a quarter of the citizens showed support for the proposal (Gauld & Gould, 2002). Most citizens opposed the concept of compulsory health insurance or a medical savings accounts, with the stated the reasons including preference for freedom of choice, free market principle, and the like. More importantly, Hong

Kong was suffering from a serious economic downturn following the 1997 Asian Financial Crisis. Therefore, the general public were expecting greater government involvement and provision in social protection rather than a mandatory scheme that would increase individual financial commitments (Chan, 2008). As a result, fierce public opposition once again became a major stumbling block to the government's reform attempt.

The Harvard Report formed the basis of the third financing reform in 2000, known as *Lifelong Investment in Health*. As there was scant support for compulsory health insurance from the general public, more focus was put on the idea of medical savings accounts. The Health Protection Account, a compulsory savings program, was proposed for adults aged between 40 and 60 to finance their medical needs after the age of 65. However, the pitfall of this proposal lied in its inopportune timing. The swift release of another reform proposal that essentially shared the same policy logic of the thwarted reform attempt earlier triggered even wider public resentment. Most citizens disapproved of the proposal because of its perceived financial inflexibility, arguing that since a big portion of accumulated wages would have to be withheld for a long period before retirement, the living standards of low-income groups would further decline (Gauld & Gould, 2002). The general public clearly demonstrated their preference for flexible saving schemes rather than mandatory contributions (Wong & Luk, 2007). Failing to garner the necessary essential popular support, this third reform effort inevitably followed its predecessors' trajectory of downfall.

Mindful of the previous failed efforts to reform health care financing, the SAR Government decided to change the mode of service in launching its fourth reform attempt in 2005. Titled *Building a Healthy Tomorrow*, the consultation paper attached a great deal of importance to strengthening public health care services for low-income groups and placed greater emphasis on primary, acute, and emergency care (Yu, 2006). This reform also proposed the transfer of

inexpensive inpatient and specialist outpatient care to private providers. Regrettably, the government did not accord equal attention and effort on promoting the reform and persuading citizens to accept its recommendations. The snubbed proposal eventually disappeared from the public domain.

The fifth reform proposal was later initiated in 2008. Titled *Your Health Your Life*, the consultation paper reintroduced the concept of medical savings accounts, despite the repeated failure of such proposals in the past. As expected, the proposal received very little public support. The SAR Government eventually recognized that any reform proposal that entailed compulsory contributions on the part of citizens would have a dim chance of winning popular support in Hong Kong (Ramesh, 2012). The general public, instead, indicated a strong preference for a government-subsidized voluntary financing program.

Notwithstanding the apparent limitations of voluntary health insurance, the SAR Government had to accept that this was only political feasible option under the local socio-political climate, and hence, in 2010, it pursued a sixth attempt at reform attempt known as *My Health My Choice*. The proposed Health Protection Scheme (HPS) was a voluntary health insurance program intended to encourage insure the segments of the society that have the ability-to-pay and the desire to seek care in private sector. After 20 years of frustratingly unsuccessful attempts, this reform proposal was finally endorsed in principle by the general public.

### 3.5. The current health care financing reform

Following the success of the 2010 health reform consultation, the SAR Government amended the HPS in accordance with the feedbacks collected from the general public and eventually proposed the VHIS to citizens for public consultation in 2014. Ultimately, this scheme attempts to encourage citizens with the ability to pay—predominantly the middle- and high-

income groups—to leave the over-pressured public hospitals and seek care in the private sector to enjoy quality services, with the underlying suggestion that scarce public health care resources should be left for the vulnerable and low-income groups (Voluntary Health Insurance Scheme, 2020a; Yin & He, 2018). Strategically, the VHIS is expected to serve as an alternative instrument to finance the health care system and relieve the pressure of public hospitals towards long-term sustainability (Food and Health Bureau, 2014).

Under the VHIS, all certified commercial health insurance plans must be regulated by the SAR Government, which imposes a set of minimum requirements (MRs). All commercial insurers have to abide by these requirements, which are intended to increase price transparency, enhance product quality in the PHI market, and protect consumer rights. The key features of the VHIS are as follows: (a) guaranteed renewal up to the age of 100 without rewriting the insurance policy; (b) no "lifetime benefit limit" under the age of 100; (c) full refund of premium provided within a 21-day grace period; (d) easy access to insurance premium through the Internet; and (e) extending coverage to hospitalization for unknown pre-existing conditions, and ambulatory procedures (Voluntary Health Insurance Scheme, 2020b; SAR Government, 2018). Table 3.6 lists the key features of the VHIS.

Table 3.5. Key features of the VHIS

| | |
|---|---|
| Nature | Voluntary but regulated by the SAR Government on basis of MRs |
| Policy | Products need to be certified by the FHB by fulfilling the MRs of the VHIS to become a "Certified Plan" |
| Premium | Depends on age |
| VHIS providers | Commercial insurance companies (e.g. Bupa, AIA, Bank of China etc.) |
| Eligibility | Up to the age of 80 |
| Inpatient coverage | Yes (depends on type of service) |
| Outpatient coverage | Prescribed ambulatory procedures and non-surgical cancer treatments<br>Day case procedures |
| Preexisting conditions | Partially cover in 2nd year (25%) and 3rd year (50%); full cover (100%) thereafter |
| Coinsurance | 30% for prescribed diagnostic imaging tests |
| Renewal | Guarantee up to age of 100 |
| Lifetime benefit limit | No (before age of 100) |
| Annual benefit limit | HK$420,000 per policy year (cannot be carried over to next year) |
| Premium transparency | Premium schedule easily accessible on the Internet (e.g. VHIS website, etc.) |
| Tax deduction | Up to HK$8,000 |

Note. The table pertains the standard plan of the VHIS only.
Sources: Yin & He, 2018; SAR Government, 2018; Voluntary Health Insurance Scheme, 2020b.

At the start of the consultation, a high-risk pool was originally proposed to subsidize parts of the premiums of individuals with greater health risks. Full portability without underwriting was also proposed. Unfortunately, these two key features of the VHIS were strongly opposed by the insurance industry and some scholars (Ko, 2017; Hong Kong Federation of Insurers, 2015) and had to be abandoned by the government eventually. In addition, citizens aged over 80 are ineligible for the proposed plan. In order to provide incentives for citizens to subscribe to the VHIS, the Legislative Council passed a bill to provide a tax deduction of up to HKD$8,000 for the paid premiums. Although the VHIS is operated by commercial insurers, it is essentially a voluntary scheme with public insurance characteristics (He, 2017).

### 3.6. Summary

Hong Kong has long been described as a reluctant welfare system. The doctrines of self-sufficiency, low taxation, balanced budget, and minimum government intervention have dominated economic and social welfare development in the past century. Yet, the pursuit of democratization, the structural changes of family structure, and economic volatility, together, have gradually altered the welfare ideology of Hong Kong people over the past decades (Chan, 2008; Cheung, 2002; Wong et al., 2002; Schwartz, 2001). As a result, the variety of socio-economic challenges have rendered the old policy paradigm increasingly unviable in the present context, forcing the government to shoulder greater welfare responsibility in both service provision and financing, especially in health care.

A government-funded health care system is a very exceptional component of Hong Kong's welfare system. Its universal coverage, minimum charge, and extraordinary equality have provided seven million citizens with an essential health safety net. Yet, rapidly ageing population, high prevalence of chronic diseases, and citizens' overreliance on the public system have all but aggravated the heavy burden on the government's finances. Escalating public health care expenditure has brought alarming challenges to the system's long-term sustainability. A significant rebalance of the public-private mix in health financing was deemed urgent by policy-makers. Unfortunately, waves of health care financing reform efforts have all floundered in the past decades under strong opposition of the general public. Apparently, popular support was a significant—and to some extent decisive—factor behind the vicissitudes of health care reforms in this highly liberal society.

After suffering repeated failures in health financing reform, the SAR Government eventually came to embrace the VHIS. The reform seeks to regulate all commercial hospitalization insurance products with government-imposed MRs which are intended to overcome the

deficiencies of pure private health insurance products and safeguard citizens' rights. Related insurance plans have become available in the market since early 2019. It is crucial to note that since the VHIS reform is initiated on a voluntary rather than mandatory basis, public endorsement of the reform itself and their actual willingness to purchase VHIS plans are fundamental for establishing its legitimacy and will eventually determine its outcome.

# Chapter 4: Research Design and Methodology

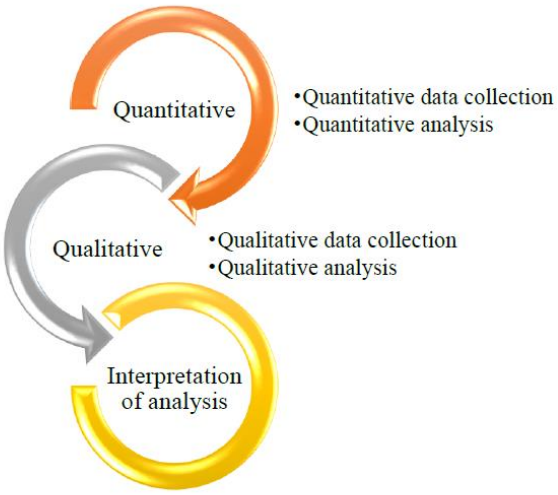
This chapter lays out the research design and methodology adopted in this doctoral research. Section 4.1 discusses the overall research design of this study. The methodological roadmaps for quantitative and qualitative investigation are presented in Section 4.2. and Section 4.3., respectively. Section 4.4. summarizes the chapter.

## 4.1. Research design

### 4.1.1. A mixed-methods approach

This research employs a mixed-methods approach to guide its empirical investigation. Specifically, an explanatory sequential mixed-methods design is adopted to answer the research questions posed in Chapter 1. This two-phase mixed research design begins with the collection and analysis of quantitative data, followed by a qualitative phase that further explains and interprets the quantitative results by means of quantitative data collection and analysis (Creswell & Clark, 2011). The strength of quantitative methods lies in their ability to establish statistical relationship between variables and generalize outcomes to the population in a large-*N* fashion (Moffatt et al., 2006), whereas qualitative methods enable the links among concepts and behaviours to be better identified and theories to be generated or refined in a small-*N* but in-depth setting (Bradley, Curry & Devers, 2007; Miller & Crabtree, 1999). A mixed-methods design integrating both methodological approaches helps to enhance overall understanding of the research questions and facilitates the validation of results (Creswell & Clark, 2011). In addition, the weakness of single research method can then be mitigated to a large extent through a mixed-methods approach. The overall research design is presented in Figure 4.1 below.

Figure 4.1. Research flow of the explanatory sequential mixed design




Source: adapted from Creswell & Clark (2011).

With respect to this study, the explanatory sequential mixed-methods design attempts to seek benefits of multiple research methods, which can better address the complex formation of attitudes towards welfare reform in multiple dimensions. First, this study is designed to identify the multi-dimensionality of attitudes towards the health care financing reform in Hong Kong and the predictive power of alternative explanatory mechanisms. By using mixed research methods, it allows the comparison of findings obtained from different sources to strengthen both the internal and external validity of the investigation (Jogulu & Pansiri, 2011). Second, this study attempts to discover the mechanisms for explaining the complexities of attitude formation. Despite the merits of large-*N* quantitative method, it may not be sufficient for explaining the richness and depth of individuals' real-life experiences. Nor are the numerical data capable of resolving the paradoxes that do not conform to theoretical predictions. In contrast, qualitative methods allow me to examine the phenomenon in-depth and within its real-life context, so that the findings help generate insights into *how* and *why* the attitudes are formed in certain ways. Therefore, qualitative analysis can

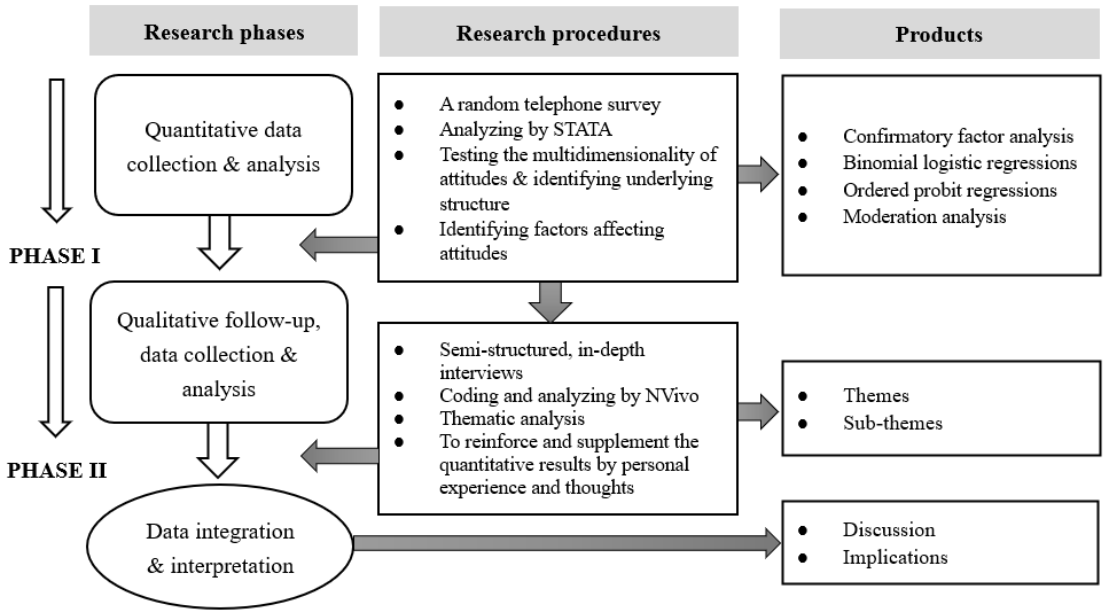
overcome the limitations of quantitative methods by supplementing individuals' subjective views, offering valuable in-depth insights.

4.1.2. Analytical procedure

Diagrammed in Figure 4.2., an analytical road map is formulated to substantiate the research design introduced above. Overall, the priority of this sequential design is accorded to quantitative methods since they serve as the core component of data collection and analysis in this study. In the first phase, the quantitative data collected from a telephone survey will be analysed to examine the multi-dimensionality of Hong Kong people's attitudes towards the health care financing reform and their determinants, against the three explanatory frameworks—self-interest, ideology, and trust, and across three attitudinal dimensions. A series of statistical techniques will be used.

The second phase analyses qualitative data collected from thirty semi-structured interviews. The qualitative thematic analysis allows me to corroborate the quantitative findings and resolve any potential unexplained puzzles arising from the first phase. Finally, the quantitative and qualitative results are compared and integrated into an overall interpretation directed towards answering the research question of this study (Creswell & Clark, 2011).

Figure 4.2. Procedural diagram of the mixed-methods design adopted




Source: the author.

## 4.2. Phase I: quantitative methods

The quantitative data used in this study were collected through a telephone survey funded by the Department of Asian and Policy Studies of The Education University of Hong Kong in September 2014. My access to the dataset was granted by Associate Professor Alex Jingwei He, Principal supervisor and Principal Investigator of the survey project. Ethical approval was obtained from the Human Research Ethics Committee of the University.

### 4.2.1. Data source and sampling

Data collection was outsourced to the Public Opinion Programme of the University of Hong Kong, a professional think-tank with extensive experience in conducting opinion polls. Respondents were selected by random-digit dialling. The randomized dialling encompassed both landline and mobile phone numbers so as to expand the pool of potential respondents. By March 2020, the residential landline penetration rate was 84.88 % and the mobile

subscriber penetration rate even reached 273.9%[2] (Office of the Communications Authority, 2020). Since the telephone (including mobile phone) non-subscription rate in Hong Kong is very low, selection bias due to exclusion was minimal.

The target population was Cantonese-speaking (the lingua franca in Hong Kong spoken by more than 90% of the population) adults aged 18 years and above with Hong Kong citizenship. A total of 1,016 respondents formed the survey sample through random sampling, registering a response rate of 67.5%. Compared with other random digit dialling-based telephone surveys (Wheelock et al., 2012; He, Qian & Ratigan, 2020), the opinion data collected in this study achieved a fairly favourable response rate. The demographic profile of the respondents is presented in Table 4.1.

Table 4.1. Profile of survey respondents

| | Obs. | Mean | S.D. | Minimum | Maximum |
|---|---|---|---|---|---|
| Gender | 1,016 | 1.612 | 0.486 | 1 (male) | 2 (female) |
| Age group | 995 | 3.357 | 1.355 | 1 (18-29) | 5 (≥65) |
| Education level | 1,005 | 2.172 | 0.707 | 1 (≤primary) | 3 (≥tertiary) |
| Personal monthly income | 955 | 1.578 | 0.711 | 1 (<HK$10,000) | 3 (≥HK$50,000) |
| Marital status | 913 | 1.741 | 0.439 | 1 (single) | 2 (married) |
| Self-reported health status | 1,015 | 2.512 | 0.782 | 1 (very good) | 5 (very bad) |
| Insurance enrolment status | 1,009 | 1.690 | 0.906 | 1 (not yet insured) | 4 (insured by both PHI & GHI) |

Source: the author.

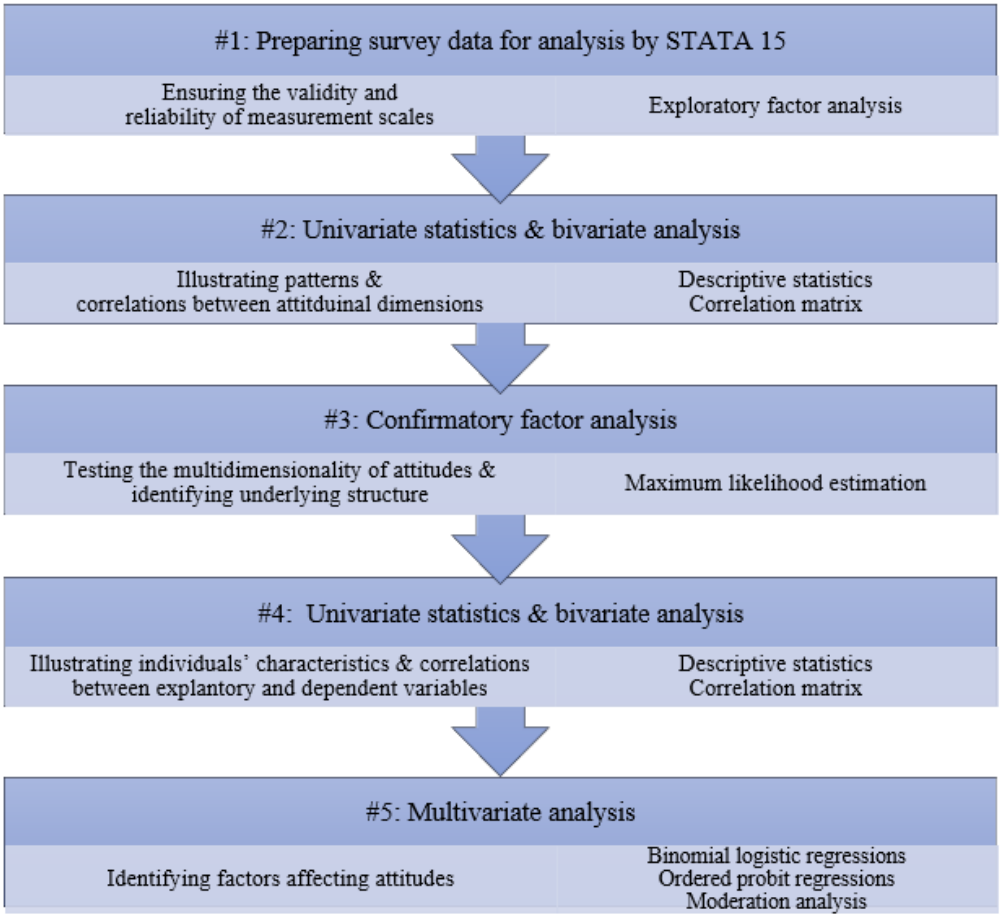
### 4.2.2. Analytical procedure

This study follows a five-step statistical process to analyse the survey data, as shown in Figure 4.3. Step #1 prepares the survey data with the test of validity and reliability of

[2] A portion of Hong Kong people own more than one mobile phone number.

measurement scales. Step #2 and Step #3 assess the multi-dimensionality of welfare attitudes. Step #4 and Step #5 perform statistical analysis to provide empirical explanations. All statistical analyses are performed in STATA 15.

Figure 4.3. Analytical steps of the quantitative phase




Source: the author.

## 4.2.3. Statistical techniques

### *4.2.3.1. Exploratory factor analysis (EFA)*

In this study, two explanatory variables, i.e. egalitarianism and political trust, pertain to more than one measurement item. Hence, the construct validity and reliability must be established at the very beginning (Bryman, 2012). Exploratory factor analysis (EFA) is employed with a

principal component method and varimax rotation to identify the underlying structure of the latent construct. A few indicators are used to determine the fitness, including the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy, the Bartlett's test of sphericity, factor loading score of each item, and Cronbach's alpha test. The value of KMO should equal or exceed 0.60 and Bartlett's test of sphericity should be significant ($p < 0.0001$) to validate the measurement scale (Hair et al., 2006). To ensure the reliability of measurement scale, factor loading score of each item must be at least 0.5 or above (Williams & Brown, 2013) and the value of Cronbach's alpha test should be no less than 0.6 (Nunnally, 1978).

*4.2.3.2. Univariate and bivariate statistics*

The univariate analysis is performed on the raw data collected from the telephone survey, depicting the broad patterns of the dataset. Bivariate analysis is also conducted to examine the correlations between the variables of key concern.

*4.2.3.3. Confirmatory factor analysis (CFA)*

One-factor confirmatory factor analysis (CFA) is employed to test the multi-dimensionality of attitudes towards the health care financing reform. Both EFA and CFA are common statistical techniques used to examine the underlying structure of a latent construct. In the literature, CFA has been frequently employed to examine the multi-dimensionality of welfare attitudes (Van Oorschot & Meuleman, 2012; Roosma et al., 2013). EFA is a data-driven technique primarily exploring the data and identifying the underlying structure without imposing any hypothesis or theoretical assumption. In contrast, CFA is a hypothesis-driven multivariate statistical method that allows the test of underlying dimensions of a latent construct based on theoretical understanding derived from the past studies (Jöreskog, 1969; Thompson, 2004). Hence, CFA estimation is a critical step to hypothesize and examine which dimension (latent variable) is related to which concept (latent construct), specifying the best

number of attitudinal dimensions based on theoretical expectations.

To identify a valid and reliable underlying attitudinal structure, a hypothesized CFA model is evaluated based on a series of goodness-of-fit indices (Nunkoo & Smith, 2013). The Chi-square value ($\chi 2$) is a common fit indicator to test the validity of models. Yet, conventional $\chi 2$ is very sensitive to a large sample size (Byrne, 2001). Hence, it is necessary to employ other fit indices to gain a more accurate assessment of construct validity (Kline, 2016). Four additional fit indices are included: 1) root mean square error of approximation (RMSEA), 2) Comparative fit index (CFI), 3) Tucker–Lewis index (TLI), and 4) standardized root mean residual (SRMR). To measure a reasonably good model fit, the values of CFI and TLI should be no smaller than 0.95, while the value of RMSEA and SRMR should be smaller than 0.05 (Byrne, 2013; Williams & Brown, 2013).

In addition, CFA is a powerful tool to justify the number of latent variables underlying a latent construct (Byrne, 2013). The standardized regression weight helps me interpret how each variable composes the latent construct in a positive or negative direction. Such weight (factor loading) serves as an indicator for assessing the reliability of hypothesized models (Nunkoo & Smith, 2013). If the factor loading score is 0.50 or above, the latent variable can be considered as a reliable dimension to be loaded onto that concept (Bagozzi & Yi, 2012; Williams & Brown, 2013).

*4.2.3.4. Multivariate analysis*

Multivariate binomial logistic and ordered probit regression models are used to analyze the factors associated with the dependent variables. The collinearity between explanatory variables should be low to ensure the validity of results. The value of tolerance statistics should be greater than 0.2, while the value of Variance Inflation Factor (VIF) should be close

to 1. To examine the robustness of the regression results, several regression models are used for each attitudinal dimension with and without controlled variables. Chi-square test and the percentage of explained variance of the dependent variables are also shown.

The literature has shown that the effect of an individual's ideological beliefs on welfare perception may differ across social positions (Azar et al., 2018; Gilessen, 2000). In this study, the moderation effects between self-interest orientations and ideological dispositions are tested by moderated regression analysis. Moderation analysis helps me to examine *when* the impact of egalitarian beliefs on welfare attitudes varies due to one's socio-economic position. A moderation regression model is performed for each attitudinal dimension to detect interaction effect, controlling for other explanatory variables. A higher value of Pseudo $R^2$ indicates stronger effect size for the interaction and thus strengthens the reliability of the results (Hayes, 2018).

### 4.3. Phase II: qualitative methods

#### 4.3.1. Data collection

Qualitative data are collected from semi-structured, in-depth interviews in a face-to-face fashion. The strength of this method lies in its high degree of flexibility for both researchers and informants and in the rich and extensive details it reveals pertaining to the phenomenon under investigation that would otherwise be impossible to achieve (McIntosh & Morse, 2015; Bryman, Becker& Sempik, 2008).

Most interview questions are grounded on the quantitative findings and are formulated in an open-ended manner to encourage free expression of participants' views and yield rich and illuminative descriptions that are rooted in the context as they occur. Only a small number of closed questions are included for capturing informants' socio-demographic characteristics and

their standpoints with regard to health care financing reform. An interview guide consistent with the conceptual framework outlined in Chapter 2 and with both English and Chinese translations has been developed prior to the interviews for the informants' reference (see Appendix A).

All interviews are structured into four sections. First, the socio-demographic characteristics of each informant are asked. As hypothesized, one's socio-demographic characteristics serve as the proxies of self-interest mechanisms. Second, informants are asked about their opinions regarding the health care financing reform. This part of the interview is geared towards the three attitudinal dimensions framed in the quantitative phase (support for the reform, willingness to purchase VHIS plans, and expectation regarding government responsibility). Third, informants are invited to answer open-ended questions and explain the reasons why they hold such perceptions. Finally, informants are encouraged to raise or discuss any other important issues deemed relevant to the reform. Pilot interviews were conducted prior to the main round of data collection. The pilot study allows me to modify and refine the interview guide as preparation of the actual, full-scale study.

4.3.2. Sampling

Informants are selected through purposive sampling in a convenient approach to identify research subjects who possess greater knowledge of the phenomenon under investigation for the study. The goal is to strategically establish a better correspondence between the research questions and the sample data (Bryman, 2006). In order not to miss any key informants, the chosen participants fulfil the following selection criteria: 1) Hong Kong citizens aged 18 years or above; 2) from different classes; and 3) basic knowledge of the reform and have personal experience with local health care system.

A critical issue that qualitative researchers often confront is the determination of adequate sample size. With respect to this, data saturation is the most commonly employed principle for deciphering when data collection is discontinued (Guetterman, 2015). The minimum sample size of at least 12 interviews is recommended to reach data saturation and yield no new information or themes in the data (Braun & Clarke, 2013; Fugard & Potts, 2015). In this vein, Creswell and Clark (2011) suggest that a range between 20 and 30 interviews should be sufficient to meet thematic saturation. In this study, the saturation of data occurs when the sample size reaches thirty.

A total of 30 informants from a variety of backgrounds participated in the interviews on a voluntary basis. All interviews were conducted in Cantonese. The sample represented a wide range of stakeholders in the health care reform process, including ordinary citizens of the upper, middle, and lower classes; medical professionals; representatives of the insurance industry; and legislators. Face-to-face, in-depth interviews were conducted from January to June 2017, each lasting between 75 and 100 minutes. Consent was obtained from each informant prior to every interview. Table 4.2 presents the main characteristics of the informants.

Table 4.2. Main characteristics of informants

| Interview Code | Gender | Age group | Education | Self-reported class status | Marital status | Occupation |
|---|---|---|---|---|---|---|
| IN1 | F | 65+ | Tertiary | Upper class | Married | Deputy managing director of a listed company |
| IN2 | M | 50-64 | Secondary | Upper class | Married | CEO |
| IN3 | M | 50-64 | Tertiary | Upper class | Married | Managing Director of a listed company |
| IN4 | F | 30-39 | Tertiary | Upper class | Single | Fashion designer |
| IN5 | F | 40-49 | Tertiary | Upper class | Married | Banker |
| IN6 | M | 30-39 | Secondary | Middle class | Single | Assistant to Legislative Council member |
| IN7 | F | 30-39 | Tertiary | Middle class | Married | Event manager |
| IN8 | F | 18-29 | Tertiary | Middle class | Single | Not provided |
| IN9 | M | 65+ | Secondary | Middle class | Married | Retired |
| IN10 | F | 50-64 | Tertiary | Middle class | Married | Housewife |
| IN11 | M | 50-64 | Tertiary | Middle class | Married | Manager |
| IN12 | F | 65+ | Primary | Low class | Windowed | Retired |
| IN13 | F | 30-39 | Secondary | Low class | Single | Sales |
| IN14 | F | 65+ | Primary | Low class | Married | Retired |
| IN15 | F | 30-39 | Secondary | Low class | Married | Clark |
| IN16 | M | 65+ | Primary | Low class | Married | Security Guard |
| IN17 | M | 30-39 | Tertiary | Upper class | Married | Doctor |
| IN18 | M | 40-49 | Tertiary | Upper class | Married | Ophthalmologist |
| IN19 | F | 30-39 | Tertiary | Middle class | Married | Chinese Medical Practitioner |
| IN20 | F | 18-29 | Tertiary | Middle class | Single | Nurse |
| IN21 | M | 18-29 | Tertiary | Middle class | Married | Nurse |
| IN22 | M | 40-49 | Secondary | Middle class | Married | Insurer |
| IN23 | M | 50-64 | Tertiary | Upper class | Married | Managing director of insurance company |
| IN24 | F | 40-49 | Secondary | Middle class | Married | Insurer |
| IN25 | F | 30-39 | Tertiary | Middle class | Married | Insurer |
| IN26 | F | 18-29 | Tertiary | Middle class | Single | Insurer |
| IN27 | M | 40-49 | Tertiary | Upper class | Married | Secondary School Teacher/District councillor |
| IN28 | M | 50-64 | Tertiary | Upper class | Married | Professor/Member of LegCo |
| IN29 | M | 50-64 | Tertiary | Upper class | Married | Private urologist/Member of LegCo |
| IN30 | M | 65+ | Tertiary | Upper class | Divorced | Member of LegCo representing labourers |

Source: the author.

### 4.3.3. Data analysis

Thematic analysis was adopted as the key analytical method for analysing the qualitative data thus gathered. This method represents an analytical process for identifying and interpreting the qualitative data according to the patterns of meaning, known as “themes” (Clarke & Braun, 2017). Not only summarizing the data, thematic analysis can generate rich and

detailed thematic interpretations deductively on the basis of my quantitative results derived from the first phase. This method is commonly used in health care research to identify the rationale behind public perceptions of health services (Ayres, 2007). In this study, thematic analysis helps to expand the ideas and provide in-depth explanations of the quantitative findings, thus enhancing the clarity of each theoretical point of view.

The process of qualitative data analysis consists of five steps (see Figure 4.4). In step #1, I prepare the qualitative data for coding in NVivo 11 by converting all interviews into digital transcripts.

In step #2, open coding is performed on the data. The transcripts and field notes are broken into smaller fragments for developing initial codes that facilitate the identification of common features and patterns. Individuals' viewpoints of the three attitudinal dimensions are categorized into three separate themes. Different reasons for holding such attitudes are characterized into different subthemes.

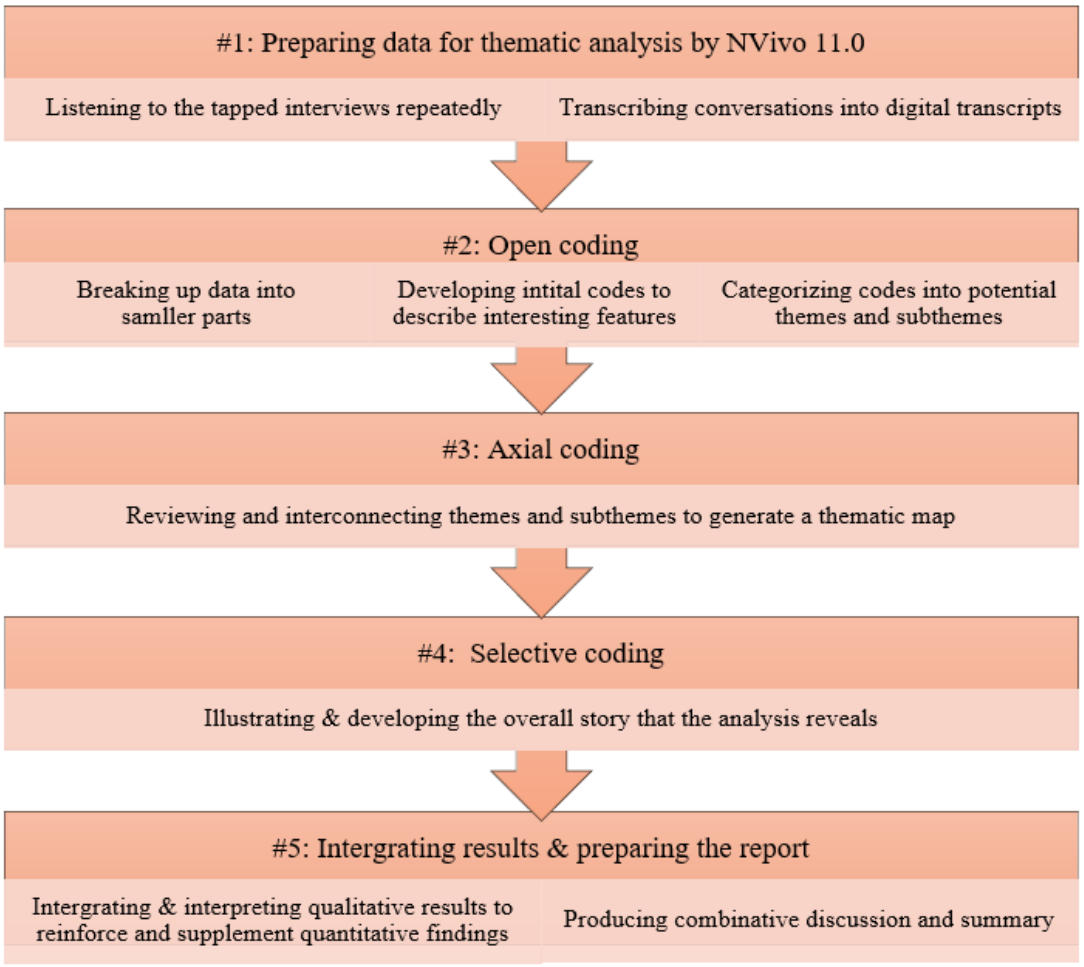
In step #3, I review the interconnection between themes and subthemes identified from the previous step, and connect them by addressing how the explanatory mechanisms (self-interest, ideology and trust) influence Hong Kong citizens' attitudes towards the health care financing reform.

In step #4, I refine and integrate the interconnected themes obtained from axial coding, with the aim of developing an integrated theoretical explanation that addresses the complexity of public attitudes towards the health care financing reform.

In step #5, the findings analysed in the previous steps are summarised and explained. Since

this research design is conducted using an explanatory mixed-methods approach, the qualitative results are compared and integrated with the findings obtained from the quantitative phase to reach an overarching interpretation.

Figure 4.4. Analytical steps of the qualitative phase




Source: the author, adapted from Braun & Clarke (2006), Creswell & Clark (2011).

### 4.3.4. Reliability and validity

In qualitative research, the reliability of data can be ensured through achieving similar and consistent qualitative results (Collingridge & Gantt, 2008). Several techniques are employed to improve the validity of qualitative analysis. First, this study utilizes low-inference descriptors during the process of data collection (Silverman, 2001). In practice, I paid close

attention to informants when conducting interviews, and asks follow-up questions if necessary. Such a low inference approach provided ample room for informants to express their views freely, hence reducing possible bias. Second, in order to guarantee the accuracy of the collected data, digital transcripts of the interviews were sent to all the informants for verification, who were invited to clarify possible misunderstanding or ambiguity. Third, the semi-structured interview guide was designed in a neutral tone in order to capture the informants' real views without imposing any assumption. All these methods help improve the accuracy of data by soliciting and capturing maximal and genuine opinions from the informants.

### 4.4. Summary

This chapter outlines the methodological roadmap of the research study. This mixed-methods research adopts quantitative approach in the first phase, followed by qualitative approach in the second phase. The explanatory sequential design is substantiated by coherent analytical steps to guide the empirical research. A mixed-methods design methodology allows me to triangulate the quantitative and qualitative data obtained through different research techniques and identify aspects of a phenomenon more accurately by synthesizing different vantage points, while overcoming the weaknesses inherent to using separate research methods. This contributes to the overall interpretation both in terms of breadth and depth, thus strengthening both internal and external validity of the study.

Despite its strengths, the integration of analytical results obtained from different data sources and methodological approaches often pose a common challenge, that is, how to merge various findings in an appropriate and rigorous manner (Bryman, 2007). The link between the two phases of this study is established through three ways. First, semi-structured interview questions are formulated in congruence with the preliminary results obtained from statistical

tests while leaving flexibility for emergent themes. Second, the interpretation of both quantitative and qualitative results is undertaken through the guidance of related theoretical frameworks. In case inconsistencies emerge, I review the results and resolve the inconsistencies through examining them with close reference to the contextual dynamics specific to the Hong Kong society and its health system. Third, quantitative components assume a heavier weight in sequential explanatory designs, and hence, qualitative components mainly play a supplementary role in analysis. As a result, the final interpretation of this study has a clearer learning towards the first phase and caveats are provided when inconsistencies are not resolved.

# Chapter 5: Public Attitudes towards Health Care Financing Reform in Hong Kong: Quantitative Investigation

Public support lays a crucial foundation for maintaining the legitimacy of public policy-making and securing a positive outcome of welfare reforms. Multi-dimensional in nature, popular support is shaped by three key sets of factors: self-interest, ideology, and political trust-related variables. With this in mind, this study sets out to develop an integrated conceptual framework (see Figure 2.1) in order to identify the multi-dimensionality of Hong Kong citizens' attitudes towards the health care financing reform in question (i.e. the VHIS), and their determinants. A two-phase explanatory sequential mixed-methods design is adopted. This chapter elucidates the quantitative investigation and its outcomes.

The chapter is structured as follows. Section 5.1. operationalizes the measurement of dependent and explanatory variables. Section 5.2. presents the empirical results of CFA in testing the multi-dimensionality of Hong Kong citizens' attitudes towards the reform and identifying the underlying attitudinal structure. The empirical results of the univariate statistics, bivariate analysis, and multivariate analysis are reported in Section 5.3., Section 5.4., and Section 5.5., respectively. The theoretical discussion and summary of the quantitative findings is presented in Section 5.6.

## 5.1. Measurements

### 5.1.1. Dependent variables

As discussed in Chapter 2, the multi-dimensional conception of attitudes towards health care reform in Hong Kong is represented by three dependent variables. The two binary variables were named *support for the health care financing reform* (SUPPORT) and *willingness to purchase VHIS plans* (WILLINGNESS). The third variable, *expectation regarding*

*government responsibility in health care* (RESPONSIBILITY), is an ordinal variable.

Respondents were first invited to indicate their nominal support for the financing reform by answering the following question: "Do you support the VHIS health care financing reform?" In this binary variable, a value of 1 denotes support for the reform while opposition to the reform is labelled as "2". The second dependent variable, willingness to purchase VHIS plans, was measured by the following item: "Are you going to participate in this scheme?"; a value of 1 represents the intention to purchase a VHIS plan while a value of 2 indicates one's unwillingness to do so. Respondents were reminded of the benefits of the VHIS coverage as well as its contributory nature. These two binary dependent variables are recoded reversely in an ascending order to present Hong Kong citizens' positive attitudes towards the reform in different dimensions.

The final dependent variable, public expectation regarding government responsibility in health care, was captured by the following question: "Some say that the SAR Government should only provide necessary health care services (such as the medical treatment of critical illnesses) for everyone and should encourage individuals to take care of other health care services. Do you agree with this statement?". Respondents were invited to answer on a 5-point Likert scale: 1 represents *absolutely agree*, 2 represents *agree*, 3 represents *neither agree nor disagree*, 4 represents *disagree*, and 5 represents *absolutely disagree*, with higher values indicating stronger expectation regarding government responsibility for providing health services.

### 5.1.2. Explanatory variables

#### *5.1.2.1. Self-interest variables*

Socio-demographic characteristics are often used to measure one's self-interest in health

policy research (Prus, 2011; Lindh, 2015). The first set of explanatory variables as pertaining to the concept of self-interest includes gender, age, education level, personal monthly income, marital status, self-reported health status, and insurance enrolment status.

Gender was categorized as follows: 1 = *male*; 2 = *female*. The age of each respondent was captured by one of the five range categories: 1 = *18–29*, 2 = *30–39*, 3 = *40–49*, 4 = *50–64*, and 5 = *65 or above*. Education not only reflects one's socio-economic position, but also captures his/her level of knowledge and social policy literacy, which may have substantial influence on welfare preference (Yang et al., 2019; Kulin & Svallfors, 2013). To measure the level of education, respondents were asked to indicate their highest level of education: 1 = *primary or below*, 2 = *secondary*, and 3 = *tertiary or above*.

Income represents an individual's material position in the society. The amount of monthly income was reported by the respondents and subsequently grouped into three income levels: 1 = *below HKD$10,000*, 2 = *HKD$10,000–29,999*, and 3 = *HKD$30,000 or above.* This categorization is made with reference to the population-wide statistics. According to the latest Population By-census provided by the Census and Statistics Department (2020c), the median monthly income in Hong Kong was HK$15,500, and individuals who earned more than HK$30,000 per month were classified as belonging to the top 20% of the population.

Respondents were asked to indicate their marital status in order to capture the influence of family in welfare attitudes. The following options were given to represent one's marital status: 1 = *single* (included divorced, separated or windowed) and 2 = *married*. Self-reported health status was measured by a 5-point Likert scale ranging from 1 (*very good*) to 5 (*very bad*). This variable reflects the heterogeneity in the inclination of risk aversion with regard to health policy reform (Doiron et al., 2008). The final variable in the self-interest category is

insurance enrolment status. In particular, the differences in people's insurance enrolment status potentially affect their preferences for private health insurance (Shen, 2013). Insurance enrolment status was categorized into four mutually exclusive scenarios: 1 = *insured by PHI* only, 2 = *insured by (employer-provided) group health insurance* (GHI) only, 3 = *insured by both PHI and GHI*, and 4 = *un-insured*.

*5.1.2.2. Ideology variables*

The second set of explanatory variables is related to ideological commitment of social values. Two statements were designed to capture egalitarian beliefs held by Hong Kong citizens. Respondents indicated whether they agreed with the following two statements: "In a fair society, the differences in people's living standards should be small" and "Large differences in people's incomes are necessary to reward differences in personal abilities and efforts". The options for the two items were set on a 5-point Likert scale ranging from 1 (*absolutely agree*) to 5 (*absolutely disagree*). These two questions capture egalitarian values from a bidimensional approach of both the self-transcendence and self-enhancement aspects of egalitarianism (Missinne et al., 2013). The former item captures individuals' perceptions of the equality of living standard (self-transcendence), while the latter item gauges one's acceptance of income differences (self-enhancement). The latter item was reverse coded to reflect an egalitarian view.

The two items are subjected to an exploratory factor analysis (EFA) with a principal component method and varimax rotation to ensure the bi-dimensional conception of egalitarianism. Table 5.1 presents the EFA results. The value of the KMO measure of sampling adequacy was 0.708 and the Bartlett's test of sphericity was highly significant ($p<0.001$). The EFA results suggested that egalitarianism comprises two items: equalization of living standards and equalization of incomes. The factor loadings of both items exceeded

0.7, indicating significant loads on a single factor. The score of Cronbach's alpha (0.759) met the conventional requirement of 0.7. As a result, the bi-dimensional measurement scale is reliable for capturing Hong Kong residents' egalitarian values. Thus, the ideological index, namely "egalitarianism," is formed. This variable ultimately assessed public support for social equality in Hong Kong with a 10-point scale, with a higher score indicating stronger egalitarian beliefs.

Table 5.1. EFA results: the items measuring egalitarianism

| Scale items | Factor loading |
|---|---|
| Equalization of living standards | 0.713 |
| Equalization of incomes | 0.713 |
| Cronbach's alpha (Reliability coefficient) | 0.759 |
| Eigenvalue | 1.96 |
| Variance explained | 60.90 |
| The Kaiser-Meyer-Olkin measure of sampling adequacy | 0.708 |
| Bartlett's test of sphericity | 0.000 |

Source: the author.

*5.1.2.3. Political trust-related variables*

The final set of explanatory variables reflects respondents' political trust and perceived quality of welfare institutions. Three variables were specifically considered: trust in political institutions, evaluation of government responsiveness, and perceived efficiency of the health system. The operationalization of political trust in this study rests on citizens' trust in various policy-making institutions. The typical single-dimension conception of political trust is too abstract to capture political trust since the process of policy-making generally involves multiple political actors (Stensöta and Bendz, 2020). Three items were hence proposed to measure public trust in various key political institutions involved in the formulation of social policy in Hong Kong, including the Chief Executive, government

officials, and legislators (Cheung, 2004, 2007). The questions were as follows: Respondents were asked to what extent they trusted the Chief Executive, government officials, and legislators. A 5-point Likert scale was applied to measure the three items: 1 denotes *absolutely distrust*, 2 denotes *distrust*, 3 denotes *neither distrust nor trust*, 4 denotes *trust*, and 5 denotes *absolutely trust*.

Table 5.2. EFA results: the items measuring political trust

| Scale items | Factor loading |
|---|---|
| Trust in the Chief Executive | 0.798 |
| Trust in government officials | 0.875 |
| Trust in Legislative Councillors | 0.822 |
| Cronbach's alpha (Reliability coefficient) | 0.837 |
| Eigenvalue | 2.40 |
| Variance explained | 75.50 |
| The Kaiser-Meyer-Olkin measure of sampling adequacy | 0.720 |
| Bartlett's test of sphericity | 0.000 |

Source: the author.

As shown in Table 5.2, three items formed the measurement scale of political trust and explained 75.5% of the variance. The KMO value (0.720), and Bartlett's test ($p<0.001$) both reported good factor-analytical results. The factor loadings of these three items exceeded 0.7 and Cronbach's alpha scored 0.837, demonstrating good reliability of the measurement scale. The additive index ranged from 3 to 15, with higher scores representing stronger political trust.

Perception of government responsiveness was measured by the item: "Do you think the SAR Government has considered your opinions about the VHIS reform?" Respondents were provided with binary response options, where a value of "1" indicates *not considered* and a

value of "2" indicates *considered*. For perceived systemic efficiency, respondents were asked to evaluate the level of efficiency of Hong Kong's health care system on a 10-point scale ranging from 0 (*very inefficient*) to 10 (*very efficient*).

## 5.2. The results of multi-dimensionality

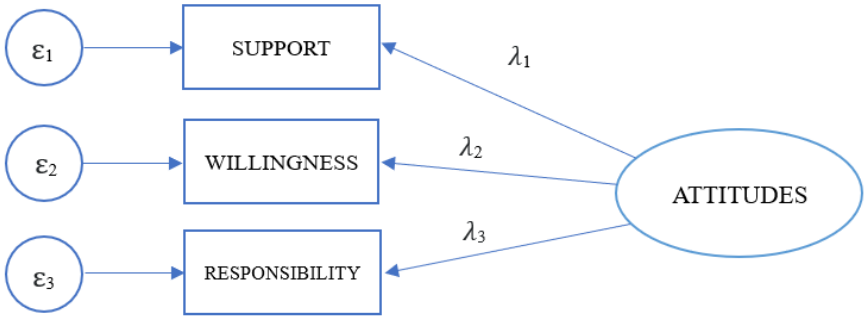
### 5.2.1. CFA model

A three-dimension CFA model with maximum likelihood estimation was used to examine the multi-dimensionality of respondents' welfare attitudes. One-factor hypothesized CFA model can be described below:

$$X_i = \lambda_i \xi + \varepsilon_i$$

where $X_i$ represents the three hypothesized attitudinal dimensions; $\xi$ is the latent construct representing public attitudes towards the health care financing reform (ATTITUDES). $\lambda_i$ are the regression coefficients in the relationship between each attitudinal dimension and the latent concept. $\varepsilon_i$ are the residual errors of $X_i$. Figure 5.1 displays the path diagram.

Figure 5.1. Path diagram of hypothesized CFA model




Source: the author.

### 5.2.2. Univariate and bivariate statistics

Univariate statistics were used to illustrate the general patterns of attitudes. Handling missing

data is a crucial issue for survey studies. The sample size of this survey is 1,016. The three attitudinal dimensions all contained missing values. Missing data include those unanswered or ambiguous answers such as “unknown” or “hard to say”. As shown in Table 5.3, the dependent variables, i.e. SUPPORT and WILLIGNESS, report a larger percentage of invalid responses. Most Hong Kong citizens were sitting on the fence since such a form of moderate retrenchment reform in health care was newly introduced. Hence, discarding missing data that fails to illustrate clear individual viewpoint is important for ensuring the accuracy of data.

Table 5.3 Frequency and percentage of missing data for dependent variables

| Dimensions | Frequency | % |
|---|---|---|
| Support for the health care financing reform | 164 | 16.1 |
| Willingness to purchase VHIS plans | 236 | 23.2 |
| Expectation regarding government responsibility in health care | 47 | 4.6 |

Source: the author.

Table 5.4 presents the descriptive results after discarding missing values. The SUPPORT[3] and WILLINGNESS[4] dimensions shared the same binary scale and the mean scores were 1.410 (SD=0.492) and 1.285 (SD=0.452) respectively. The mean score of the RESPONSIBILITY[5] dimension was 3.059 (SD=1.304).

[3] The median and the mode was 1 (*oppose*) for the SUPPORT dimension.
[4] The median and the mode was 1 (*unwilling*) for the WILLINGNESS dimension.
[5] The median was 3 (*neither agree nor disagree*) and the mode was 2 (*disagree*) for the RESPONSIBILITY dimension.

Table 5.4. Descriptive statistics for dependent variables

| Dimensions | Obs. | Mean | S.D. | Min. | Max. |
|---|---|---|---|---|---|
| Support for the health care financing reform | 852 | 1.410 | 0.492 | 1 (oppose) | 2 (support) |
| Willingness to purchase VHIS plans | 780 | 1.285 | 0.452 | 1 (unwilling) | 2 (willing) |
| Expectation regarding government responsibility in health care | 969 | 3.059 | 1.304 | 1 (absolutely disagree) | 5 (absolutely agree) |

Note: Missing values are excluded.

Source: the author.

To further interpret the descriptive results (see Table 5.5), less than half of the respondents (40.96%, *N*=852) supported the health care financing reform. Only about one third of them (28.46%, *N*=780) indicated their intention to purchase VHIS plans. The distribution of expectation regarding government responsibility in health care (*N*=969) appeared polarized, with 43.86% expressing positive views and 45.51% indicating negative views. The correlation between the attitudinal dimensions was first assessed to gain a brief understanding of how the three dimensions relate to each other. Table 5.6 reports the correlation matrix. All coefficients reflect a weak level of correlation between them.

Table 5.5. Distribution of public attitudes towards the health care financing reform

| Sample attitudinal characteristics | *N* | Frequency | % |
|---|---|---|---|
| Support for the health care financing reform | 852 | | |
| Support | | 349 | 40.96 |
| Oppose | | 503 | 59.04 |
| Willingness to purchase VHIS plans | 780 | | |
| Willing | | 222 | 28.46 |
| Unwilling | | 558 | 71.54 |
| Expectation regarding government responsibility in health care | 969 | | |
| Absolutely agree | | 167 | 17.23 |
| Agree | | 258 | 26.63 |
| Neither agree nor disagree | | 103 | 10.63 |
| Disagree | | 347 | 35.81 |
| Absolutely disagree | | 94 | 9.70 |

Source: the author.

Table 5.6. Correlations between dependent variables

| | 1 | 2 | 3 |
|---|---|---|---|
| 1. Support for the health care financing reform | 1.000 | | |
| 2. Willingness to purchase VHIS plans | 0.225 | 1.000 | |
| 3. Expectation regarding government responsibility in health care | -0.186 | -0.182 | 1.000 |

Sources: the author.

### 5.2.3. CFA results

The CFA model was conducted to detect the multi-dimensionality of attitudes towards the health care financing reform in a statistically rigorous way. The three-dimensional CFA model was analyzed using the sample size *N*=766[6]. As shown in Table 5.8, the CFA model

[6] Involving at least 200 samples in the estimation fulfils the basic assumptions of using CFA to examine the multidimensionality of instruments or scales. Larger sample size produces meaningful results with a higher level of construct validity (Shah & Goldstein, 2006; Wolf et al., 2013).

offers a good indication of multi-dimensionality. The result of Chi-square test was significant ($\chi 2$ (3) = 364.243, p-value = 0.000). The value of the root mean square error of approximation (RMSEA) and standardized root mean residual (SRMR) was 0.011 and 0.023, respectively. All these two values were both below the cut-off level of 0.05. For comparative fit index (CFI) and Tucker-Lewis index (TLI), both values (CFI = 0.972, TLI = 0.936) were substantially close to 1. All these fit indices suggest that the sample data well match the multi-dimensional measurement of attitudes towards the health care financing reform, ensuring the construct validity of the three-dimensional framework.

Table 5.7. Model description and fit indices for the CFA model

| | Three dimensions |
|---|---|
| Chi-squared | 364.243 |
| Degree of freedom (d*f*) | 3 |
| p-value | 0.000 |
| The root mean square error of approximation (RMSEA) | 0.011 |
| Comparative fit index (CFI) | 0.972 |
| Standardized root mean residual (SRMR) | 0.023 |
| Tucker–Lewis index (TLI) | 0.936 |
| *N* | 766 |

Source: the author.

Table 5.8. Factor loadings of the CFA model (standardized)

| | Factor loading | Proportion of shared variance |
|---|---|---|
| Support for the health care financing reform | -0.96*** | 0.87 |
| Willingness to purchase VHIS plans | -0.89*** | 0.81 |
| Expectation regarding government responsibility in health care | -0.82*** | 0.78 |

Source: the author.

The reliability of multi-dimensional measurement can be further examined by disentangling how the three attitudinal dimensions construct public perceptions of the reform. The factor loadings of the three attitudinal dimensions significantly exceeded the value of 0.8 (see Table 5.8). The dimensions SUPPORT and WILLINGNESS are the key constituents of a contra-attitudes towards the health care financing reform with a negative value of -0.96 and -0.89, respectively. Each of these two dimensions occupied over four-fifths of its variance. The remaining dimension RESPONSIBILITY is also strongly connected to the concept of attitudes towards health care reform in a negative way. But this dimension demonstrated a slightly lower factor loading (-0.82) and a lower percentage (three-fourths) of its variance.

The results reported above yield several important insights. First, three dimensions were discerned to constitute the underlying structure of citizens' attitudes towards the health care financing reform, including nominal support for the reform, willingness to purchase the proposed scheme, and expected role of the government in health care. It is too abstract to measure support for the reform with one single dimension, namely through support for the reform or expectation regarding government responsibility alone. It is because a successful reform that entails private financing, especially in voluntary nature, ultimately depends on people's intention to pay for the reform costs. Hence, citizens' willingness to pay serves as a critical dimension for reflecting public acceptance of individual responsibility for shouldering health care costs (Yamamura, 2015; Algan et al., 2016; Habibov, Cheung & Auchynnikava, 2017).

Second, the statistical analyses provide a clear picture of the underlying attitudinal structure. Attitudes towards the health care financing reform present a general idea of unfavorable views towards support for private financing and purchasing government-regulated insurance plans, but at the same time less desire for extensive government responsibility in health care.

In tradition, Hong Kong citizens generally have a weaker sense of private responsibility over health care since they have long enjoyed extensive and low-cost public medical services provided by the government (Leung et al., 2005). Yet, given the voluntary nature of the VHIS reform, 28.46% of respondents indicated their willingness to purchase, reflecting that public interest in private health insurance is not low. For instance, the subscription rate of private health insurance in other societies with universal health care coverage, such as the United Kingdom and Finland, is 10.4% and 21.9% respectively (OECD, 2019). As a result, this study argues that people are not necessarily unwilling to shoulder private responsibility in health care as long as market risks can be reduced.

Third, an interesting observation has been made is that citizens tend to offer less support for direct service provision by the SAR Government. Instead, people may be eager to seek government involvement in health care via other forms such as reforming the institutional structure or regulating private (insurance) market to improve systemic efficiency, ensure more equal access to private care and reduce market risks. It can be concluded that a health care financing reform emphasizing private financing may not be entirely unpopular as long as the government bears greater responsibility to reduce market risks.

### 5.3. Univariate statistics

The descriptive characteristics of the respondents are presented below (see Table 5.9). Out of 1,016 respondents, 38.29% were male. The age of the respondents was normally distributed, which was consistent with the demographic characteristics of the general Hong Kong population. 44.73% of the respondents were below 50 years old, 22.81% were aged between 50 and 59, and 32.46% were 65 years old or above. With respect to the level of education, 46.87% of the respondents had attained a secondary education and 35.42% had a tertiary education or above. Approximately 13.09% of the respondents earned HK$30,000 or more

per month, while most of them (55.18%) earned less than HK$10,000 per month. Most respondents (74.04%) were married.

Table 5.9. Descriptive statistics of variables of interest

| | Obs. | Frequency | % | Mean | S.D. | Min. | Max. |
|---|---|---|---|---|---|---|---|
| Gender | 1,016 | | | 1.617 | 0.486 | 1 | 2 |
| Male | | 389 | 38.29 | | | | |
| Female | | 627 | 61.71 | | | | |
| Age | 995 | | | 3.357 | 1.355 | 1 | 5 |
| 18 –29 | | 150 | 15.08 | | | | |
| 30 –39 | | 122 | 12.26 | | | | |
| 40 –49 | | 173 | 17.39 | | | | |
| 50 –64 | | 323 | 32.46 | | | | |
| 65 or above | | 227 | 22.81 | | | | |
| Education | 1,005 | | | 2.177 | 0.707 | 1 | 3 |
| Primary or below | | 178 | 17.71 | | | | |
| Secondary | | 471 | 46.87 | | | | |
| Tertiary or above | | 356 | 35.42 | | | | |
| Personal monthly income | 955 | | | 1.579 | 0.782 | 1 | 3 |
| Below HK$10 ,000 | | 527 | 55.18 | | | | |
| HK$10 ,000 –29 ,999 | | 303 | 31.73 | | | | |
| HK$30 ,000 or above | | 125 | 13.09 | | | | |
| Marital status | 913 | | | 1.740 | 0.439 | 1 | 2 |
| Single | | 237 | 25.96 | | | | |
| Married | | 676 | 74.04 | | | | |
| Self-reported health status | 1,015 | | | 2.515 | 0.782 | 1 | 5 |
| Very bad | | 17 | 1.67 | | | | |
| Bad | | 47 | 4.63 | | | | |
| Neither good nor bad | | 463 | 45.62 | | | | |
| Good | | 403 | 39.70 | | | | |
| Very good | | 85 | 8.37 | | | | |
| Insurance enrolment status | 1,009 | | | 2.790 | 1.384 | 1 | 4 |
| Un-insured | | 530 | 52.53 | | | | |
| Insured by PHI only | | 351 | 34.79 | | | | |
| Insured by GHI only | | 40 | 3.96 | | | | |
| Insured by both PHI and GHI | | 88 | 8.72 | | | | |
| Egalitarianism | 884 | | | 5.412 | 1.597 | 2 | 10 |
| 1– 5 (Disagree) | | 372 | 42.08 | | | | |
| 6 – 10 (Agree) | | 512 | 57.92 | | | | |
| Political trust | 894 | | | 8.200 | 2.407 | 3 | 15 |
| 0 – 7 (Distrust) | | 750 | 83.89 | | | | |
| 8 – 15 (Trust) | | 144 | 16.11 | | | | |
| Perceived responsiveness | 797 | | | 1.501 | 0.500 | 1 | 2 |
| Not considered | | 398 | 49.94 | | | | |
| Considered | | 399 | 50.06 | | | | |
| Perceived systemic efficiency | 1,003 | | | 5.682 | 1.884 | 0 | 10 |
| 0 – 4 (Inefficiency) | | 184 | 18.34 | | | | |
| 5 (Neither inefficiency nor efficiency) | | 318 | 31.70 | | | | |
| 6 – 10 (Efficiency) | | 501 | 49.95 | | | | |

Note. Missing values are excluded from the descriptive statistics.

Source: the author.

Many respondents (45.62%) self-reported their health status as average and almost half of

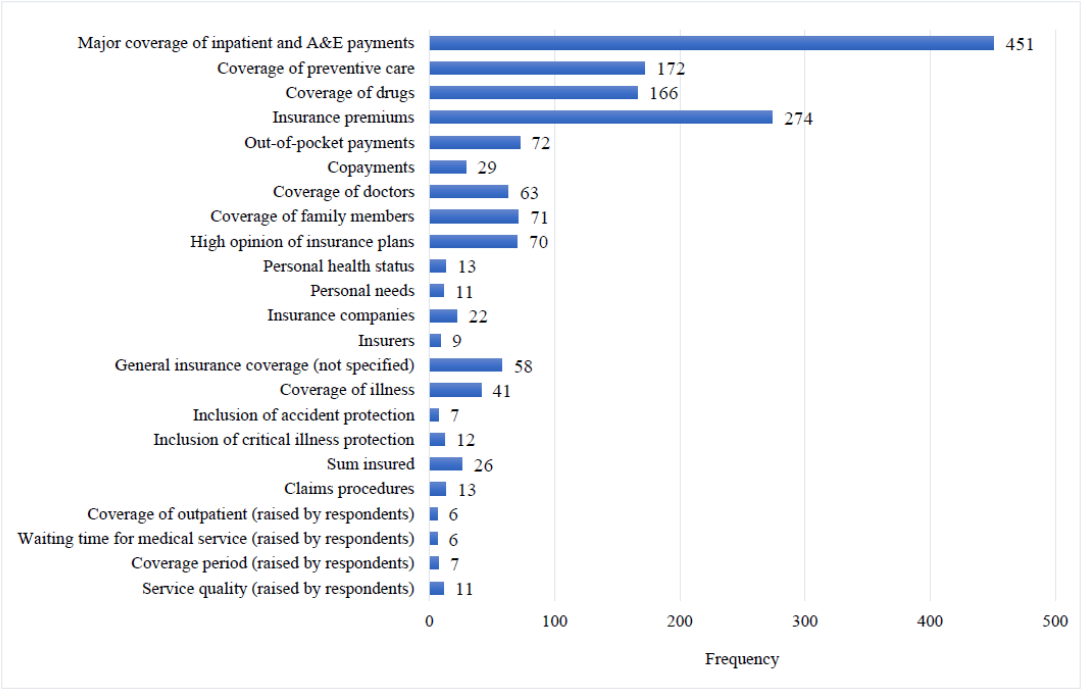
them (48.07%) claimed their health status as either good or very good. In terms of insurance enrolment status, 34.79% already held private health insurance, 3.96% were insured by group health insurance only, 8.72% were insured by both PHI and GHI, and 52.53% were not insured at all. Clearly, private health insurance has barely penetrated to one third of the sample.

In addition, 57.92% of the respondents held clear egalitarian views, reflecting a relatively high level of egalitarianism in the sample (Mean=5.412, S.D.=0.473, Min=2, Max=10). 83.9% distrusted the political institutions (i.e., the Chief Executive, government officials, and legislators), denoting a low level of political trust (Mean=8.2, S.D.=2.407, Min=3, Max=15). Nearly half of the respondents (50.06%) perceived that the SAR Government had taken into account their views in the reform (Mean=1.501, SD=0.500, Min=1, Max=2). Finally, about half of the respondents (49.95%) evaluated the local health system as being efficient while 31.7% reported a neutral perception, resulting in a moderate level of perceived systemic efficiency (Mean=5.682, S.D.=1.884, Min=0, Max=10).

Respondents were also invited to indicate the most important factors that they consider when making decisions about purchasing private health insurance. The results are shown in Figure 5.2. The two most important factors were (a) whether the insurance plan covers inpatient and emergency services and (b) the amount of premiums. Given the long waiting times in public hospitals, private insurance is expected to mainly cover inpatient costs incurred in private hospitals and provide the insured persons with faster access to care. In addition, the VHIS plans are provided by commercial insurance companies but must be regulated by the SAR Government with MRs. To avoid risk selection, premiums are likely to rise with increasing age and health risks. Therefore, insurance premiums have become an important factor that can affect people's purchase decisions. These univariate statistics suggest that citizens were

not completely resistant to the idea of shouldering private responsibility in health care, but their decisions rather depend on various practical considerations.

Figure 5.2. Respondents' general views on important factors in purchasing PHI




Source: the author.

## 5.4. Bivariate results

Bivariate analysis is employed to estimate the correlation between key variables. Table 5.10 presents the estimated correlations together with the descriptive statistics. The correlation analysis provides a preliminary estimation of the relationships between sets of hypothesized factors and welfare attitudes in multiple dimensions. With respect to the self-interest concept, gender ($p<0.01$), age ($p<0.05$), and insurance enrolment status ($p<0.05$) were found to be significantly correlated with individuals' support for the financing reform. Public willingness to purchase VHIS plans was significantly linked to most of the factors related to self-interest, including gender ($p<0.01$), age ($p<0.05$), personal monthly income ($p<0.01$), and insurance enrolment status ($p<0.05$). Expectation regarding government responsibility in health care

was related to most of the explanatory variables, including gender ($p<0.1$), age ($p<0.01$), education ($p<0.01$) and marital status ($p<0.01$).

Egalitarian values demonstrated significant correlation with Hong Kong citizens' support for the proposed reform ($p<0.05$) and their expectation regarding government involvement in the healthcare arena ($p<0.01$). The three trust factors were significantly correlated with perceptions of the reform across dimensions. Both political trust ($p<0.01$) and perceived government responsiveness ($p<0.01$) were strongly related to all attitudinal dimensions. Perceived efficiency of health system was correlated with nominal support for the reform ($p<0.05$), and preferences for government responsibility in healthcare ($p<0.05$). No statistically significant relationship was noted between perceived efficiency of the health system and willingness to shoulder private responsibility by purchasing private insurance. Overall, these results suggested that the effects of various predictors on attitudinal dimensions varied, and two institutional evaluation factors, that is, political trust and perceived responsiveness, demonstrated strongest correlations with all attitudinal dimensions.

Table 5.10. Bivariate analysis of explanatory and dependent variables

| | Support for the reform | | Willing to purchase | | Government responsibility | |
|---|---|---|---|---|---|---|
| Variables | % | $\chi^2$ | % | $\chi^2$ | % | $\chi^2$ |
| Total sample | 40.96 | | 28.46 | | 43.86 | |
| Gender | | 15.9570*** | | 8.5794*** | | 9.3369* |
| Male | 20.19 | | 13.59 | | 15.69 | |
| Female | 20.77 | | 14.87 | | 28.17 | |
| Age | | 14.8778** | | 10.5615** | | 43.0377*** |
| 18 –29 | 6.93 | | 3.65 | | 9.15 | |
| 30 –39 | 4.07 | | 2.63 | | 6.31 | |
| 40 –49 | 6.78 | | 4.85 | | 8.21 | |
| 50 –64 | 9.33 | | 8.47 | | 9.04 | |
| 65 or above | 13.85 | | 8.86 | | 11.15 | |
| Education | | 2.3811 | | 2.4481 | | 25.7053*** |
| Primary or below | 7.34 | | 4.39 | | 6.16 | |
| Secondary | 18.23 | | 13.60 | | 19.18 | |
| Tertiary or above | 15.39 | | 10.47 | | 18.52 | |
| Personal monthly income | | 0.7405 | | 9.8327*** | | 9.5440 |
| Below HK$10 ,000 | 21.77 | | 13.14 | | 23.08 | |
| HK$10 ,000 –29 ,999 | 13.12 | | 10.16 | | 15.46 | |
| HK$30 ,000 or above | 6.07 | | 5.16 | | 5.32 | |
| Marital status | | 2.3723 | | 0.2187 | | 30.2350*** |
| Single | 12.02 | | 7.01 | | 12.98 | |
| Married | 28.94 | | 21.45 | | 30.88 | |
| Self-reported health status | | 0.6054 | | 0.9069 | | 16.8423 |
| Very bad | 0.70 | | 0.76 | | 0.40 | |
| Bad | 2.00 | | 1.41 | | 1.75 | |
| Neither good nor bad | 17.95 | | 12.56 | | 19.93 | |
| Good | 16.67 | | 11.30 | | 17.76 | |
| Very good | 3.64 | | 2.43 | | 4.02 | |
| Insurance enrolment status | | 3.9464** | | 7.920** | | 6.9065 |
| Un-insured | 19.55 | | 13.63 | | 22.43 | |
| Insured by PHI only | 15.90 | | 10.81 | | 15.37 | |
| Insured by GHI only | 1.87 | | 1.32 | | 1.99 | |
| Insured by both PHI and GHI | 3.64 | | 2.70 | | 4.07 | |
| Egalitarianism | | 9.8219** | | 11.6535 | | 86.5492*** |
| 1– 5 (Disagree) | 17.64 | | 13.38 | | 17.46 | |
| 6 – 10 (Agree) | 23.32 | | 15.08 | | 26.40 | |
| Political trust | | 37.7615*** | | 43.0299*** | | 112.8441*** |
| 1 – 7 (Distrust) | 7.82 | | 7.32 | | 4.28 | |
| 8 – 15 (Trust) | 33.14 | | 21.14 | | 39.58 | |
| Perceived responsiveness | | | | | | |
| Not considered | 15.19 | 28.9412*** | 9.37 | 34.2601*** | 24.78 | 24.4127*** |
| Considered | 25.77 | | 19.09 | | 19.08 | |
| Perceived systemic efficiency | | 22.3150** | | 9.8390 | | 62.5790** |
| 0 – 4 (Inefficiency) | 6.55 | | 4.53 | | 9.76 | |
| 5 (Neither inefficiency nor efficiency) | 12.46 | | 8.54 | | 13.14 | |
| 6 – 10 (Efficiency) | 21.95 | | 15.39 | | 20.96 | |

Note: Missing values are excluded from the descriptive statistics and bivariate analysis; *p<0.1, **p<0.05, ***p<0.01.

## 5.5. Multivariate results

Multivariate analyses were employed to examine the determinants of public attitudes towards the health care financing reform in multiple dimensions. In this study, binomial logistic regression and ordered probit regression models were chosen as the key statistical methods to

examine how the factors derived from the three theoretical perspectives shape public attitudes. In addition, the interplay between self-interest and ideological explanatory mechanisms was tested by moderation analysis.

5.5.1. Logistic regression models and moderation analysis

Given the nature of the dependent variables, the binomial logistic and ordered probit regression methods were selected for analysing binary and ordinal dependent variables, respectively. The independent effects of each of the orientations of self-interest were tested in the first model. Seven socio-demographic factors representing self-interest were included, i.e. gender, age, education, monthly income, marital status, self-reported health status, and insurance enrolment status (i.e. Model 1, Model 5, Model 9). The second regression model added the ideology-related variable, egalitarianism. This model identified the individual impact of ideological commitment to egalitarianism on attitudes towards the reform by controlling for the self-interest factors (i.e. Model 2, Model 6, Model 10). In the third model, a set of trust-related factors (i.e. political trust, perceived government responsiveness, and perceived systemic efficiency) were included to give a more comprehensive illustration of the trust-related arguments, while controlling for self-interest and ideological factors. This model examining twelve explanatory variables provided the central core for analysis under the integrated framework (i.e. Model 3, Model 7, Model 11).

In addition, ideological orientations and self-interest motivations are not contradictory frameworks (Azar et al., 2018; Gilessen, 2000). To test the moderation effect between egalitarian ideology and one's socio-economic position, a moderated regression model was performed on each attitudinal dimension. The fourth model included the two-way interaction terms egalitarianism × income, with the other self-interest and trust-related variables controlled for (i.e. Model 4, Model 8, Model 12). This model gives a more comprehensive

explanation for the complex formation of welfare attitudes towards the reform. Since the purpose of this study was to examine and compare the determinants of public attitudes towards the health care financing reform in multiple dimensions, the models for each dependent variable were formulated and specified in the same way.

5.5.2. Reliability and validity of regression models

Twelve regression models were analysed to test the hypotheses. No multi-collinearity (VIF < 10) between the variables was found in the models. The values of tolerance were all greater than 0.5, exceeding the minimum requirement (i.e. 0.2). Hence, these results satisfied the basic statistical assumption of using the regression models in this study. Table 5.11 shows the result of multi-collinearity tests of all the explanatory variables in different regression models.

Table 5.11. Multi-collinearity tests of the explanatory variables

| | Support for the reform | | Willingness to purchase | | Government responsibility | |
|---|---|---|---|---|---|---|
| | VIF | Tolerance | VIF | Tolerance | VIF | Tolerance |
| Gender | 1.08 | 0.9262 | 1.07 | 0.9318 | 1.07 | 0.9388 |
| Age | 2.06 | 0.5845 | 2.00 | 0.6000 | 2.04 | 0.5911 |
| Education | 1.54 | 0.6480 | 1.52 | 0.6562 | 1.53 | 0.6552 |
| Personal monthly income | 1.57 | 0.6352 | 1.64 | 0.6094 | 1.57 | 0.6363 |
| Marital status | 1.81 | 0.5516 | 1.82 | 0.5500 | 1.83 | 0.5475 |
| Self-reported health status | 1.11 | 0.8980 | 1.14 | 0.8774 | 1.10 | 0.9062 |
| Insurance enrolment status | 1.32 | 0.7587 | 1.35 | 0.7422 | 1.30 | 0.7703 |
| Egalitarianism | 1.07 | 0.9317 | 1.09 | 0.9136 | 1.08 | 0.9240 |
| Political trust | 1.27 | 0.7855 | 1.26 | 0.7923 | 1.25 | 0.8024 |
| Perceived responsiveness | 1.20 | 0.8342 | 1.21 | 0.8276 | 1.19 | 0.8390 |
| Perceived systemic efficiency | 1.10 | 0.9125 | 1.11 | 0.9044 | 1.11 | 0.8999 |
| Mean VIF | 1.38 | | 1.38 | | 1.37 | |

Source: the author.

To examine the reliability of the model results, several regression models were employed for each attitudinal dimension with and without controlled variables. Table 5.12, Table 5.13, and Table 5.14 present the multivariate results of the three dependent variables, respectively. All models produced significant Chi-square statistics (d$f$, $p<0.001$), indicating that the explanatory variables reliably predicted all the dependent variables. In the SUPPORT dimension, the percentage of variance explained increased from 7.51% to 10.88% in Model 2, and further to 20.85% and 25.28% in Model 3 and Model 4, respectively. Model 5 explained 10.5% of the variance in the WILLINGNESS dimension. The percentage increased to 11.29% in Model 6, and further strengthened to 19.76% and 24.58% in Model 6 and Model 8, respectively. The percentage of variance explained in Model 9 was 5.01% in the

RESPONSIBILITY dimension. The percentage increased to 9% in Model 10, to 17.95% in Model 11, and finally to 23.93% in Model 12.

5.5.3. Predictors of public support for the health care financing reform

The general level of support for the reform served as the first attitudinal dimension in this study. This dimension was regressed with binomial logistic models, given the binary outcomes (see Table 5.12). Gender was a very powerful indicator for predicting support for the health care financing reform. Women were more likely to oppose the reform than men. The association between gender and support for reform was found to be very significant in all four models ($p<0.01$). In line with the theoretical expectation, it was found that Hong Kong women tend to be more reluctant to support a health care financing reform that emphasizes individual responsibility, even though the VHIS is not mandatory. This echoes the results of most previous studies that women tend to support government-funded health policies instead of retrenchment reforms, even a moderate one (Gevers et al., 2000; Staerklé et al., 2012). The desire of risk aversion appeared to be at play.

Individuals aged between 30 and 39 tended to oppose the reform ($p<0.05$), while those aged 65 or above ($p<0.05$) were more likely to support it. While the statistical effect of other age groups was insignificant, the attitudinal cleavage in age did emerge. This link reflected that the older generation held a positive perception of stronger private responsibility whereas the middle aged appeared more likely to oppose such initiatives. The results of generational differences offer room for investigation for two lines of self-interest expectations. On one hand, the results reflect some degree of risk aversion: older adults tend to oppose private financing and seek greater government protection against unintended health costs due to their higher exposure to health risks and declining health conditions. On the other hand, the VHIS reform attempts to improve the efficiency of public medical system if people with higher

levels of financial capability would shift from the public to the private sector. As the major users of public hospitals, the elderly believe that the reform would relieve pressure on the overloaded public system, leading them to faster access to care.

This study found significant effect of educational levels in people's attitudes towards the financing reform. Individuals with higher educational qualifications were more supportive of the reform, although the statistical significance of having secondary education slightly declined in Model 3 and Model 4 ($p<0.1$). As expected, the results can be explained by the fact that people with a better education tend to have richer financial literacy that in turn prompts them to appreciate the value of private health insurance as well as the principle of individual responsibility in welfare.

The statistical relationship between marital status and public support for the reform were significant. When compared with singletons, married individuals demonstrated a negative perception of the reform. The levels of statistical significance were consistent across the four models ($p<0.05$). In line with the theoretical prediction, the result implies that married Hong Kong citizens were more likely to oppose private financing in health care, in part reflecting the influence of defamilization in Hong Kong (Walker & Wong, 2005).

Table 5.12. Results of binomial logistic regression analysis of support for the health care financing reform

| | Model 1 | | Model 2 | | Model 3 | | Model 4 | |
|---|---|---|---|---|---|---|---|---|
| | OR | 95% CI | OR | 95% CI | OR | 95% CI | OR | 95% CI |
| Gender | | | | | | | | |
| Male | 1 | | 1 | | 1 | | 1 | |
| Female | 0.526*** | [0.381, 0.729] | 0.523*** | [0.375, 0.731] | 0.444*** | [0.291, 0.677] | 0.447*** | [0.297, 0.692] |
| Age | | | | | | | | |
| 18 –29 | 1 | | 1 | | 1 | | 1 | |
| 30 –39 | 0.824** | [0.423, 1.606] | 0.715** | [0.404, 1.567] | 0.566** | [0.251, 1.278] | 0.590** | [0.318, 1.500] |
| 40 –49 | 1.140 | [0.584, 2.229] | 1.140 | [0.571, 2.277] | 1.150 | [0.500, 2.645] | 1.153 | [0.509, 2.811] |
| 50 –64 | 1.130 | [0.602, 2.121] | 1.089 | [0.569, 2.081] | 1.037 | [0.467, 2.303] | 1.029 | [0.535, 2.383] |
| 65 or above | 2.289** | [1.149, 4.559] | 2.174** | [1.059, 5.062] | 2.095** | [0.816, 5.381] | 2.093** | [0.798, 5.489] |
| Education | | | | | | | | |
| Primary or below | 1 | | 1 | | 1 | | 1 | |
| Secondary | 1.091** | [0.560, 1.485] | 1.097** | [0.579, 1.610] | 1.077* | [0.387, 1.526] | 1.079* | [0.398, 1.663] |
| Tertiary or above | 1.186** | [0.558, 1.743] | 1.127** | [0.567, 1.860] | 1.148*** | [0.383, 1.883] | 1.157*** | [0.471, 1.842] |
| Personal monthly income | | | | | | | | |
| Below HK$10 ,000 | 1 | | 1 | | 1 | | 1 | |
| HK$10,000 –29,999 | 1.089 | [0.670, 1.501] | 1.098 | [0.647, 1.492] | 1.095 | [0.571, 1.589] | 1.096 | [0.518, 1.370] |
| HK$30,000 or above | 1.160 | [0.605, 1.860] | 1.195 | [0.534, 2.169] | 1.254 | [0.606, 2.594] | 1.272 | [0.669, 2.607] |
| Marital status | | | | | | | | |
| Single | 1 | | 1 | | 1 | | 1 | |
| Married | 0.592** | [0.362, 0.969] | 0.618** | [0.370, 1.032] | 0.692** | [0.366, 1.304] | 0.662** | [0.364, 1.134] |
| Self-reported health status | | | | | | | | |
| Very bad | 1 | | 1 | | 1 | | 1 | |
| Bad | 1.291 | [0.522, 2.624] | 1.386 | [0.437, 2.413] | 1.383 | [0.643, 2.975] | 1.347 | [0.574, 2.951] |
| Neither good nor bad | 1.921** | [0.620, 3.930] | 1.982** | [0.847, 3.764] | 1.834** | [0.849, 3.961] | 1.841** | [0.801, 3.794] |
| Good | 4.631*** | [0.651, 8.085] | 4.499** | [1.573, 7.919] | 4.750** | [1.209, 8.658] | 4.719** | [1.249, 8.819] |
| Very good | 1.838 | [0.172, 2.070] | 1.929 | [0.174, 2.270] | 1.700 | [0.143, 2.286] | 1.742 | [0.128, 2.273] |
| Insurance enrolment status | | | | | | | | |
| Un-insured | 1 | | 1 | | 1 | | 1 | |
| Insured by PHI only | 1.689*** | [1.141, 2.356] | 1.702*** | [1.173, 2.869] | 1.914** | [1.186, 3.090] | 1.897** | [1.183, 2.962] |
| Insured by GHI only | 1.734 | [0.730, 4.119] | 1.814 | [0.734, 4.484] | 1.582 | [0.520, 4.816] | 1.585 | [0.605, 4.917] |
| Insured by both PHI and GHI | 1.248* | [0.689, 2.263] | 1.264* | [0.690, 2.316] | 1.447* | [0.692, 3.149] | 1.444** | [0.600, 2.924] |
| Egalitarianism | | | 1.154** | [0.989, 1.347] | 1.110** | [0.915, 1.346] | 1.136** | [1.050, 1.782] |
| Political trust | | | | | 1.115*** | [1.017, 1.222] | 1.116*** | [1.024, 1.119] |
| Perceived responsiveness | | | | | | | | |
| Not considered | | | | | 1 | | 1 | |
| Considered | | | | | 2.085*** | [1.364, 3.187] | 2.095*** | [1.372, 3.015] |
| Perceived systemic efficiency | | | | | 1.063*** | [0.948, 1.192] | 1.069*** | [0.963, 1.189] |
| Egalitarianism × Personal monthly income | | | | | | | | |
| Below HK$10 ,000 | | | | | | | 1 | |
| HK$10,000 –29,999 | | | | | | | 0.799 | [0.541, 1.181] |
| HK$30,000 or above | | | | | | | 0.587** | [0.341, 1.008] |
| Model summary chi square | 72.52 | | 100.70 | | 128.52 | | 139.50 | |
| (d.f. p value) | (18, p < 0.001) | | (18, p < 0.001) | | (22, p < 0.001) | | (23, p < 0.001) | |
| Pseudo $R^2$ | 0.0751 | | 0.1088 | | 0.2085 | | 0.2561 | |
| -2 Log likelihood | 440.378 | | 412.379 | | 257.421 | | 234.810 | |
| N | 730 | | 694 | | 548 | | 548 | |

Note. Missing values are excluded from the multivariate analysis; *p<0.10, **p<0.05, ***p<0.01.

When compared with individuals in poor health, those who reported health status as neither bad nor good ($p<0.05$) and very good ($p<0.05$) held a favourable stance towards the VHIS reform. Clearly, people in poor health—one of the high-risk groups—showed opposition to the reform that carries moderate retrenchment. As the major users of Hong Kong's public hospital system, they are very likely to adhere to this highly equitable system, in part offsetting the intended effects of the reform.

Contrary to common expectations that people without any insurance coverage tend to be more risk averse, this study has found that individuals who are already covered by private health insurance were actually more supportive of the reform. Although the statistical significance diminished in Model 3 and Model 4, the influence on public support for the reform remained strong ($p<0.05$). Those insured by both PHI and GHI also demonstrated stronger support for the reform, albeit with a slightly lower explanatory power. Having an existing private insurance policy usually reflects individuals' greater risk awareness and financial literacy, and thereby reinforces his/her recognition of the value of the VHIS reform. Since the public medical system offers universal accessibility to all citizens regardless of their financial capability, the absence of insurance coverage does not create an urgent need for an insurance coverage even for people in poor health.

Unexpectedly, high-income individuals did not necessarily favour the health care financing reform. No statistical significance was found between income and nominal support. Hypotheses $H_{4a}$ and $H_{5a}$ were thus rejected. The empirical result offers additional evidence in the East-Asian context that welfare attitudes in the health system are largely independent from socio-economic class and social position (Gelissen, 2002), but rather are mainly built on social solidarity (He, 2018). In Hong Kong, equal access to public medical system is guaranteed to every citizen. Given the voluntary nature of the reform, citizens are not

obligated to bear private responsibility or sacrifice current benefits. Therefore, public support for the reform depends more on the welfare-related status of the individuals, such as being welfare beneficiaries, taxpayers, or service providers, than on their socio-economic status.

Model 2, Model 3 and Model 4 strongly indicate that public support for the reform was influenced by social ideology to a larger extent. Individuals with a stronger belief in social equality showed a significantly higher level of support for the reform ($p<0.05$). The principle of equality might foster social solidarity (Miller, 2000; Newdick, 2017): Egalitarians in Hong Kong, as seen elsewhere, may feel obligated to assume private responsibility for their health care costs in order to contribute to efficient resource allocation in the public medical system.

In Model 3 and Model 4, all political trust-related factors, namely political trust, perceived responsiveness of the government and perceived efficiency of the health system, demonstrated a strong impact on public support for the reform. Individuals with a higher level of political trust were significantly more likely to support to the VHIS reform ($p<0.01$). Citizens' trust in the capability of various policy-making institutions to properly regulate the insurance market is a crucial factor to foster their acceptance of health care reform that involves trade-offs. This statistical link could be further extrapolated to people's fundamental trust in the political institutions, reassuring citizens that the government decisions, no matter how unpopular they are, are most conducive to people's interest in the long-run. Unfortunately, as this study suggests, the harsh political landscape during the leadership of the Leung administration (when this reform was undertaken) posed serious constraints in the policy-makers' ability to undertake major reforms due to mounting political distrust.

Government responsiveness considerably influenced public acceptance of private financing. In line with the theoretical prediction made in this study, it was found that individuals who

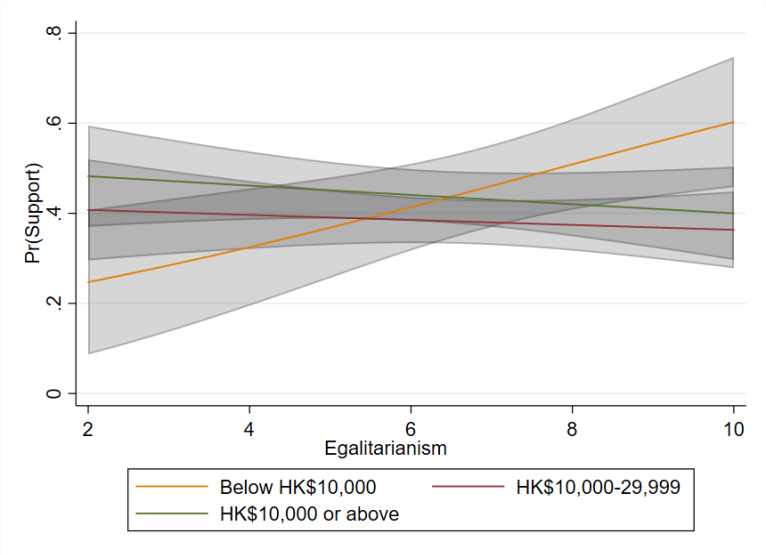
perceived the SAR Government as responsive were more supportive of the reform ($p<0.01$). Hong Kong citizens have become increasingly concerned with democratic development in the post-handover era. As a result, they have growing expectations regarding the SAR Government to be more responsive and accountable to the society. Therefore, when citizens have the opportunity to participate in and influence policy-making, they tend to develop a more supportive stance towards government-led policy reforms (He & Ma, 2020). This finding provides strong empirical support to substantiate the importance of being responsive in order to maintain the legitimacy of health policy, especially when it comes to retrenchment reforms emphasizing private responsibility.

This study has also identified an interesting paradox: perceived systemic efficiency was positively linked to support for the health care financing reform. Individuals who perceived the system as efficient showed greater support for the reform ($p<0.01$). Conventional wisdom suggests that if the public attribute the poor performance of the health system to insufficient resource allocation, people tend to expect necessary reforms (Wendt & Naumann, 2018; Calzada & Del Pino, 2008). In Hong Kong, as the quantitative result reveals, favourable assessment of the health system actually prompts people to support the reform, creating a positive policy feedback (He, Ratigan & He, 2020). Because the VHIS attempts to transfer economically better-off patients to the private sector, it somehow serves as a solution to address the current challenge of having an over-pressured public system. The fairly high level of satisfaction with Hong Kong's health care system seems to have raised public expectations for more efficient delivery of quality care. Therefore, this study offers unique evidence of how positive experience with a health system actually increases popular support for moderate retrenchment reform, especially in a system that enjoys wide public endorsement.

After estimating the impact of the three theoretical frameworks, the interplay between self-

interest considerations and ideological disposition was examined. Model 4 discovered that interaction term of egalitarianism × monthly income HK$30,000 or above (OR = 0.587, $p<0.05$) was negatively significant. To further disentangle how egalitarian effects vary across income levels, Figure 5.3 presents a stronger conditioned effect among low-income groups. There results indicate that as egalitarianism increases, stronger support for the reform is found among the low-income individuals rather than the high-income individuals.

Figure 5.3. Probability of support dimension by egalitarianism, moderated by income




Source: the author.

The result above provides support for the expectation that ideological beliefs are more important to shape policy preferences of citizens' in low-income status (Geliseen, 2000). One possible explanation is that low-income groups hold stronger egalitarian beliefs due to their relatively economically insecure position and weaker competitiveness in the labour market (Korpi & Palme, 2003; Svallfors, 2004). One of the major goals of the VHIS reform is to promote private financing and leave more resources to the poor. Therefore, these socio-economically disadvantaged individuals tend to offer stronger support for government's efforts to improve the efficiency of public medical system and reduce social inequality.

5.5.4. Motivation for public willingness to purchase VHIS plans

As health care reforms often involve trade-offs, an investigation into public willingness to purchase VHIS plans provides a practically relevant attitudinal dimension to measure the incentive for Hong Kong people to pay for financing reform. In contrast to the general support for the reform, the intention to purchase VHIS plans acts as a key and necessary attitudinal dimension to examine what factors motivate people to shoulder greater private financial responsibility in health care.

As on the first dependent variable, gender still served as a strong predictor, although the statistical significance slightly diminished in the subsequent three models ($p<0.05$) (see Table 5.13). Women opposed the reform that emphasizes private responsibility, and they also demonstrated less motivation to purchase VHIS plans than men. This result reinforced the finding identified in the first dimension in that women, tend to stand against welfare retrenchment reforms in comparison with men.

People aged between 50 and 64 ($p<0.01$) and those aged 65 or above ($p<0.5$) were more willing to pay for the reform by purchasing VHIS plans, a vivid reflection of adverse selection and risk aversion. Exposed to higher health risks, the aged naturally demonstrated a stronger intention to purchase VHIS plans for financial protection against catastrophic expenditures. Having a private insurance policy would also grant them faster access to the private system a fact that is particularly appreciated by those who are deterred by the long waiting times in the public medical system and have the financial capability to pay. In addition, the statistical significance of the group aged 60 and above was smaller than that of the 50–59 age group; their lower interest in the VHIS may be explained by the availability of a broader range of medical benefits for older adults provided by the SAR Government, such

as the Elderly Health Care Voucher Scheme, that lowers their demand for additional financial protection.

People with higher educational attainment were more willing to purchase VHIS plans. Having a secondary level of education ($p<0.1$) and tertiary level of education ($p<0.05$) was significantly associated with stronger intention to obtain additional insurance coverage, arguably because of higher financial literacy and risk awareness.

In contrast to the support dimension, monthly income became a negative predictor in the second attitudinal dimension. Individuals who earned a higher income tended to demonstrate greater interest in purchasing VHIS plans ($p<0.05$). The economically better-off people welcomed the wider range of alternatives in the private sector that provided greater flexibility and higher quality health services (He, 2017; Wong et al., 2010). Clearly, this insurance-subscription decision was chiefly determined by self-interested motives. Middle-income earners (HK$10,000-29,999/month) demonstrated greater motivation to obtain private health insurance than their high-income peers. According to the research by Statista Research Department (2019) in Hong Kong, high-income groups are the major patrons of private health insurance, and hence, many of the high-income earners in the sample are very likely to have already been insured. As a result, the middle-income groups should be taken as the key target group of the VHIS reform.

Marital status was also noted to be a significant predictor of one's motivation for purchasing VHIS plans. Married individuals appeared to be less willing to support private financing and shoulder private responsibility in health care through obtaining private insurance ($p<0.05$). Again, one possible explanation is the diminishing role of mutual family support. The proliferation of nuclear families, coupled by mounting pressure of daily living in Hong Kong,

has considerably weakened married individuals' ability to shoulder the responsibility of financing health care for their family members. Instead, they are very likely to continue to rely on the public hospital system.

Self-reported health status was statistically significant in predicting one's intention to purchase VHIS plans in all models. When compared with individuals in poor health, those who reported health status as neither bad nor good ($p<0.01$) and very good ($p<0.05$) were more inclined to subscribe to VHIS plans. This finding appears to defy the adverse selection effect as high-risk people do not necessarily intend to obtain insurance coverage. In effect, if we examine the finding with reference to the Hong Kong context, this simply suggests that those in poorer health, namely the frequent users of health services, will remain with the public hospital system, one that provides a reliable safety net for all.

Table 5.13. Results of binomial logistic regression analysis of willingness to purchase VHIS plans

| | Model 5 | | Model 6 | | Model 7 | | Model 8 | |
|---|---|---|---|---|---|---|---|---|
| | OR | 95% CI | OR | 95% CI | OR | 95% CI | OR | 95% CI |
| Gender | | | | | | | | |
| Male | 1 | | 1 | | 1 | | 1 | |
| Female | 0.564*** | [0.363, 0.876] | 0.559** | [0.455, 0.955] | 0.488** | [0.304, 0.783] | 0.484** | [0.294, 0.764] |
| Age | | | | | | | | |
| 18 –29 | 1 | | 1 | | 1 | | 1 | |
| 30 –39 | 0.964 | [0.391, 2.374] | 0.940 | [0.427, 2.072] | 0.889 | [0.348, 2.267] | 0.880 | [0.309, 2.106] |
| 40 –49 | 1.882 | [0.658, 4.564] | 1.669 | [0.617, 3.840] | 1.763 | [0.675, 4.608] | 1.761 | [0.600, 4.305] |
| 50 –64 | 2.631*** | [1.177, 6.173] | 2.637*** | [1.026, 6.453] | 2.690*** | [1.091, 6.635] | 2.631*** | [1.071, 6.285] |
| 65 or above | 2.289** | [1.388, 5.272] | 2.208** | [0.980, 5.976] | 2.386** | [0.845, 6.733] | 2.377** | [0.836, 6.197] |
| Education | | | | | | | | |
| Primary or below | 1 | | 1 | | 1 | | 1 | |
| Secondary | 1.159* | [0.583, 2.309] | 1.138* | [0.711, 2.160] | 1.190* | [0.521, 2.284] | 1.188* | [0.511, 2.287] |
| Tertiary or above | 1.306* | [0.587, 2.905] | 1.282** | [0.617, 2.262] | 1.278** | [0.457, 2.542] | 1.279** | [0.432, 2.594] |
| Personal monthly income | | | | | | | | |
| Below HK$10 ,000 | 1 | | 1 | | 1 | | 1 | |
| HK$10,000 –29,999 | 1.780* | [0.989, 3.091] | 1.650* | [0.955, 2.517] | 1.764** | [0.979, 3.178] | 1.762** | [0.941, 3.101] |
| HK$30,000 or above | 1.417** | [0.653, 3.074] | 1.389** | [0.731, 2.638] | 1.379** | [0.598, 3.047] | 1.378** | [0.532, 2.968] |
| Marital status | | | | | | | | |
| Single | 1 | | 1 | | 1 | | 1 | |
| Married | 0.686** | [0.296, 1.161] | 0.784** | [0.445, 1.381] | 0.707** | [0.348, 1.447] | 0.717** | [0.348, 1.518] |
| Self-reported health status | | | | | | | | |
| Very bad | 1 | | 1 | | 1 | | 1 | |
| Bad | 1.280 | [0.483, 3.017] | 1.242 | [0.438, 3.618] | 1.381 | [0.577, 3.309] | 1.323 | [0.542, 3.236] |
| Neither good nor bad | 1.381** | [0.612, 4.079] | 1.452** | [0.543, 4.011] | 1.801** | [0.748, 4.337] | 1.862*** | [0.760, 4.566] |
| Good | 2.180 | [0.462, 4.296] | 2.247 | [0.431, 3.610] | 2.230 | [0.563, 4.391] | 2.248 | [0.567, 4.884] |
| Very good | 2.268** | [0.647, 3.684] | 2.861** | [0.656, 3.493] | 2.880*** | [0.685, 3.287] | 2.857** | [0.766, 3.699] |
| Insurance enrolment status | | | | | | | | |
| Un-insured | 1 | | 1 | | 1 | | 1 | |
| Insured by PHI only | 1.427** | [0.928, 2.221] | 1.397** | [0.921, 2.120] | 1.303** | [0.762, 2.228] | 1.306** | [0.730, 2.266] |
| Insured by GHI only | 2.239 | [0.803, 6.025] | 2.275 | [0.806, 5.343] | 2.353 | [0.717, 7.717] | 2.356 | [0.657, 7.884] |
| Insured by both PHI and GHI | 1.705* | [0.846, 3.496] | 1.804* | [0.808, 3.183] | 1.909* | [0.796, 4.579] | 1.876* | [0.795, 4.566] |
| Egalitarianism | | | 1.046 | [0.810, 1.138] | 1.057 | [0.684, 1.244] | 1.068 | [0.617, 1.610] |
| Political trust | | | | | 1.130*** | [1.023, 1.248] | 1.139*** | [1.030, 1.260] |
| Perceived responsiveness | | | | | | | | |
| Not considered | | | | | 1 | | 1 | |
| Considered | | | | | 2.849*** | [1.767, 4.592] | 2.941*** | [1.807, 4.787] |
| Perceived systemic efficiency | | | | | 1.108** | [0.971, 1.265] | 1.109** | [0.957, 1.255] |
| Egalitarianism × Personal monthly income | | | | | | | | |
| Below HK$10 ,000 | | | | | | | 1 | |
| HK$10,000 –29,999 | | | | | | | 1.111 | [0.918, 1.345] |
| HK$30,000 or above | | | | | | | 1.329** | [1.064, 1.660] |
| Model summary chi square | 79.31 | | 81.88 | | 118.31 | | 137.13 | |
| (d.f., p value) | (18, p < 0.001) | | (19, p < 0.001) | | (22, p < 0.001) | | (23, p < 0.001) | |
| Pseudo $R^2$ | 0.1050 | | 0.1129 | | 0.1976 | | 0.2443 | |
| -2 Log likelihood | 337.994 | | 321.806 | | 240.235 | | 223.103 | |
| N | 660 | | 627 | | 489 | | 489 | |

Note. Missing values are excluded from the multivariate analysis; *p<0.10, **p<0.05, ***p<0.01.

Interestingly, individuals already insured by PHI ($p<0.05$), and those insured by both PHI and GHI ($p<0.1$) were more willing to purchase VHIS plans than those uninsured. Again, the result contradicts the general assumption of risk aversion that people who are not yet protected by health insurance should be more willing to purchase a private policy. Yet, the finding merely mirrors the strong inclination of insured individuals to be risk averse and their preference for more flexibility and quality in health care services. Another possible reason is that citizens usually deem the VHIS plans as a supplementary health protection mechanism to seek more comprehensive care on top of public medical services or existing insurance coverage.

Social ideological commitment did not explain people's willingness to subscribe in a statistically significant manner, as shown in Model 6, Model 7 and Model 8. Clearly, the decision to purchase insurance appeared to be independent from an individual's social ideology and was mainly a personal decision based on self-interest considerations such as cost and benefit.

Political trust and perceived responsiveness again turned out to be the most powerful predictors of intention to purchase VHIS plans, as shown in Model 7 and Model 8. Individuals with higher political trust were more willing to purchase VHIS plans ($p<0.01$), suggesting that political trust significantly fosters citizens' confidence in government-regulated insurance plans in a semi-democratic system (He, 2018). If citizens believe their policy-makers have the capability of regulating the private insurance market, they will be willing to shoulder private responsibility in health care and obtain a long-term source of financial protection.

Individuals who believed that the SAR Government had heeded their views and responded to

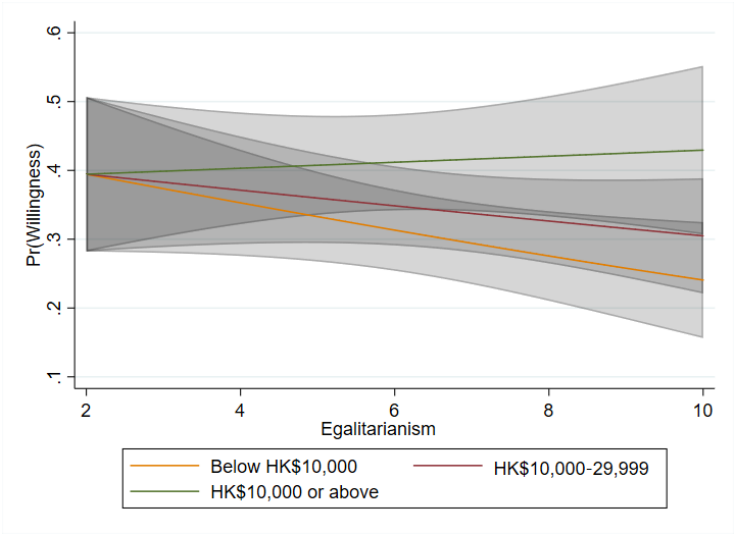
their demands showed greater interest in subscription ($p<0.01$). In accordance with the responsiveness argument, responsive governance not only mitigates public opposition toward welfare retrenchment, but also helps foster citizens' acceptance of private financing responsibilities (Yeh & Ku, 2020; He & Ma, 2020). In other words, acting responsively fosters public acceptance of necessary retrenchment reforms, even though such reforms may not be deemed materially beneficial to all citizens.

Model 7 and Model 8 revealed a positive association between perceived systemic efficiency and willingness to purchase VHIS plans ($p<0.05$). The result was inconsistent with the expectation that public evaluation of the health system has a negative impact on individuals' acceptance of private financing in health care. In this study, satisfaction with the current health system does not erode citizens' willingness to purchase additional insurance coverage, but rather motivates them to pay private insurance contributions. With the highly equitable public medical system serving as a convenient last resort, individuals typically perceive the VHIS as an alternative source of services of higher quality and with faster access (He, 2017). Hence, citizens do not have to worry about the potential loss if they shift to the private system, because the public medical system always serves as a reliable safety net for all citizens.

In Model 12, the interaction term of egalitarianism × monthly income HK$30,000 or above per month (OR=1.329, $p<0.05$) was positively significant. Interestingly, high-income egalitarians tended to be more willing to shoulder private responsibility (see Figure 5.4). This result suggests that the income effect is vigorously conditioned by egalitarian ideology. Ideological disposition exerts a strong role in shaping high-income people's intention to pay in comparison with low-income individuals (Rueda, 2018; Azar et al., 2018). High-income egalitarians may assume a stronger moral obligation, believing that the reform can leave more

resources to the underprivileged.

Figure 5.4. Probability of willingness by egalitarianism, moderated by income




Source: the author.

5.5.5. Determinants of expectation regarding government responsibility in health care

The study has found that public expectation regarding government responsibility in health care were rather polarized. In contrast to previous depiction of wide popular support for extensive government provision of health services in Hong Kong (Wong et al., 2009), it was noted that Hong Kong citizens may not necessarily give strong support for greater government involvement in health care in the form of direct service provision, but they might expect other possible forms of engagement such as market regulation.

As shown in Table 5.14, women tended to prefer greater government responsibility in health care, while men were more likely to favour individual responsibility ($p<0.05$). As argued earlier, Hong Kong women were more likely to be dependent on the public medical system, and therefore, they tended to oppose private financing and demanding extensive government-funded health services. The effects of age groups 50 to 64 ($p<0.05$) and 65 or above ($p<0.01$)

on expectation regarding government responsibility were strong. The result implies that older adults were more likely to expect the government to play a stronger role in health care, reflecting their vulnerability and associated health care needs. The effect of age confirms the theoretical expectation in the RESPONSIBILITY dimension.

Higher education positively predicted expectation regarding government responsibility in health care. In particular, those who attained a post-secondary education appeared to expect greater government responsibility ($p<0.1$). In line with the prediction, better educated Hong Kong citizens held stronger pro-welfare attitudes in the health care domain as they had a greater sense of commitment to the principle of social equality and felt stronger moral obligations to help enhance efficient resource allocation in the public medical system.

There was a significant association between marital status and the dependent variable. When compared with married individuals, single people desired greater health protection from the government ($p<0.05$). In accordance with common expectation, it can be explained by the fact that single individuals may lack support from the family to satisfy their own health needs, and therefore they tend to favour extensive government intervention in the health care system (Lang & Lai, 2008).

Table 5.14. Results of ordered probit regression analysis of expectation regarding government responsibility in health care

| | Model 9 | | Model 10 | | Model 11 | | Model 12 | |
|---|---|---|---|---|---|---|---|---|
| | Coef. | Std. Err. | Coef. | Std. Err. | Coef. | Std. Err. | Coef. | Std. Err. |
| Gender *('male' as reference category)* | | | | | | | | |
| Female | 0.218** | [0.081] | 0.237** | [0.083] | 0.258** | [0.097] | 0.257** | [0.099] |
| Age *('18 –29' as reference category)* | | | | | | | | |
| 30–39 | 0.131 | [0.170] | 0.152 | [0.172] | 0.162 | [0.197] | 0.159 | [0.196] |
| 40–49 | 0.117* | [0.170] | 0.140 | [0.174] | 0.146 | [0.204] | 0.147 | [0.202] |
| 50–64 | 0.141*** | [0.162] | 0.145** | [0.166] | 0.142** | [0.198] | 0.141** | [0.194] |
| 65 or above | 0.115*** | [0.192] | 0.125*** | [0.200] | 0.110** | [0.244] | 0.115*** | [0.242] |
| Education *('primary or below' as reference category)* | | | | | | | | |
| Secondary | 0.046 | [0.134] | -0.038 | [0.140] | -0.057 | [0.165] | -0.052 | [0.167] |
| Tertiary or above | 0.158** | [0.152] | 0.156** | [0.158] | 0.157* | [0.188] | 0.158* | [0.187] |
| Personal monthly income *('below HK$10,000' as reference category)* | | | | | | | | |
| HK$10,000 –29,999 | 0.125 | [0.136] | 0.127 | [0.141] | 0.150 | [0.175] | 0.143 | [0.176] |
| HK$30,000 or above | 0.123 | [0.147] | 0.112 | [0.151] | 0.128 | [0.189] | 0.125 | [0.187] |
| Marital status *('single' as reference category)* | | | | | | | | |
| Married | -0.253** | [0.129] | -0.194** | [0.133] | -0.176** | [0.147] | -0.179** | [0.153] |
| Self-reported health status *('very bad' as reference category)* | | | | | | | | |
| Bad | -0.165 | [0.147] | -0.148 | [0.150] | -0.124 | [0.157] | -0.134 | [0.153] |
| Neither good nor bad | -0.153 | [0.148] | -0.158 | [0.151] | -0.123 | [0.112] | -0.129 | [0.136] |
| Good | 0.093 | [0.267] | 0.147 | [0.205] | 0.162 | [0.213] | 0.161 | [0.218] |
| Very good | 0.285 | [0.430] | 0.225 | [0.432] | 0.125 | [0.532] | 0.128 | [0.530] |
| Insurance enrolment status *('un-insured' as reference category)* | | | | | | | | |
| Insured by PHI only | -0.039 | [0.095] | -0.076 | [0.098] | -0.056 | [0.112] | -0.054 | [0.115] |
| Insured by GHI only | 0.148 | [0.213] | 0.125 | [0.222] | 0.155 | [0.267] | 0.162 | [0.266] |
| Insured by both PHI and GHI | -0.129 | [0.148] | -0.117 | [0.150] | -0.118 | [0.177] | -0.125 | [0.177] |
| Egalitarianism | | | 0.181*** | [0.041] | 0.178*** | [0.047] | 0.183*** | [0.049] |
| Political trust | | | | | -0.061*** | [0.020] | -0.060*** | [0.021] |
| Perceived responsiveness *('not considered' as reference category)* | | | | | | | | |
| Considered | | | | | -0.179** | [0.101] | -0.183** | [0.103] |
| Perceived systemic efficiency | | | | | -0.095*** | [0.027] | -0.095*** | [0.027] |
| Egalitarianism × Personal monthly income *('below HK$10,000' as reference category)* | | | | | | | | |
| HK$10,000 –29,999 | | | | | | | -0.150 | [0.105] |
| HK$30,000 or above | | | | | | | -0.257** | [0.146] |
| */Cut 1* | -1.576 | [0.469] | -1.162 | [0.258] | -2.070 | [0.356] | -1.674 | [0.408] |
| */Cut 2* | -0.389 | [0.467] | -0.616 | [0.256] | -0.869 | [0.351] | -0.484 | [0.406] |
| */Cut 3* | 0.125 | [0.467] | 0.317 | [0.256] | -0.600 | [0.351] | 0.212 | [0.406] |
| */Cut 4* | 0.691 | [0.467] | 0.137 | [0.258] | 0.220 | [0.351] | 0.618 | [0.406] |
| Model summary chi square | 53.74 | | 82.16 | | 121.20 | | 133.22 | |
| (d.f. p value) | (18, p < 0.001) | | (18, p < 0.001) | | (21, p < 0.001) | | (22, p < 0.001) | |
| Pseudo $R^2$ | 0.0501 | | 0.0900 | | 0.1795 | | 0.2390 | |
| -2 Log likelihood | 769.687 | | 705.070 | | 610.492 | | 576.687 | |
| N | 730 | | 697 | | 540 | | 540 | |

Note. Missing values are excluded from the multivariate analysis; *p<0.10, **p<0.05, ***p<0.01.

Monthly income, self-reported health status, and insurance enrolment status did not explain the variance in the dependent variable in a statistically significant fashion. The results somehow support Wong et al.'s (2006) argument, that is, Hong Kong citizens' expectation regarding government involvement in health care is largely independent from class or economic self-interest, but is rather shaped primarily by stable ideological commitments such as moral obligation and empathy. It is because people tend to believe that provision of sufficient health care services is the basic social right. Furthermore, the SAR Government provides universal care to every citizen regardless of socio-economic status, health status and insurance coverage, and thus, self-interest mechanisms provide a very limited explanation for the formation of attitudes towards the role of government in health care in Hong Kong.

Social ideology significantly shaped public expectation regarding government responsibility. Those holding stronger egalitarian beliefs expected the government to intervene more in health care ($p<0.01$). Egalitarians believe that health policy interventions can strengthen social equality, and that government has the responsibility to provide sufficient resources and services to the public as one of the basic social rights (Feldman & Steenbergen, 2001). In line with the general positive relationship between social ideology commitment and preferences for government engagement, egalitarianism provides a reliable prediction for public support for collective responsibility in health care in Hong Kong.

In Model 11 and Model 12, political trust and perceived systemic efficiency were once again strong determinants in the third attitudinal dimension. Interestingly, citizens who trusted the SAR Government were not inclined to support greater government responsibility in health care ($p<0.01$). This result contradicted the usual positive link between political trust and public expectation regarding government responsibility. It may be explained by the fact that Hong Kong people with lower political trust tend to hold negative assessment of government

performance and thus expect the government to expend more efforts (Rothstein, 1998). With this special "trust paradox" in mind in the Hong Kong context, boosting the level of political trust is critically important for the SAR Government when undertaking necessary retrenchment reforms.

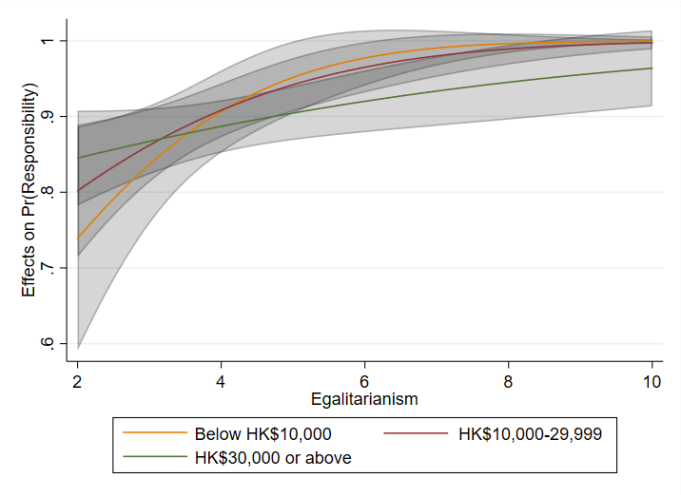
The same logic illustrated above can also be used to explain the negative association between perceived systemic efficiency and expectation regarding government responsibility. Lower assessment of the systemic efficiency led to stronger support for government commitment in health care ($p<0.01$). In line with the expectation, negative perception of systemic efficiency did not lead to "exit" from the public medical system, but rather increased public expectation regarding government intervention in health care. Since people tend to attribute unsatisfactory performance of the system to their governments' incompetence, and therefore, they prefer greater government effort in improving the status quo (Calzada & Del Pino, 2008).

As shown in Model 11 and Model 12, a significant negative impact of perceived responsiveness on public expectation regarding government responsibility in health care has been found. Individuals who perceived that the SAR Government had considered their views were less likely to desire the active role of government in health care ($p<0.05$). This observation defied the typical expectation that an unresponsive government tends to increase citizens' demand for government involvement in health care. In other words, a responsive government "crowds out" Hong Kong citizens' desire for greater service provision by the government as they believe the government has already taken their interests and needs into account.

As in the support dimension, the effect of ideology varied across different levels of income

over the responsibility dimension. In Model 12, a significant and negative coefficient of egalitarianism × monthly income was noted among high-income individuals (HK$30,000 or above per month) ($\beta = -0.257$, $p<0.05$). A greater positive impact of egalitarian ideology on demanding greater government intervention was found among low-income individuals, which is in line with prior expectation. In other words, low-income egalitarians tended to expect greater government responsibility for providing health services than high-income egalitarians (see Figure 5.5). These lower-income groups are the major users of the public health care system, and therefore they tend to expect greater government efforts to improve the service provision.

Figure 5.5. Probability of responsibility by egalitarianism, moderated by income




Source: the author.

## 5.6. Discussion and summary

This chapter presents an empirical investigation on citizens' attitudes towards the health care financing reform in Hong Kong, through quantitative analyses. Several important insights have emerged from this phase of the research. First, the CFA results endorse the multi-dimensionality of attitudes towards the reform, which are comprised of three attitudinal

dimensions: (a) support for the health care financing reform, (b) willingness to purchase VHIS plans, and (c) expectation regarding government responsibility in health care.

Overall, the underlying structure reveals a negative perception of private financing, limited intention to purchase the insurance products, and relatively low expectation regarding government involvement in health care. Yet, considering the voluntary nature of the VHIS, the revealed consumer interest is not low. Hence, there is no absolute evidence that a welfare reform emphasizing private financing is destined to be unpopular and subject to strong opposition (Giger & Nelson, 2011; Giger, 2011). People in a high-quality universal health system are not necessarily reluctant to shoulder private responsibility, but this rather depends on different motivations. Individuals' private contribution is an essential attitudinal dimension that should not be neglected in order to maintain policy legitimacy and achieve the intended outcome of the reform.

Second, the logistic regression analyses reveal notable variations in explanatory mechanisms across attitudinal dimensions. The two prominent frameworks (i.e. self-interest and ideology) were tested to explain public attitudes towards the reform. Unexpectedly, the concept of self-interest held limited explanatory power in the in the first and the third attitudinal dimension but provided strong predictors in the second dimension, i.e. people's interest in purchasing the insurance plans. Clearly, self-interest motivations vigorously underpin people's (hypothetical) behavioural decisions while ideological disposition plays a more powerful role in shaping their normative views. The egalitarian ideology not only strengthened public endorsement of government-funded health arrangements, but also significantly fostered public support for reform weighing on private financing.

Third, this chapter shows a moderate level of adverse selection and risk aversion. Not all

high-risk groups are more favourable to the reform and more willing to subscribe to VHIS plans. Women, citizens in poor health, and those uninsured did not necessarily have a stronger desire to purchase the regulated insurance plans. Some high-risk groups, particularly as women and older adults, tend to continue to rely on the public system and demand greater government responsibility. This observed outcome may offset the intended impact of the VHIS reform to a certain degree.

Fourth, the most significant finding arising from this chapter is that public attitudes towards the health care financing reform are considerably linked to citizens' past experience with welfare institutions, which override the influence of both self-interest and ideology. The political trust-related argument received the strongest empirical confirmation in this study. Political distrust and negative perceptions of welfare institutions in Hong Kong create a greater expectation for government responsibility in health care, and lead to stronger opposition to welfare retrenchment. If citizens have trust in their policy-makers' capability to undertake reforms and maintain institutional competence, they tend to be more receptive to the notion of private financing responsibility. Hence, maintaining a higher level of political trust and upholding responsive welfare institutions are fundamental for the success of social policy reforms. This is especially true for the reforms incurring welfare retrenchment.

# Chapter 6: Public Attitudes towards Health Care Financing Reform in Hong Kong: Qualitative Investigation

The determinants of public attitudes towards the health care financing reform were examined in Chapter 5 in a quantitative manner. However, while quantitative methods are able to shed light on statistical associations between variables, they are typically weak in providing in-depth explanations characterized by contextual richness. This chapter supplements the quantitative results reported in Chapter 5 with qualitative insights. Since the methodological protocol has already been detailed in Chapter 4, this current chapter shall proceed directly to the presentation of key findings. The self-interest explanations, the ideology explanations, and the political trust-related explanations are discussed in Section 6.1., 6.2. and 6.3. respectively. Section 6.4. summarizes the qualitative results.

## 6.1. Self-interest explanations

First, the concept of self-interest was captured in the data to examine whether it was the underlying motive behind the informants' attitude towards the health care financing reform. Grounded on the rational choice theory, the concept of self-interest argues that individuals are rational utility maximisers based on their material circumstances. Thematic analysis yielded three prominent themes that saliently emerged from the abundant qualitative data.

### 6.1.1. The concept of affordability

Demand for private health insurance is highly interest-oriented. Many informants claimed that they would make their decision on whether or not to subscribe to the VHIS based on their own health needs and financial ability. In general, higher-income people were more willing to purchase VHIS plans than lower-income people because of their greater ability to pay. Some informants who supported the VHIS reform, however, hesitated to purchase VHIS

plans. The concept of affordability became a key consideration when people were asked to make tangible financial contribution to the reform. For instance, one informant (IN15, female, lower class, secondary education, 30-39 years old) stated: "It (a VHIS plan) may increase my financial burden if I do not make an insurance claim much after I have purchased it." Other informants expressed similar concerns:

> *I'm eager to have more comprehensive protection in health care against unexpected medical costs, but I'm not sure whether I could afford the insurance premiums in the long run. It seems that the insurance premiums for the VHIS plans are higher than those for other standard plans. As the government imposes basic requirements on the VHIS plans in an attempt to ensure product quality, the total costs of the VHIS plans may increase accordingly. As the insurance companies are profit oriented, they may transfer the costs to us by increasing the premiums.* (IN7, female, middle class, tertiary education, 30-39 years old)

> *Hong Kong's private hospitals charge for services item by item. The price transparency of private hospitals is relatively low. The full price list of chargeable items and services provided by the private hospitals is usually not available to us. The exact prices of procedures and surgeries within private hospitals are extremely difficult to determine. I am worried that I will still need to pay high medical costs even if I'm covered by a VHIS plan.* (IN6, male, middle class, secondary education, 30-39 years old)

People with a lower income based their negative purchase decisions according to supply-side constraints, such as potential increases in insurance premiums and a lack of price transparency in private hospitals. Evidently, the limited interest in the VHIS is a result of concomitant worries over affordability and trust in private hospitals.

The qualitative results also found clear signs of adverse selection from the younger group of informants. The stated reasons for limited support to the reform point to little anticipated utilization and high living costs that crowd out other expenses, including private insurance. Four interviews were most illustrative of such opinions.

> *I am young and healthy. I know that the reform is tailored for us. But I'm not in urgent need of health insurance… I'm much more interested in endowment insurance for wealth accumulation instead.* (IN8, female, middle class, tertiary education, 18-29 years old)

> *We are facing great pressures of everyday life. My husband and just got married. At the current stage, we have to tackle lots of things, such as housing mortgage. And we plan to have a baby. We need to save money for these… The government should seek ways to reallocate public resources more efficiently rather than imposing financial pressure on us.* (IN4, female, upper class, tertiary education, 30-39 years old)

> *My wife and I are both the only child in our families… We have been facing great financial challenges. The major portion of our salary is used to pay for the housing rent. And we have to regularly give money to our parents. I am afraid that if I support the reform, it will send a wrong signal to the government in saying that we are able to afford private consumption in other welfare domains such as education and pensions.* (IN21, male, middle class, tertiary education, 18-29 years old)

> *We (my wife and I) are young and healthy. Health care is not our first priority at this moment, but maybe someday in near future.* (IN17, male, upper class, tertiary education, 30-39 years old)

These qualitative insights clearly reflect the younger generation's reluctance to support a retrenchment reform and to shoulder additional financial responsibilities. This is not merely an economic explanation of adverse selection, but is practically constrained by prevalent financial stress encountered by the younger cohort of the Hong Kong population who live in a very expensive and competitive city. With reference to the above quotes, income, particularly an individual's financial capability to pay, serves as the fundamental self-interest consideration affecting willingness to purchase VHIS plans, which is in line with the reasoning and the quantitative results discussed in the previous chapter.

### 6.1.2. The notion of self-reliance

Despite the income effect, an interesting puzzle has been discovered among older adults regarding their intention to purchase a VHIS plan. Conventional wisdom is that welfare beneficiaries such as older adults tend to be more supportive of the public medical system and oppose private financing (Blekesaune & Quadagno, 2003; Wendt et al., 2010; Missinne et al., 2013). In other words, they are typically reluctant to bear private responsibility in health care. Yet, the qualitative interviews conducted pointed to different attitudinal dynamics. The notion of "self-reliance" in health care is saliently observed among the elderly informants, while only a few of them explicitly expect the government to take greater responsibility in health care.

In my interview, eight out of ten middle-aged and elderly informants expressed the intention to purchase VHIS plans, a clear sign of adverse selection. Yet, the result also reflects a certain degree of advantageous selection as most of these older adults perceived themselves to be healthy. The rationale behind this is far more complicated. Why were these healthy older adults willing to shoulder private responsibility in health care? The narratives of the older

adults showed that they realized the high costs of living in Hong Kong today. Hence, the older adults showed a remarkably strong desire to be self-reliant and to avoid passing financial burdens to the next generation. IN22 (a father, middle class, secondary education, 40-49 years old) elucidated the financial challenges facing the younger generation: "It is much more difficult for this generation to live in Hong Kong. High housing prices and high living costs impose tremendous financial burden on them. I don't want to impose my medical costs on them (his sons) anymore." Other informants shared a very similar viewpoint. IN12 (a grandmother, lower class, primary education, 65+ years old) explained her intention to subscribe to a VHIS plan:

> *I'm not prone to illness, but I'm willing to purchase a VHIS plan because I don't know how long I will live. My daughter has only one child. I can foresee my grandson facing the financial burden of supporting the family. I don't want to leave them a burden. That's why I need the insurance to protect myself.*

Hong Kong people's life expectancy has been ranked the highest in the world (Census and Statistics Department, 2020b). Rising life expectancy, inevitably exacerbates the pressure on the public medical system. The interviewed older adults stated that perpetual dependence on the public medical system would be unrealistic, and noted they should be self-reliant. IN10 (a mother, middle class, tertiary education, 50-64 years old) stated the following:

> *The ageing population will be aggravated in the near future. The public medical system will be forced to support a larger population. The problems of overcrowded care conditions and long waiting times will not be alleviated but will only get worse. It will be unrealistic for us (older adults) to keep relying on the public system. I can't ask for my child's financial support… So, I must be self-reliant.*

The results above correspond with some recent studies which propose that changing family structure and inter-generational dynamics have reinforced the spirit of self-reliance of older adults in Hong Kong (He & Chou, 2020, 2021). As long as they are not entirely financially independent, the majority of the current cohort of Hong Kong elderly show keen desire to get financially prepared for possible risks in old-age, notably health care risks. The VHIS reform offers them such an option (IN5, a mother, upper class, tertiary education, 40-49 years old; IN9, a grandfather, middle class, secondary education, 65+ years old; IN10, a mother, middle class, tertiary education, 50-64 years old). In particular, the well-known Lion Rock Spirit appears to hold true among the current cohort of older adults, fostering their intention to take welfare responsibilities for themselves. Lion Rock Spirit is said to constitute the core values of Hong Kong which emphasizes diligence, self-discipline and self-reliance and has helped drive the city's economic boom in the 1970s (Chan, 2009). In this vein, the notion of self-reliance can be further interpreted in the context of Hong Kong's traditional neoliberal values that emphasize individual responsibility. IN2 (a father, upper class, secondary education, 50-64 years old) stated:

> *I started the business of my own without depending on others. This is our Hong Kong lion spirit that I always share with my children. I always tell them to be self-sufficient and responsible for their own needs and expenses. I'm proud of being self-reliant.*

As shown above, the interviewed older adults endorsed the value of self-reliance in health care regardless of their income and health status. The qualitative result reveals that many older adults have adjusted their expectations on the public medical system and family dependence. They tend to be self-sufficient and willing to pay for the reform through purchasing VHIS plans in order to ease the financial burden of the younger generation.

6.1.3. New expectation regarding government responsibility

Only half of the respondents demonstrated high expectations regarding government responsibility in health care. A few older adults expressed their demand for state involvement, and similar patterns were found among women and the higher educated groups. Some prior studies found that Hong Kong people strongly expect greater direct public financing or public provision in the health care system (Yang et al., 2019; Wong et al., 2009). Yet, in this study, both the quantitative and qualitative data only indicate a moderate expectation for government engagement. Most informants appeared to prefer the government to play a greater role in addressing systemic issues instead of directly providing public medical services. Strengthening social systems to prevent long-term crises should be an important policy agenda for all nations (Wang, Wong & Tang, 2013; Bonnet, Ehmke & Hagemejer, 2010). Out of the 15 informants who expected greater government responsibility in health care, 11 were keen on the government regulating the private medical system. This pattern is particularly salient among those better educated middle-class informants.

IN7 (female, middle class, tertiary education, 30-39 years old) stated: “I think the government has already provided extensive services… The main constraint on seeking care in the private system is poor price transparency… The government should regulate private hospitals by means of increasing the price transparency or setting ceiling for the chargeable services.” Another informant, IN11 (male, middle class, tertiary education, 50-64 years old), also expressed similar concerns over the exorbitant medical bills she may have to pay by seeking care in private hospitals, remarking:

> *I have heard my friend’s case. Just a few months ago, she went to a private hospital for eye screening... She said that she only stayed there for one night but was charged for*

*approximately HK$100,000. The insurance company barely covered one-third of the expenses. I know that the charges vary depending on individual circumstances, but it sounds quite unreasonable.*

IN17 (a representative of a medical federation) claimed that the government was not well-prepared to promote private financing through regulating hospital insurance products. He particularly stressed the need for developing medical guidelines for treatment and tightening government supervision of the VHIS plans on the part of government. Clinical pathways were the key reference for private medical professionals to make clinical decisions and for the insurers to reimburse claims. He provided foreign examples for comparison:

*Regulating insurance product without clear medical guidelines will be useless. In the United States and the United Kingdom, medical professional colleges offer these clinical guidelines, such as what kinds of pills should be prescribed for a specific disease. On the basis of the standardized clinical pathways, insurance companies are required to set the "packages" accordingly, and the medical costs of treatment can be estimated. But Hong Kong has no such pathways, so what can insurance companies make reference to? How can the government monitor the operations of the VHIS?*

With reference to the above results, Hong Kong people seem to have presented new expectations with regard to government responsibility in health care. Due to the rapid development of the private market, there has been a growing public demand for government regulation (Wang et al., 2013). As a result, Hong Kong citizens, especially those in the middle class, do not necessarily continue to demand extensive government investment in health care, but rather prefer a more active role of the government in introducing corrective reforms to improve the quality of the system.

### 6.2. Social ideological explanations

The quantitative results indicate that egalitarian ideology strongly predicted the SUPPORT and the RESPONSIBILITY attitudinal dimensions. The in-depth interviews further probed individuals' ideological orientations towards the reform and welfare responsibilities at large. Some results in the interviews substantiated the quantitative findings in a real-life context, while other observations were not captured in the quantitative survey but offered additional valuable insights. Three themes stood out in this regard.

#### 6.2.1. Equality in health

Most of the informants across socio-economic groups determined their attitudes towards the health care financing reform in accordance with the principle of social equality. Hong Kong's public health care system provides universal access to care to every citizen based on the notion of "no one should be denied medical care through lack of means". Such a system emphasizes a strong sense of social solidarity. Some egalitarians interviewed opposed the retrenchment reform and were unwilling to shoulder private responsibility as they believed that the reform violates the egalitarian principle, i.e. people in higher socio-economic position are allowed to obtain better service quality and coverage in the private sector. In the meantime, most of them acknowledged the reform as being egalitarian in terms of its goals: leaving valuable public medical resources to the vulnerable groups, although a few of them rejected the idea that the VHIS was the most suitable reform policy to correct the public-private imbalance.

Many informants in lower socio-economic status, however, believed that the reform is in accord with egalitarian principles. They perceived the reform as a "fair" policy instrument to promote vertical equality in health care, which is, equalizing access for those in equal need of

health care. For example, one informant explained:

> *I support the reform very much because it can allow me to enjoy faster care to public medical care, because people with higher financial ability will shift to private sector and the public hospitals will not be so overcrowded. To be fair, those higher-income individuals should pay more to consume higher quality of care because they have stronger financial means.* (IN13, female, lower class, secondary education, 30-39 years old)

Another informant who was the recipient of Comprehensive Social Security Assistance (CSSA; Hong Kong's last-resort social assistance program) also expressed a similar view:

> *My monthly salary is barely enough to support my basic everyday needs. I can only seek care in the public medical system… I think the reform is fair to us and the rich. Because we have no choice in seeking better care by other means, but they do. Each takes what he/she needs.* (IN15, female, lower class, secondary education, 30-39 years old)

In the opinions of these underprivileged people, promoting private responsibility among the middle and upper classes was deemed as an egalitarian means to achieve equal health outcomes with regard to the varied needs of different social groups. Interestingly, some informants in higher social strata also shared a similar view, reflecting a high degree of social solidarity. IN11 (male, middle class, tertiary education, 50-64 years old) said: "It is fair to leave more public resources to the vulnerable groups since they have greater needs. We can meet our own needs."

Going beyond the connotation of equalizing opportunities, equality in health care is further

understood in terms of equal distribution of health resources, that is, “fairness of financing” (Rawls, 1999). This egalitarian principle implies allocating resources with reference to individuals’ socio-economic status. Contributions to health care should be proportional to one’s ability to pay (Sassi, Le Grand & Archard, 2001). A system that guarantees a basic level of health care to the socially disadvantaged and also enables the economically better-off to enjoy higher standards of services is considered by the Hong Kong egalitarians as a more efficient and equitable dual-track mechanism. This egalitarian view is well epitomized in one of the interviews:

> *Equality in health care means addressing the health disparities between the poor and the rich. It doesn’t mean that the poor are forced to stay in the crowded public system. It would be unfair if the rich remained in the public system and competed for the medical benefits with the poor. The VHIS provides a more equitable way to relieve the pressure on the overloaded public medical system and improve the efficiency of public medical services for the poor.* (IN30, a deputy of lower-class citizens).

6.2.2. Free market competition

As shown above, high-income earners were not necessarily against redistribution and pro-poor policy interventions. Those in higher socio-economic conditions support the financing reform not only because of sheer self-interest motivations but they were also driven by ideological disposition. Yet, when they held a negative stance towards the reform, the reasons behind were multifold, some of which were not revealed in the quantitative results. In particular, some informants expressed a major concern over the potential impairment of free competition principles. They were doubtful of the appropriateness of promoting private financing in the form of market regulation to achieve the egalitarian goals. Two informants remarked:

> *I agree that public resources should be better reallocated to the needy… But I am also worried about the possibility of damaging the free-market system. Government intervention may impede, erode, and obstruct free market competition.* (IN25, female, middle class, tertiary education, 30-39 years old).

> *As Hong Kong is a well-known liberal economy, government intervention in the insurance market may hinder free-market mechanisms. The products may become unattractive eventually. A high level of government intervention in the private market is not a good sign.* (IN2, male, upper class, secondary education, 50-64 years old).

Such insights observed in the qualitative analysis suggest that the attitudinal menu of Hong Kong citizens in higher socio-economic positions is rather mixed. The long-held values of laissez-faire and free market competition have been deeply entrenched, leading to hesitation towards welfare reforms that incur government regulation. The better-off Hong Kong citizens typically gained their current status through competition and social mobility, and may thus hold concerns about the possible loss of opportunities if the government strengthens regulation.

### 6.2.3. Moral responsibility

The qualitative data reveals that moral responsibility serves as an important motive behind Hong Kong citizens' support for the reform. Moral responsibility typically stems from the principle of social solidarity (Arts & Gelissen, 2001; Bergmark, Thorslund & Lindberg, 2000; Brown, 2013). From a theoretical perspective, moral responsibility is conducive to fostering support for the welfare state and government-funded health arrangements (Van Oorschot, 2000, 2002). In other words, people with a sense of moral responsibility are expected to

oppose welfare retrenchment reforms and avoid private financing. Surprisingly, the influence of moral obligation on public welfare attitudes in Hong Kong differs substantially from that in other liberal economies. In Hong Kong, moral obligation seems to bolster public support for government responsibility in health care, as well as their endorsement of the reform and willingness to bear private responsibility. In other words, the sense of moral obligation strongly underpins public support for the retrenchment reform in Hong Kong, a highly liberal Chinese society.

Some informants from lower social strata expressed contradictory views, opposing private responsibility in health care while acknowledging such perceptions to be "immoral." They expected the government to bear the major responsibility in health care financing and criticized the VHIS as an "irresponsible" reform. IN14 (female, lower class, primary education, 65+ years old) stated: "It is so irresponsible for the government to leave financial problems to us. We pay tax and in return the government should provide us with a safety net rather than demanding more from us." IN16 (male, lower class, primary education, 65+ years old), who also strongly believed in government responsibility in health care, complained that the "residual" government always acts in a reluctant way:

> *The government is always "reluctant" to increase public health spending. We (the SAR Government) have a large budget surplus, but the government is still unwilling to spend it. Unlike other policy areas, health care is our basic welfare right. Even if the government has the responsibility to improve the crowded environment in public hospitals, it still tries to impose the financial burden on us. I really don't understand the rationale behind this.*

However, when asked if they believed in in the principle of social solidarity, IN14 responded:

"If necessary, people should be morally obligated to serve or financially contribute to the society." IN16 made the following comment: "If the government cannot cope with the financial burden of health care in the long term, I will accept the reform and take responsibility for my medical expenses as I am obligated to do so." Obviously, the concept of moral obligation fostered support for private financing and the inclination to pay. The sense of moral obligation not only appeared among the vulnerable groups, people in higher socio-economic status placed a stronger emphasis on the importance of moral obligation:

> *We have a social obligation to contribute to the society in terms of volunteering or donating. The VHIS not only requires us to take responsibility for tackling problems, but also provides us with better opportunities to seek higher quality of services. It is a win-win situation*. (IN1, female, upper class, tertiary education, 65+ years old)

> *As ordinary citizens, everyone is morally obligated to give mutual support... Although purchasing VHIS plans is purely a self-interest decision, the reform attempts to improve the overcrowding public system... I am obliged to contribute to the society.* (IN18, male, upper class, tertiary education, 40-49 years old)

These qualitative observations illustrate the crucial impact of moral obligation on public endorsement of a health care reform that embodies moderate retrenchment in the liberal Hong Kong society. Hong Kong citizens tend to show empathy and the sense of moral obligation towards each other in the society. Extending the research findings offered by Wong et al. (2006), the sense of moral responsibility not only motivates citizens to pay more taxes for social welfare, but also bolsters their intention to make necessary financial sacrifice to a retrenchment reform emphasizing private responsibility in health care. As a consequence, Hong Kong citizens are actually willing to accept private financing when they identify with

such social obligations, reflecting a high degree of social solidarity.

### 6.3. Political trust-related explanations

The trust-related factors rendered very strong explanatory power in the quantitative phase, which also yielded some paradoxical findings. Thus, the qualitative phase probed the informants' attitudinal dynamics and the rationale behind in an in-depth fashion. Primarily, eight subthemes emerging from qualitative analysis which were subsequently merged into two principal themes have gone beyond my quantitative understanding on the critical role played by trust in the formation of Hong Kong people's welfare attitudes.

#### 6.3.1. Political trust and government responsiveness

In the recent decades, a sharp decline in political trust across the society has given rise to strong public criticism of the SAR Government and its officials, and therefore undermined the administration's credibility in policy formulation (Cheung, 2005; Scott, 2007). Consistent with the quantitative results, political trust provides strong explanations for the formation of public attitudes towards the health care financing reform. The low level of public trust in the policy-making institutions led to stronger opposition from the public and limited public intention to subscribe to a VHIS plan. All the informants attributed negative perceptions of the reform to trust deficit. In general, involving the public more in the policy-making process will increase public endorsement of or reforms.

Informants underscored that political trust means mutual trust between citizens and the policy-making institutions. They were willing to trust these institutions and support the reform if they believed that the government had considered their opinions. Mutual trust can be explained by the theory of political efficacy. Internal efficacy (whether the individuals perceive themselves as being capable of political participation) influences their level of

political participation, while external efficacy (government responsiveness) fosters political trust (Park & Kim, 2014). All informants acknowledged the importance of government responsiveness in the formation of their attitudinal stance towards the current health care reform as well as broad social welfare reforms at large. Very few of them considered that the SAR government was responsive enough to citizens' opinions during the reform process. IN27 (a district councillor) explained:

> *The government must respond to citizens' needs. Even though the government is not truly able to respond to all opinions, it must at least show a positive gesture towards public engagement in the policy-making process and be willing to collect public opinions. Citizens are more willing to trust the government and support any reform proposal when they feel respected.*

Some other informants also expressed a similar view, emphasizing that they did not necessarily expect the government to satisfy all of their demands. Being responsive with open attitudes towards public participation was the major consideration for the informants. Therefore, they were willing to support the reform that may not be beneficial to them. IN18 said:

> *Policy-making is not an easy task. No policy can benefit everyone. To be honest, this (VHIS) reform is not favourable to me because I am required to bear private responsibility. But I have joined the closed-door face-to-face consultation before and offered my opinions. The (Food and Health) Bureau has given a detailed reply. I know that not all my concerns can be addressed. But at least, they paid attention to it.* (IN18, male, upper income, tertiary education, 40-49 years old)

In practice, mutual trust between policy-making institutions and the public can be built by encouraging public participation in policy formulation (Avidar, 2013, Kent et al., 2003). If citizens believe that they can influence policy-making, they tend to trust that policy-makers are responsive to their demands, concerns, and complaints. To achieve effective communication, a two-way dialogue appears to be instrumental. IN9 (a middle-class citizen) explained why he was so optimistic about the reform:

> *I had participated in the face-to-face public consultation session in the district. I have received a lot of information about the reform. In the final session of the consultation, I had voiced out my concerns over high premium and asked for clarification. Dr. Ko (Secretary for Food and Health) and his colleagues had immediately answered my questions thoroughly. And they also mentioned that they would take my opinions into account. I'm glad that I could help. I must support the reform anyway.* (I9, male, middle class, secondary education, 65+ years old)

When the government demonstrates a sincere attitude towards opinion feedback, it will be rewarded with stronger trust, which in turn fosters citizens' positive perceptions of the reform. In this study, although a few informants were involved in the public consultation process and offered their immediate support for the scheme, the majority of informants underlined a lack of participation in the process and expressed dissatisfaction with the government's citizen engagement mechanisms, both of which have led to insufficient dialogic communication, public opposition to the reform and unwillingness to purchase VHIS plans.

For the rest of the informants who did not participate in public consultation, a common view shared was that the government was "working behind closed doors" and showed a low level of acceptance of policy feedback. Most of them complained that the SAR Government failed

to demonstrate an active attitude towards policy feedback. Even face-to-face consultation sessions were limited to certain groups of people. The lack of means to voice their opinions and ineffective communication channels contributed to their reluctance to accept the reform. For instance, IN20 (female, middle class, tertiary education, 18-29 years old) criticized the outdated means of collecting feedback:

> *The government only accepts essay writing, and requires citizens to submit it through email or mail. Why can't they accept opinions in other digital forms like voice or video? Some citizens may not be able to express their opinions appropriately in words. The government may miss important comments.*

Another informant, IN19 (female, middle class, tertiary education, 30-39 years old), also explained her discontent about the apparent absence of "response" from the government:

> *I have submitted my opinions. But I only received a notification of receipt. That's all. I even do not know whether the government officials had read it or not. If they can be more attentive, I may not oppose the reform and the notion of private responsibility in health care.*

As pointed out by IN30 (a deputy, legislative councillor), lower level of political trust and strong public opposition to private financing were largely due to the improper development of public consultative mechanisms at the district administrative level:

> *There are several official channels to collect public opinions, including District Officers, District Councils, Mutual Aid Committees, Area Committees and Owners' Corporations… Currently, if the government would like to hold a consultation in the*

*district for a specific policy or reform, the district officers will contact the mentioned groups and invite them to provide opinions. However, those groups are mainly composed of the elites. The opinions of other social groups are usually neglected… Citizens are therefore unwilling to trust the government and support the reform*.

I4 (female, upper class, tertiary education, 30-39 years old) shared a similar view. At the very beginning, she strongly opposed the reform and claimed that policy-makers always missed her opinions. But when asked what motivated her to support the reform, she explained, "If the government can be more open to public engagement in policy-making and explain more about the rationale behind policy formulation, I would definitely be more supportive of the reforms which may not even be beneficial to me, and I would be willing to pay the costs. It is because I know that the government is willing to heed my views."

The length of public consultation is also an important consideration. Some informants suggested that the short period of consultation showed the government's passiveness and, at times, reluctance towards public engagement. For example:

*The consultations always only last for a few months. For the VHIS reform, the consultation period was only three months. I do not trust that the government can collect sufficient opinions about the reform. It seems that there is only a "yes" option provided to us. I will not support the reform and purchase VHIS plans*. (IN6, male, middle class, secondary education, 30-39 years old)

*The consultation period is too short. Many of us even did not know when it had started. We did not have enough time to express our opinions at all.* (IN19, female, middle class, tertiary education, 30-39 years old).

These qualitative findings underlie that encouraging public engagement in policy-making process is strategically important to strengthen the relationship between Hong Kong citizens and policy-making institutions, which can further reduce possible opposition. Overall, individuals' support for private financing and intention to bear private responsibility in health care can be earned from responsive governance. Being responsive is not just simply about perceptions of government performance and whether government decision-making is based on citizens' needs. Government responsiveness should transcend public perceptions of how the government promotes the effective participation of every ordinary citizen and whether a reform is the result of everyone's input. The results reveal the value of external efficacy in explaining citizens' perceptions of the health care financing reform in Hong Kong from the perspective of political trust.

Another important source of public dissatisfaction with the reform seems to stem from inadequate disclosure of information. Providing transparent information can show how the government modifies policies through incorporating opinions collected from the people. Many informants mentioned that they had received very little information about the reform and policy-makers did not expend enough effort to explain the advantages of the reforms. As a result, they were not willing to purchase the VHIS. For instance, IN19 stated:

> *I have received limited information about the reform and how the VHIS plans can benefit us. For example, will the premium be more attractive if the government imposes regulation? What is the difference between VHIS plans and existing plans? Insurance is quite complicated and I wish to have more understanding. If I do not have enough information, I cannot say that I really want to purchase one.* (IN19, female, middle class, tertiary education, 30-39 years old)

IN27, a legislative deputy, noted the government has chosen an inappropriate channel of making the information about the VHIS reform available to the public:

> *The government always presents a complex idea in the form of words. Actually, not all citizens are willing to read such a thick piece of consultation document. And more importantly, they may not be able to understand it well. If the government cannot explain policy initiatives in simple words, it is hard to persuade citizens and promote the advantages of VHIS reform. The government may highlight the key points and present them in a more innovative form such as pictures, comics or short videos.*

In Hong Kong, public perceptions of institutional responsiveness and competence are, to a large extent, influenced by information obtained from social media. Some informants related their reluctance to subscribe to VHIS plans to how social media shapes the image of the reform. For instance, IN6 explained his point of view:

> *I have read a lot of information about the VHIS plans in the Internet. They listed a lot of disadvantages of purchasing VHIS plans such as higher premium due to higher administrative costs. I think I will have to reconsider whether or not to join the scheme.* (IN6, male, middle class, secondary education, 30-39 years old)

Another informant also shared a similar view:

> *Many netizens analysed why the government finally cancelled the two minimum requirements (high risk pool and free portability). They argue that the government considered more about the interests of insurance companies rather than ours. I very*

*much agree with them. In this case, I will not buy VHIS plans that is not in favour of my interest.* (IN20, female, middle-income, tertiary education, 18-29 years old)

6.3.2. Trust in policy competence

After suffering several economic shockwaves, Hong Kong people's expectations regarding government involvement in the welfare system has been on a steady raise. The management of public expectations become a central issue in maintaining good governance and political legitimacy (Cheung, 2013). The qualitative data suggests that government's competence in managing public expectations influenced the level of public trust in the policy-making institutions, and thereby the degree of public inclination to pay for the reform costs. Hong Kong citizens developed political trust based on their expectations of the present and future actions of the authorities (Wong et al., 2009).

The government's ability to manage public expectation is an important source of public trust in the SAR Government and thereby public attitudes towards the health care financing reform. Out of the 17 informants who opposed the reform, 12 linked government inability to manage public expectations with political distrust, and out of the 22 informants who were unwilling to purchase a VHIS plan, 15 raised the same concerns. Informants felt disappointed with the cancellation of two MRs (high-risk pool and free portability) after the consultation period. Informants were particularly dissatisfied with the fact that the government first stirred up high public expectations during the policy formulation process but then conceded in the final phase. In consequence, this led to a sharp decline in political trust as the government failed to manage public expectations properly. IN30 (a deputy) explained: "The government is always good at raising public expectation and providing 'unrealistic' vision in the policy formulation process. However, if the public finds the government has failed to meet public expectations, political trust will drop dramatically."

Political trust is a reward for meeting public expectations. Failure to properly manage public expectations has created serious negative impacts on public attitudes towards the health care financing reform, disseminating negative sentiments towards the reform and consequently unwillingness to purchase VHIS plans. IN28 (a deputy) remarked:

> *Taking the case of universal retirement protection as an example. The government asked professors to conduct research and propose feasible plans. At that time, the government gained high political trust and raised public expectations. But after the research was completed, the government eventually rejected all the plans. Citizens may think that the government lacks the sincerity to govern the city, resulting in low trust. In the case of the VHIS, the government cut two minimum requirements after the consultation. The government once again failed to meet public expectations after raising them. This has caused members of the public to cease supporting the reform and deterred them from purchasing the plans. It is because citizens may think that the government amended the policy to serve the interests of commercial organizations.*

IN11 (male, middle class, tertiary education, 50-64 years old) shared a similar view and distrusted that the SAR Government has taken the interests of the majority into account:

> *The plans do not meet my expectation. At first, the government included a high-risk pool and a free portability policy. But now, these two MRs were scrapped. In this case, insurance premiums may further increase. It is not a good deal any more. I suspect that the government only considered the opinions of insurance companies.*

The data revealed a new insight in the Hong Kong context: that is, government competence in

managing public expectations is another central factor influencing public perceptions of the health care financing reform. Political distrust does not necessarily lead to lower expectations regarding government responsibility in health care, but may actually raise public expectations in this regard and increase citizens' reluctance to the notion of private responsibility. This explains the paradox of political trust in the Hong Kong context in that government's competence in properly managing public expectations is necessary for the SAR Government to ensure political trust and thereby obtain popular support for private financing. The health care financing reform has thus become highly politicized.

Aside from government's ability to manage public expectation, its perceived ability to tackle policy problems is also a critical predictor of Hong Kong citizens' attitudes towards the reform. Most informants believed that the track record of principal officials in managing major policy problems could provide good reference for them to evaluate the government's ability to undertake the VHIS reform. One informant who worked in public hospital explained:

> *I was really disappointed with what Dr. Ko (Secretary for Food and Health) had done during the SARS crisis. In view of the high infection rate, we had suggested shutting down the ward in the Prince of Wales Hospital. But in the end, he rejected the suggestion. We are all experienced frontline doctors...Why didn't he listen to us? I really do not believe that he can lead this reform well.* (IN17, doctor, male, upper class, tertiary education, 30-39 years old).

Another informant remarked:

> *One can refer to the past policy addresses in Leung's term of office, and note that all*

> *policy suggestions proposed were shallow and were never directed at tackling the structural problems in Hong Kong. Now, they want to initiate another reform and promote private financing in health care. It is absurd to support an incompetent government to accomplish a task that cannot be completed.* (IN6, male, middle class, secondary education, 30-39 years old).

The qualitative results above suggest that the assessment of previous performance of the entire government and principal officials serves as an important reference point for the citizens to develop their "competence trust" (Khodyakov, 2007). This is understandable from ordinary citizens' perspective in that the abstract concept of political trust practically pinpoints to the trust of key individuals who play a central role in the policy reform.

Interestingly, in contrast to the positive relationships between political trust and public support for the reform and willingness to purchase VHIS plans, some informants who distrusted the SAR Government attributed the problems of the health care system to the greater expectations regarding government responsibility in health care. Some complained that the government was incapable of responding to public health needs and performing well. They argued that the SAR Government should be fully responsible for tackling problems arising in the system by itself. For example, IN6 (a disabled person) compared the responsiveness of the SAR Government to that of the British colonial government:

> *Originally, the British colonial government did provide regular meetings with the representatives of the disabled to collect opinions. But the SAR Government has never consulted us about the reform. Our (the disabled) opinions were ignored. Also, the government heightened public expectations regarding the high-risk pool and portable insurance policy and finally failed to implement these measures. How can the*

*government convince us that it has balanced the interests among different stakeholders? I will not seek care in the private sector as it should be the government's responsibility to solve the problems.*

Another informant, IN19 (female, middle class, tertiary education, 30-39 years old), stated: "The government should bear the major responsibility for solving the problems in the public medical system. I do not think the government has put enough effort into tackling the issues. The government should play a more active role." A few other informants shared a similar view. The public will not leave the public medical system but rather will demand more state involvement in the system if they do not trust the government. Therefore, regular consultations with stakeholders are important. Frequent government communication with the public would show respect and help the SAR Government to better understand the public's needs and assist the development of the scheme.

Popular attitudes towards the health care financing reform rest strongly on competence-based political trust. Hence, rebuilding trust is the most crucial agenda for the SAR Government in order to gain popular support for the reform, increase citizens' intention to subscribe to VHIS plans, and reduce expectations regarding government responsibility in health care.

### 6.4. Discussion and summary

On the basis of the preliminary statistical results generated from the quantitative analysis, this chapter provides in-depth explanations characterized by contextual richness of the determinants of public attitudes towards the health care financing reform. Reinforcing the statistical results found in the quantitative phase, the qualitative observations further strengthened the multi-dimensionality of public attitudes towards the reform. To explain the rationale behind public perceptions of the health care financing reform, key themes were

identified in accordance with the three theoretical frameworks: self-interest, ideology, and trust. The qualitative investigation also led to new insights that were not captured in the quantitative phase, enriching the analytical rigor of this study. Synthesizing the results obtained from the first quantitative and second qualitative research phase, it can be construed that Hong Kong people's perceptions of the reform were under the mixed effects of sets of norms and motives. Several theoretical insights have emerged in this regard.

First, self-interest considerations exerted strong impact on people's welfare attitudes, particularly in terms of willingness to purchase VHIS plans. The barriers specifically pertained to the issue of financial affordability, as expected. Concerns over various problems within the private hospital system were behind people's limited interest, especially with respect to transparency in medical billing and ethical standards. People expected adequate government regulation of the private system, the absence of which would eventually lead to—as worried—escalating insurance premiums that would in turn further reduce affordability on the part of the insurees. The major form of adverse selection observed in the qualitative stage was the opting out of the younger generation, which did not stem from low anticipated medical needs per se, but was primarily due to unaffordability. As many young informants stressed, mounting financial pressure and living costs in the exceedingly expensive city of Hong Kong ultimately prevented them from paying for the private insurance.

Second, the self-interest logic did not always operate as anticipated throughout the qualitative study. If common wisdom is robust, one would naturally observe that the elderly would expect stronger responsibility on the part of families and the government in health care and the broad social welfare sector. However, as far as the interviews results have suggested, this conventional assumption is not necessarily true. In effect, a highly salient notion of self-

reliance was identified among elderly informants. One often-cited reason for supporting reform and purchasing VHIS plans was not to leave a "burden" to family members and to be self-sufficient in health care consumption. This "counterintuitive" finding was explained with reference to the distinctive Hong Kong cultural beliefs as inherited from the past era which still exerts its influence in the 21st century.

This finding above illustrates a crucial point: the mass media and many policy-makers have become so accustomed to regarding the elderly as being dependent on the welfare system, that they take that for granted this important cohort of users in their policy narratives. However, to what extent this dependency is a social construct or an economic reality needs to be revisited, at least in the Hong Kong context. Clearly, the residual welfare system of Hong Kong, together with the long-held value of self-reliance and self-sufficiency, vigorously limited the old generation's expectations regarding government responsibility. Such moderate expectations may also in part mirrors the elderly's frustration with the under-provision of social welfare (especially universal retirement protection) which have caused them to expect little from the government.

Third, the qualitative investigation shed light on a crucial aspect of "new" expectation regarding government responsibility in health care that was not revealed in the quantitative results. Many informants, especially the educated middle-class, clearly demonstrated a preference for the government to address more systemic policy issues within the health system, including regulation of the private sector and visionary strategic planning of the public sector. They tended to attribute the current health policy challenges to various deeply-rooted deficiencies at the systemic level and did not necessarily expect government's extensive engagement in direct service provision. This finding, together with the second point made above, offers critical understanding as to what Hong Kong people really expect in

terms of government involvement in health and social welfare. The linear depiction of Hong Kong people expecting stronger or less government presence in a particular welfare domain appears to be too simplistic and fails to generate necessary nuances on their attitudinal dynamics.

Fourth, while the quantitative phase did reveal the prominent explanatory power of egalitarianism in people's welfare attitudes across dimensions, the numbers themselves were unable to further elucidate the formation of attitudes in depth. The qualitative phase offered very useful insights in this regard. A remarkable division was noticed within egalitarians even on the same attitudinal dimension. While some of them opposed the reform arguably due to their long-held egalitarian views, others, particularly those in lower socio-economic positions supported the reform allegedly for the same reason. The former tended to value the principle of equality and the sameness of health care entitlements, whereas the latter built their views on the ideological ground of proportional fairness. Although the small sample size prevents me from generalizing if Hong Kong people's welfare ideologies truly fracture along this line, the finding itself is very invaluable as it offers useful clues as to the nuanced ideological leaning of various sections of the Hong Kong population when forming their welfare attitudes.

Fifth, the qualitative results further disentangled the ideological disposition by illustrating the role of moral responsibilities held by most informants. The sense of moral obligations very vigorously fostered people's positive attitudes towards the reform and helped diminish the counter-effect generated by self-interest motives. In other words, the sense of social solidarity offers a crucial source of attitudinal support for a moderate welfare retrenchment reform that promotes private responsibilities. Normative values override the sheer calculation of material interest, and they seem to have largely transcended conventional lines of social classes.

Though it remains to be substantiated if there is indeed a positive attitudinal feedback, it is posited that the universal nature of Hong Kong's public health care system has functioned to allow the public to internalize these fundamental social values into their cognitive system, in a way that resembles what He, Ratigan and Qian (2020) have described.

Lastly, and most importantly, the qualitative investigation highlighted the critical influence of political trust, citizen participation, and government responsiveness in people's support for the reform. Qualitative results well reinforced the quantitative findings, and offered additional insights. Low political trust did significantly hinder people's support for the reform but this trust deficit was further exacerbated by perceived irresponsiveness of the government, as well as problematic citizen participation mechanisms. Informants were not entirely against the reform as some citizens with positive participatory experience in the consultation process did offer remarkable support for the reform proposal. In a political system with limited universal suffrage, citizens appeared to value public consultations as well as other alternative mechanisms of participation. A strong linear relationship has been observed between people's positive evaluation of the government and their support of the reform. When citizen participation was perceived to be sincere and interactive, citizens appeared to be more willing to support a welfare reform that may incur welfare retrenchment. Unfortunately, the in-depth interviews have witnessed a swathe of negative sentiments as a result of perceived government responsiveness and defective citizen engagement mechanisms.

Moreover, the concept of trust here does not narrowly refer to trust in political institutions which might be too "remote" to citizens of the lower classes, but pertains also to a competency-based trust that hinges on how citizens evaluate the government and its principal officials. This broadened view of trust yielded a very high explanatory power in both phases

of the research and underlined the critical importance of various types of trust in social welfare reforms of a liberal semi-democracy that suffers from daunting trust deficit.

# Chapter 7: Conclusion

## 7.1. Research summary

This thesis has sought to examine citizens' social policy attitudes in Hong Kong, a member of the East Asian welfare regime. In particular, this study has focused on health care, a specific social policy domain, and examined people's attitudes towards a major financing reform. The remarkable trend of welfare retrenchment in many welfare systems in response to global economic uncertainty and escalating welfare expenditures has prompted this research study to investigate how citizens responded to a moderate welfare retrenchment reform in Hong Kong, a liberal semi-democratic polity.

Citizens' support ultimately underpins the legitimacy of modern welfare systems, both enabling and constraining social policy reforms. Welfare retrenchment is a formidable political undertaking because it is easy to trigger social resistance and electoral backfire. Fully appreciating the attitudinal dynamics in the society is therefore critically important. It is even more so in a highly liberal society plagued by daunting political distrust. The absence of universal suffrage put the Hong Kong SAR Government in an extremely awkward position when pushing difficult reforms because it can neither resort to political mandate gained from popular competition, nor completely ignore public opinions. Moreover, the universal nature of health policy makes it a welfare domain typically characterized by strong social solidarity. In Hong Kong's highly equitable public health care system that grants all citizens with universal access, how citizens would react to a reform that increases private financing responsibilities is hence an intriguing topic to examine.

This doctoral research seized the opportunity when the Hong Kong SAR Government was undertaking a major health financing reform in 2014. The purpose of the reform was to

relieve the mounting burden on the public health care system by introducing voluntary private health insurance. Policy-makers were expecting to divert a considerable number of middle- and upper- class citizens from the tax-funded public hospital system to the private sector. To fulfil this mission, the VHIS was intended to regulate all commercial hospital insurance plans and create conducive environment for potential subscribers to join. Although policy-makers branded the reform as a progressive one that would not undermine the government's commitment to high-quality public health care services, the VHIS in its very nature, represents moderate welfare retrenchment, or, layering, in social policy language.

Built on a multi-dimensional conception of welfare attitudes, this study tested an integrated analytical framework which synthesizes self-interest, ideology, and trust explanations. Specifically, this study analysed people's level of support for the health financing reform, their willingness to purchase VHIS plans, and their expectation regarding government responsibility in health care.

To fulfil the research mission, this study adopted a mixed-methods design that synthesized quantitative and qualitative approaches. A telephone survey was used to collect quantitative data on a sample of adult Hong Kong citizens while in-depth interviews were extensively employed to collect qualitative data. The quantitative analysis first examined the statistical relationship between the explanatory variables and citizens' multi-dimensional attitudes towards the health care financing reform. In the second qualitative analysis phase, the explanatory power of the three sets of predictors was further examined by analysing the semi-structured interview data in order to provide an in-depth interpretation of the attitudinal patterns observed. This design allowed both research strategies to complement each other and thus strengthened both internal validity and external validity of key findings derived from the empirical investigation.

Broadly, this study has yielded four significant conclusions. First, reinforcing some recent studies in the international literature, the thesis, through confirmatory factor analysis, revealed the multi-dimensionality of welfare attitudes in the quantitative sample. The latent attitudinal structure indeed contained three dimensions: nominal support for the reform, willingness to purchase the proposed VHIS plans, the expectation for government responsibility in health care. People's attitudinal patterns varied considerably across the three dimensions. While their nominal support and intention to purchase were both moderately low, people's expectation for government involvement in health care was polarized. Taken as a whole, there was no overwhelming evidence showing that a welfare reform emphasizing private financing responsibility is destined to be drawn in massive social opposition.

Second, the observation above inspired me to further examine the determinants of people's attitudes across the three dimensions. As expected, the influence of the self-interest explanations dominated people's intention to purchase the proposed insurance, a practical behavioural decision, whereas ideological leaning, egalitarianism in particular, played a significant role in shaping their normative views in the other two dimensions (i.e., public support for the health care financing reform and expectation regarding government responsibility). Remarkably, trust turned out to be the fundamental motive behind people's welfare opinions. Importantly, trust included not only the general political trust in policy-making institutions, but also how citizens perceived government responsiveness, its citizen participation, and policy competency. If citizens trust in policy-makers' capability to undertake reforms and maintain good institutional competence, they tend to be more receptive of welfare reforms that do not materially benefit themselves.

Third, a few explanatory variables in the quantitative stage did not work in the expected way,

thus prompting me to unpack the complexities through qualitative investigation. A tricky but salient phenomenon warrants close attention and is very illustrative of the dynamics of health care reform in Hong Kong: individuals typically associated with higher health risks did not favour the alternative financing instrument, nor did they seem to be desperately concerned with health care, because the highly equitable government-funded health system always provides a reliable safety net for all in Hong Kong. As a result, policy-makers are trapped in a situation in which only marginal reforms are politically possible.

Fourth, this thesis, particularly its qualitative phase, has discovered a battery of nuanced attitudinal dynamics that are peculiar to Hong Kong and hardly documented in the existing literature. For example, the traditional principles of self-reliance and self-sufficient seem to be upheld by the current generation of older adults too, in part limiting their expectation for extensive government responsibility in health care, something that was not expected prior to the interviews. Moreover, some people did not necessarily expect the government to extensively engage in direct provision of health services but instead, preferred the government to tackle more fundamental issues such as strengthening health regulation. In addition, Hong Kong's public health care system appears to be built on the strong value of social solidarity and positive attitudinal feedback, but the ideological framework goes beyond the linear depiction of egalitarianism and should be further unpacked in future studies.

Most of the broad theoretical expectations set out in Chapter 2 were reinforced. For those that were not supported by empirical evidence, explanations were sought with reference to the peculiar socio-political context of Hong Kong. Overall, this thesis sheds light on the politics and the attitudinal dynamics of social policy reforms in Hong Kong, an East Asian society characterized by a free-market economy, a liberal society, but low political trust.

### 7.2. Research contributions

This thesis contributes to the literature related to welfare attitudes and health care financing reform by providing empirical evidence from a liberal but semi-democratic society in the East Asian context. The study makes several theoretical contributions. First, given the growing trend of political distrust around the world, this study developed an integrated framework that adds political trust as a potential explanatory predictor into the two prominent frameworks of self-interest and ideology. By adopting both quantitative and qualitative research methods, this integrated framework provides a new and comprehensive analytical approach to study welfare attitudes in the times of austerity. The quantitative analysis significantly identified the statistical links between the predictors and citizens' perceptions of the health care financing reform in multiple dimensions, while the qualitative analysis substantially explored the reasons behind citizens' perceptions with contextual richness.

Second, this study enriches the theoretical debates on ideology and its impact on public attitudes towards health care financing reform in the Hong Kong context. Social ideology is considered an important explanatory variable in the welfare world, and this thesis provides a more nuanced understanding of the influence of social ideological commitment on public preferences for private financing in health care through triangulation. The findings demonstrate that the influences of ideology on citizens' perceptions vary in multiple dimensions. These normative values foster rather than reduce public acceptance and support for private financing in health care. Hence, the results show a complex interaction between social ideologies and welfare attitudes in the contemporary world. Moreover, Hong Kong people's nuanced attitudes towards health care, social welfare, and government responsibilities have been revealed in great depth in the qualitative stage, offering rich insights for further investigation into the influence of social ideologies on welfare reforms in East Asia.

Third, this doctoral thesis contributes to the theory of political trust and further extends the explanatory power of the trust argument to public attitudes towards health care financing reform in a semi-democratic society characterized by low political trust. Links between political trust and citizens' perceptions of the health care financing reform were investigated by quantitative and qualitative analysis. The findings show the critical importance of competence-based political trust in all attitudinal dimensions. The "trust paradox" in Hong Kong reflects that public distrust in the policy-making institutions boosts rather than reduces public expectations regarding government responsibility in health care in Hong Kong and undermines support for private responsibility in health care. Overall, this thesis enriches scholarly understanding on the attitudinal dynamics of social welfare reforms in a liberal East Asian society plagued by mounting political distrust, and highlights the strategic importance of citizen participation and government responsiveness in undertaking welfare reforms.

**7.3. Policy implications**

The SAR Government launched the VHIS after a long period of discussion that started in the 1990s. The findings of this doctoral thesis leas to several useful policy implications. First, the public showed a high level of opposition to the reform but generally expressed an encouraging interest in purchasing VHIS plans. Given the voluntary nature of the VHIS, the intention of citizens to subscribe to a VHIS plan was not low when compared to other economies. People do not necessarily oppose a moderate retrenchment reform nor are they completely unwilling to shoulder private responsibility if market risks can be reduced.

Second, most empirical evidence suggests the continued reliance of the Hong Kong population on the public medical system. Hence, whether this financing reform is able to achieve its stated goals remains doubtful. More high-powered policy instruments on the

financing side and more concerted reforms on the provision side are necessary to address the long-standing health policy problems in Hong Kong. For instance, stronger positive incentives such as tax benefits or packing the VHIS with other government-promoted financing programs may strengthen its appeal, especially to the middle class, the target population of this reform.

Third, the key barrier to the success of the VHIS reform does not rest on the demand side but mainly on the supply side, as poor regulation of the private health system severely aggravates people's hesitation to participate. The SAR Government should abandon its long-held non-interventionist stance and impose—with strong political courage—a fair, transparent and robust regulatory framework on private health practices and the private hospital system at large.

Lastly yet importantly, prevalent mistrust in the government stands out as a very powerful hurdle to welfare reforms in Hong Kong. The lack of political trust is further exacerbated by low perceived government responsiveness and the defective citizen participation mechanisms. Social policy making does not happen in vacuum. Popular support must be firmly built on sincere citizen engagement and strategic communication with the society. The SAR Government should certainly review and improve its public consultation mechanisms and strive to rebuild essential trust with citizens.

### 7.4 Limitations

Despite its theoretical and empirical contributions, this thesis is certainly not without limitations. First, although the quantitative data were collected through random sampling, the reduced sample size after missing values in some attitudinal dimensions were excluded might undermine the statistical rigor of the study. Second, the cross-sectional nature of the

quantitative findings pinning the data at a specific point in time also prevents me from tracking and identifying potential shift in people's attitudes over time. Third, the operationalization of some variables in the survey instrument may have been improved. These limitations are humbly acknowledged.

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**Appendix A: Interview Guide**

Suggested interview questions *(with follow-up questions based on informants' answers)*

**A. Self-interest perspective**

1. Do you support the Voluntary Health Insurance Scheme (VHIS)? Why?
   你支持「自願醫療保障計劃(自願醫保)」嗎？為何支持/不支持呢？
2. Are you willing to purchase VHIS plans? Why?
   你是否計劃購買「自願醫保」？為何購買/不購買呢？
3. Do you think the SAR Government should responsible for providing health care protection for all citizens instead of emphasizing private responsibility? Why?
   你認為政府有政有責任為所有市民提供醫療保障，而非由個人承擔？原因何在？

**A. Ideology perspective**

1. In a fair society, the differences in people's living standard should be small. Do you agree? Why?
   在一個公平的社會中，市民生活水平的差異應該是很小。你是否認同？原因何在？
2. Large differences in people's incomes are necessary to reward differences in personal abilities and efforts. Do you accept? Why?
   根據市民的個人能力和努力作獎勵，所以市民的收入差異大是可以接受的。你是否認同？原因何在？
3. Do you accept that there may be differences in the medical coverage enjoyed by people with different social background (e.g. the higher the income, the more medical protection)?
   你是否接受社會上不同階層的人士所享有的醫療保障可以存有差異（如收入愈高，可自己承擔費用享受更多的醫療保障）嗎？原因何在？

**B. Trust perspective**

1. Do you trust the SAR Government? Does the trust in government affect your perceptions of supporting the reform/purchasing VHIS plans? Why?
   你信任香港政府嗎？你對政府的信任是否影響你支持/購買「自願醫保」的決定？原因何在？
2. Have you participated in the consultation of the VHIS?
   你是否曾參與「自願醫保」的公眾諮詢？
   a. (If the informant replies: I have participated) Do you think the SAR Government have response to your opinion? Does your participation increase your confidence level of the health care financing reform initiated by the SAR Government?

（如答「曾參與」者）你認爲特區政府是否有考慮到你的意見？你認爲參與諮詢是否有提高你對改革的信心？

b. (If the informant replies: I did not participate) Why you did not participant in the consultation?
（如答「不曾參與」者）你為何當時沒有參與對該政策提案的公眾諮詢呢？

3. What can be done to increase your confidence/trust in the SAR Government and your support for the reform?
你認為如何能提高你對特區政府的信任及對改革的支持？

**C. Conclusion**

1. Do you have any suggestions for making better policy reforms in health care in future?
你有甚麼建議令特區政府在未來制訂醫療改革可以做得更好嗎？
2. Any other point you would like to add?
你還有其他的意見想表達的嗎？