Studies on Voluntary Supplementary Financing Scheme

Consumer Market Research

Report of Focus Group Study

Prepared for

Food and Health Bureau

Hong Kong Special Administrative Region Government

BY

CONSUMER SEARCH

Content

Introduction

Research Background (1)

- In his Policy Address of 2009-10, the Chief Executive announced the plan to propose a supplementary healthcare financing option based on voluntary participation with insurance and savings components for the second stage public consultation on healthcare reform in 2010. This option will be standardized, regulated, and incentivized by the Government through the use of the $50 billion previously set aside to support healthcare reform. To take this forward, the Food and Health Bureau ("FHB") has commissioned a series of studies to devise a proposal for a feasible incentivized Voluntary Supplementary Financing Scheme ("the Scheme").

Research Background (2)

- The Consumer Market Research represents an integral part of the series of studies commissioned by FHB for the purpose of devising a proposal for the Scheme. It is aimed to generate both quantitative and qualitative analyses regarding consumer preferences about the Scheme, willingness-to-pay, and perceived changes in behaviour on healthcare utilization upon joining the Scheme. In particular, these findings are expected to provide important reference for two other studies in the series, namely “Feasibility Study on the Key Features of the Health Protection Scheme” and “Assessment of the Long-term Implications of the Health Protection Scheme”.
- This report presents the findings of the qualitative analysis in this Consumer Market Research. Findings of the quantitative analysis are presented in another report separately.

Research Objective (1)

- The key objectives of this Consumer Market Research are two-fold:
  a) To provide quantitative and qualitative analyses on attitudes, preferences, expectations and concerns of consumers, who include the currently insured and uninsured, and who are the decision-makers or major influencers on healthcare expenditures of the households, regarding basic design parameters of the Scheme, covering:
     - standardized insurance terms and coverage
     - benefit structure
     - medical savings component
     - premium structure
     - mode and level of subsidy, etc.

The analyses are expected to support mainly the tasks performed by "Feasibility Study on the Key Features of the Health Protection Scheme".

Research Objective (2)

b) To provide quantitative and qualitative analyses on:

1) willingness-to-pay of consumers (currently insured and uninsured) subject to variation in the basic design parameters of the Scheme and/or hypothetical templates of the Scheme; and
2) perceived changes in consumer behavior on healthcare utilization upon joining the Scheme.

The analyses are expected to support mainly the tasks performed by "Assessment of the Long-term Implications of the Health Protection Scheme".

Research Methodology (1)

- In this qualitative research, focus groups were conducted to collect views of participants on design of the Scheme. Hypothetical templates of the Scheme were presented in the sessions to facilitate formulation of ideas and test responses.
- The recruitment pool of Consumer Search, containing around 300 recruiters, was used in the recruitment process. Screening was conducted on all the referrals from the recruiters to ensure they met the participant requirements. 10 participants were recruited for each group, and 8-9 participants were selected to participate in the focus groups. (Participants' profile is provided in Appendix 1).
- A discussion guide was prepared in close consultation with FHB while hypothetical scheme design and features were provided by FHB for concept testing. Three in-depth interviews were conducted as a pilot test for improving the discussion guide and stimuli used in the focus groups. The discussion guide and focus group stimuli are shown in Appendix 2 and 3 respectively.

Research Methodology (2)

- Following the three pilot interviews conducted on June 6, a total of 10 focus groups were conducted at the facilities of Consumer Search between June 14 and 22, 2010.
- All these groups consisted of nine participants except the last group which consisted of eight participants.
- These groups were segregated according to whether or not the participants were paying out-of-pocket (OOP) for private hospitalization insurance, their age bands and income levels. The non-paying participants comprise those who did not have hospitalization insurance at the time of interview (about 70%) and whose insurance coverage were financed by family members or employers (about 30%).
- Both genders were represented and in each group, there were 2-4 participants suffering from some chronic disease.

Research Methodology (3)

Composition of Focus Groups

	Descriptions
Group 1	Age 20-35, Paying Out-of-pocket
Group 2	Age 20-35, Not Paying Out-of-pocket
Group 3	Age 36-49, Paying Out-of-pocket, Higher Income
Group 4	Age 36-49, Paying Out-of-pocket, Lower Income
Group 5	Age 50-65, Paying Out-of-pocket, Higher Income
Group 6	Age 50-65, Paying Out-of-pocket, Lower Income
Group 7	Age 36-49, Not Paying Out-of-pocket, Higher Income
Group 8	Age 36-49, Not Paying Out-of-pocket, Lower Income
Group 9	Age 50-65, Not Paying Out-of-pocket, Higher Income
Group 10	Age 50-65, Not Paying Out-of-pocket, Lower Income

Research Methodology (4)

- The ten focus groups were facilitated by a group moderator who has extensive experience in consumer research of health insurance products. All sessions were fully audio-taped and verbatim transcribed. The moderator identified key concepts and themes through systematic reviews of the data collected.
- We would like to issue our normal caution that for all qualitative research, the projected figures are based on a selective, and usually rather small samples. These figures are not meant for statistical inferences but should be used for supplementing the qualitative analysis with regard to the views and underlying rationales expressed by the focus group participants. Statistical inferences should rely on the telephone survey results provided in another report separately, which do not necessarily tally with indicative figures in this report.

Executive Summary (1)

Attitudes & experience towards comprehensive health insurance

- Group participants who were paying for comprehensive health insurance (the “paying” segment) did so because: (1) they preferred private hospitals and doctors they were familiar with; (2) health insurance was part of their life insurance plan; (3) they wished to supplement the insurance benefits from their employers; (4) they wished to protect their family from financial burden and (5) they sought peace of mind.
- They were largely satisfied with their purchase and most of them said they would continue with their coverage. As one would expect, those who had made claims felt the premium they paid were well-justified. Even those who had not made claims largely treasured the peace of mind provided by insurance.

Executive Summary (2)

- However, some participants felt that because they had not made any claims on their health insurance, the premium they paid was for nil. They felt it would be fairer if they could receive partial refund of their paid premium.
- Participants who did not have or were not paying for comprehensive health insurance (the “non-paying” segment) gave the following reasons: (1) their employers provided sufficient coverage as part of their employment benefit; (2) private hospitalization insurance was too expensive and did not offer enough coverage; (3) insurance premium kept rising with age and inflation; (4) public hospitals ran by Hospital Authority (HA) provided acceptable service anyway.
- There was a common feeling that health insurance was worthwhile only for people who often got sick and required hospital admission.

Executive Summary (3)

- Some individuals with pre-existing conditions had the experience of subscribing health insurance but were either rejected or scared away by prohibitive premium loading.
- Some mid-age participants covered by employer-provided medical benefits worried that the benefits would lapse when they needed them most in post-retirement life.

Executive Summary (4)

Reactions to the Hypothetical Scheme Plans (see Appendix 3)

- Some participants felt that Plan 1 did not provide adequate coverage, according to their previous hospitalization experience or knowledge about common private hospital charges.
- Plan 2 was relatively more appealing in terms of coverage, but still around one-third of the group participants felt it was not good enough.
- Compared to the younger and middle age segments, the older segment attached higher price tags for the proposed plans. They appeared to understand well the reality that health risks increased with age.
- As a way to achieve premium discount, the “expensive cases only” option was accepted by most participants, followed by “deductible” option and then “long-queue cases only”.

Executive Summary (5)

- Some participants favored the “expensive cases only” option because it would protect them from the financial shock of expensive treatments. Chronic disease patients had particularly deep feeling about this. Those who did not favor this option worried that the treatment they needed would probably not fall within the scope of “expensive cases”.
- Some participants felt that deductible was a good way to reduce premium because the deductibles would apply only in case of a claim. Those who were not receptive to the idea opined that deductibles would defeat the purpose of buying insurance.

Executive Summary (6)

- Some participants found the “long-queue cases only” option attractive because they could be freed from long waiting time that might result in worsened health condition. Others, however, found this option unattractive because they believed that HA would schedule a prompt admission if the case warranted it. Therefore in their minds, this option could not add much value to them.
- The participants also suggested other ways to reduce the premium including: discount for family members, no claim discount, payment from the MPF account of the individuals, discount for annual payment or single premium for 10-20 years, loyalty discount, referral discount, tax deduction and company discount (group discount for employees).

Executive Summary (7)

Key Features of the Hypothetical Scheme

- Before the key features of the hypothetical Scheme were unveiled and explained, participants appeared to be lukewarm in general. The “non-paying” segment tended to think that there was no compelling reason to get insured through the Scheme. The “paying” segment did not show a strong push to switch to the scheme.
- After the key features were introduced and discussed, the participants’ attitude towards the hypothetical Scheme turned more positive. More of the “non-paying” segment expressed willingness to consider buying. More of the “paying” segment spoke firmly that the plans compared favorably with their current products in terms of coverage and indicated a strong interest to switch to the Scheme Plans. Compared with the indications before the key scheme features were explained, they would raise the “reasonable” premium for both hypothetical Scheme Plan 1 and Plan 2 by an average of about 20%.

Executive Summary (8)

- “No claim discount” appealed to a full range of participants because they felt it was fair that those who had not made claims should pay a lower premium.
- “Coverage of pre-existing conditions” was well received by participants with chronic diseases as well as other participants. The participants were in general sympathetic towards disadvantaged people and would appreciate that these Scheme Plans could cover them.
- “Guaranteed renewal for life” was a selling feature as participants generally viewed health insurance as a long-term protection rather than short-term relief. They were concerned that they might be rejected by insurers when they turned old and needed protection the most.

Executive Summary (9)

- “Packaged benefit limit” was well received by most of the participants who considered the budget certainty it brought about attractive. Yet a few participants were concerned that it might not compare favourably with itemized benefit structure if the hospitalization lasted longer than normal. Besides, some participants needed more elaboration to comprehend how this innovative feature worked and benefitted them.
- “Standardized terms and coverage” did not receive as much attention as the aforesaid features. Some people found it difficult to comprehend how this element would create value, but they appreciated the assurance provided by the insurance service standards of a scheme overseen by the government.
- “Premium increment guidelines” did not appear to impress many participants as they did not seem to worry too much about unfair pricing. A few participants pointed out that market competition would safeguard against unfair pricing.

Executive Summary (10)

Ways to Promote the Scheme

- The participants suggested different ways that the government could consider in making the Scheme more popular.
- In terms of promotion, the government can: (1) promote the Scheme through the media, get the information out, make sure people understand; (2) emphasize the key features in the Scheme Plans that make the difference and that will attract people's attention.
- In terms of financial incentives, the government can: (1) ensure that the premium is reasonable; (2) provide premium subsidies; (3) offer tax deduction; (4) offer special discount to the elderly who have to pay high premiums and (5) offer special discount to low-income people who can least afford high premiums.
- In terms of administrative measures, the government can: (1) pay claims promptly, deliver good service and (2) make it mandatory like MPF through payroll deduction.

Executive Summary (11)

Attitudes towards Post-retirement Medical Expenditure

- Most of the mid-age and older-age participants had saving habit for post-retirement living needs, including but not limited to healthcare need. Very few of them set a saving target for healthcare specifically. Some bought life insurance that had a hospitalization insurance rider and a savings component.
- The young-age segment had less tendency/propensity to save, partly due to their lower income. Also, post-retirement healthcare sounded too remote and would not drive their savings behavior.
- Participants generally did not resist the idea that they should start savings, but were hesitant about being told why and how to save.

Executive Summary (12)

Attitudes towards Savings Component of the Scheme

- The participants were ambivalent toward the inclusion of a savings component to the Scheme. While the initial responses from many participants were positive, as the discussion proceeded, some had second thoughts about the need for this component and voiced their concerns over the extra financial burden.
- Some participants were concerned about the hypothetical age limit of using the savings component. They desired the flexibility to withdraw the savings for contingency use if and when the occasion arose at all time.
- They were also concerned about the investment return and risks of the savings component. Too conservative an investment strategy might yield too little to catch up with inflation, while too aggressive a strategy would raise the risk for loss.

Executive Summary (13)

- A few participants cited the mini-bond incident in support for their cautious attitude towards investments in financial assets.
- Despite their reservation, the participants generally welcomed the idea of government incentives to encourage savings and opined that it would increase their likelihood to join the Scheme.

Ways to Promote the Savings Component

- To promote the savings component, the Government should: (1) offer a guaranteed return like government bonds; (2) remove the restriction on using the fund until reaching age 65; (3) contribute in part to the savings and (4) allow the insured to pass on the unused savings to family members.

Executive Summary (14)

Desired Forms of Government Incentives

- Most participants opined that the Government should provide some forms of subsidy to encourage people to join the Scheme and to ease their financial burden.
- Subsidy to premium was the most popular form of subsidy among different ideas. On average, the "paying" segment considered that a subsidy equivalent to about one-third of insurance premium was reasonable. The "non-paying" segment indicated a higher desired level of subsidy. This might indicate that there was an inherent gap between the perceived value of health insurance between the "paying" and "non-paying" segments.
- Tax deduction was proposed by some participants. It was relatively well received by participants with middle to higher income. Those with lower income and did not have to pay tax did not consider the idea attractive to them.

Executive Summary (15)

- On the timing of subsidy, a majority of the participants (especially the middle and older segments) did not have a strong view and would accept the idea of the subsidy being deferred until retirement. However, some participants (especially among the younger segment) strongly preferred it paid out now.
- When asked whether the subsidy could take the form of free insurance product upgrade rather than premium discount to standardized product, a majority of the participants preferred premium discount as they considered it more straightforward. Besides, if they wished to upgrade their coverage, they could always do so with the money they had saved from the premium discount.

Executive Summary (16)

The Government's Role

- The participants were more or less equally split on whether the government should manage and operate the scheme internally or outsource to the private insurance companies.
- Those in favor of government management cited the advantages of security/trust, public accountability and simplicity if the government manage and operate the proposed scheme internally.
- Some of these participants felt that they did not need the insurance companies/agents as middlemen. Some did not like the experience they had with insurance companies/agents in claims handling and customer charges.

Executive Summary (17)

- Those in favor of outsourcing to private insurance companies cited the advantages of better marketing expertise; sales, competition and servicing mindset; as well as operational efficiency. Nevertheless, they stressed that government oversight and regulation to safeguard consumer interest would be paramount if the scheme was to be outsourced.
- Some opined that the government was not responsive and might not deliver good service compared to insurance companies/agents. Some said it would be more costly if the government operated the scheme all in-house.

Executive Summary (18)

The Concept of "Middle-tiered" Hospitals

- If needed, the idea of Government operating a number of private hospitals that would provide economy class services at a charge lower than the private hospitals was welcomed by most of the participants.
- Some participants felt that Hong Kong needed more hospitals anyway. "Middle-tiered" hospitals could provide for the middle class a viable third alternative to expensive private services on one hand and long-queue public services on the other. One proviso was that the manpower, professional quality and standards of medical facilities must not be compromised. Less convenient locations and no-frill amenities were considered acceptable tradeoffs to achieve lower costs.

Executive Summary (19)

- For the few who resisted or were reserved about the idea of “middle-tiered” hospitals, there was a common view that a “middle-tiered” service was actually being provided through private beds in some HA hospitals and that new types of hospitals were not necessary to deliver this service.

Utilization of HA services after insured

- A majority of the participants indicated that they might still use the services of public hospitals even though they had health insurance coverage through the Scheme or other channels.
- They cited the following reasons: (1) there is no choice in case of an accident or emergency; (2) some public hospitals are renowned for specific treatments; (3) in some cases, public hospitals have better equipments than private hospitals; (4) for some disease such as cancer, a prolonged follow-up is needed and this can be done at a public hospital at a much lower cost.

報告撮要(1)

對於個人綜合住院保險的經驗、態度和看法

- 自行購買綜合住院保險的受訪者的購買原因主要包括：(1) 他們比較喜歡選擇熟悉的私家醫院及醫生；(2) 住院保險是其人壽保險的一部份；(3) 他們希望能夠補充僱主所提供的保險津貼；(4) 他們希望避免家庭陷入財政負擔及 (5) 但求心安理得。
- 他們大致滿意購買的住院保險，而且願意繼續承保。曾經申領保險賠償的受訪者一般都覺得他們購買保險的決定是正確的。即使沒有申領保險賠償的亦大致上認爲購買保險能求得心安。
- 然而，部份沒有申領保險賠償的受訪者認爲他們付出的保險供款沒有回報。他們認爲如果保險商能退回部份保險供款給他們，會相對公平。
- 非自行購買 / 沒有綜合住院保險的受訪者對醫療保險有以下看法：(1) 僱主爲員工購買的保險已提供足夠的保障；(2) 私人住院保險過於昂貴，而且沒有提供足夠的保障；(3) 保費隨年齡及通賬不斷上升；(4) 他們認爲醫院管理局(醫管局)轄下的公立醫院所提供的服務水平能夠接受。
- 受訪者普遍認爲只有經常患病及需要醫院服務的人才值得購買醫療保險。

報告撮要(2)

- 有部份受訪者曾嘗試投保，但因已知疾病而不受保或因保費附加費過於昂貴而放棄投保。
- 部分中年受訪者擔心在退休後最需要醫療保障的時候，會喪失現時由僱主提供的保險津貼。

對於假設的住院保險計劃的反應及意見 (見 Appendix 3)

- 根據過去住院經驗及私家醫院收費，部份受訪者認爲假設計劃(一)沒有提供足夠保障。
- 假設計劃(二)在保障範圍上相對吸引，但仍有大約三分之一受訪者認爲計劃保障不夠完善。
- 相對年輕及中年的受訪者，年紀較大的受訪者較爲願意給假設計劃付較高的保費。他們似乎甚爲了解健康風險會隨著年齡增加的現實情況。
- 至於減低保費方法，接受「只包括部份昂貴的治療」方案的受訪者最多，其次是「 索償墊底費」 方案，最後是「只包括部份在公立醫院輪候時間較長的手術」方案。

報告撮要(3)

- 部份受訪者較喜歡「只包括部份昂貴的治療」方案，因爲這方案能避免他們面對高昂手術費用的時候，陷入財政困難，慢性疾病的患者對此方案有特別深的感受。不喜歡這個方案的受訪者則擔心自己需要做的手術不符合「昂貴的治療」的範圍。
- 部份受訪者認爲索償墊底費是減少保費的一個好方法，因爲索償墊底費只會影響需要申領保費的人。不過，不接受這方法的受訪者認爲索償墊底費與他們購買保險的目的背道而馳。
- 部份受訪者認爲「只包括部份在公立醫院輪候時間較長的手術」方案吸引，因爲他們能夠避免漫長的輪候時間，從而減低病情惡化的風險。然而，其他受訪者認爲若有緊急的病況，醫管局自會作出適時安排，故方案並不吸引。
- 受訪者亦建議了一些方法來減少保費：包括，家庭成員優惠、無索償折扣、個人保費由強積金戶口支付，年度折扣或爲期10-20年的單一保費、忠實客戶優惠、推薦優惠、減稅及公司優惠(員工團體優惠)等等。

報告撮要(4)

假設計劃的主要特徵

- 在介紹及解釋假設計劃的主要特徵之前，普遍受訪者對計劃反應一般。一些非自行購買 / 沒有綜合住院保險的受訪者認爲沒有原因驅使他們參與這個計劃。一些自行購買綜合住院保險的受訪者則覺得沒有強大的推動力轉用此計劃。
- 在介紹及討論假設計劃的主要特徵後，受訪者的態度轉向正面。更多非自行購買 / 沒有綜合住院保險的受訪者表示會考慮購買。更多自行購買綜合住院保險的受訪者明言這計劃比現在購買的保險產品在保障範圍方面更全面，並表明有意轉用假設計劃。和解釋假設計劃的主要特徵前比較，他們會願意增加假設計劃一及二的「合理」保費平均大約20%。
- 大部份受訪者對「無索償折扣」感到吸引，因爲他們認爲沒有索償的人支付較便宜保費的做法比較公平。
- 慢性病患者及其他受訪者對「已有疾病的保障」有較好的評價。此外，受訪者普遍同情較爲不幸的社群，認爲假設計劃應盡量照顧他們的需要。

報告撮要(5)

- 「保證終身續保」是一個賣點，因受訪者普遍視醫療保險爲一項長遠保障，而非短期補助。他們擔心當年紀漸大及在最需要保障的時候，却被保險公司拒絕續保。
- 很多受訪者認爲「套餐式賠償上限」可帶來明確的醫療預算，故這特徵也廣受歡迎。然而，有少部分受訪者擔心一旦住院期需要延長，套餐式賠償的優惠或不及傳統的逐項收費架構。亦有個別受訪者需要較多細節去理解這項新特徵如何運作及自已如何受惠。
- 對比上述的特徵，「統一條款及保障範圍」沒有受到太多注意。部份受訪者無法充分理解這特徵的價值，但他們意識到由政府監管的計劃，保險服務水平將有一定保証。
- 政府對「保費增加方法」作出指引的概念似乎沒有令很多受訪者留下印象，因爲他們並沒有對不公平保費定價有太大憂慮。有少部份受訪者指出足夠的市場競爭已能防止不公平定價的出現。

報告撮要(6)

宣傳計劃的方法

- 受訪者建議政府可思考不同方面，從而令計劃更普及。
- 宣傳方面，政府可以：(1) 通過媒體宣傳及介紹計劃，確保市民明白計劃內容；(2) 突出計劃的主要特徵，從而吸引市民注意。
- 財政誘因方面，政府可以：(1) 確保保費合理；(2) 提供保費津貼；(3) 提供稅務優惠；(4) 提供特別優惠予需要繳交高保費的老年人；(5)提供特別優惠予低收入人士以支付保費。
- 行政措施方面，政府可以：(1) 加快發放保險賠償及提供優質服務；(2) 仿效強積金，通過強制工資扣減來運作。

對退休後的醫療費用的看法

- 大部份中年及年長受訪者均有儲蓄習慣，爲退休後的生活作準備，包括但不限於醫療所需開支。只有很少部份的受訪者訂下醫療的單一儲蓄目標。有部份受訪者有購買包含住院保險及儲蓄元素的人壽保險。
- 年輕受訪者有較少的儲蓄傾向，低收入是部份原因。此外，退休後的醫療需要對其感覺太遙遠，無法驅使他們積極爲此儲蓄。
- 受訪者普遍並不抗拒儲蓄觀念，但認爲須自行決定儲蓄的目標和方法。

報告撮要(7)

對計劃中儲蓄元素的看法

- 有受訪者認爲儲蓄元素與計劃存在矛盾。不少受訪者起初的反應正面，但經過討論後，部份產生是否必須儲蓄元素的疑問，甚至提出此元素只會造成額外的財政負擔。
- 部份受訪者憂慮使用儲蓄部份的年齡限制。他們期望若有緊急情況，任何時間都能夠彈性提取儲蓄。
- 他們亦對儲蓄部份的投資回報和風險存有擔憂：太保守的投資策略帶來太少回報，趕不上通脹，而太進取的策略則會提高投資風險。
- 少部份受訪者引用迷你債券事件來解釋其面對金融資產的謹慎態度。
- 儘管對儲蓄元素存有保留，但受訪者普遍歡迎政府爲醫療儲蓄提供財政誘因，並表示這會增加他們參與的可能性。

推廣儲蓄元素的方法

- 就推廣儲蓄元素的方法，有受訪者認爲政府應該：(1) 像政府債券般提供保證回報；(2) 允許在65歲前使用該儲蓄；(3) 資助部份儲蓄供款；(4) 允許儲蓄者把剩餘的儲蓄留給家庭成員。

報告撮要(8)

期望的政府補助方式

- 大部份受訪者認爲政府應該爲計劃提供某種形式的補貼，鼓勵人們參與計劃，減輕他們的經濟負擔.
- 保費補貼是最受歡迎的補助方式。平均來說，自行購買綜合住院保險的受訪者認爲合理補助須相等於約三分之一的保費支出，而非自行購買 / 沒有綜合住院保險的受訪者則認爲須有更高補助。這差異某程度反映自行購買綜合住院保險的受訪者及非自行購買 / 沒有綜合住院保險的受訪者對醫療保險價值觀的基本差異。
- 部份受訪者建議稅務優惠，這受到中高收入的受訪者歡迎，相反，低收入和不須繳稅的受訪者，認爲此建議不太吸引。
- 在支付補助時間方面，大部份受訪者(尤其是中年及老年組別)沒有明顯的傾向，並接受補助在退休後發放的建議。然而，部份受訪者(尤其是年輕組別)強烈建議補貼應即時支付。
- 當被問及應該以免費爲保險產品升級還是保費減免的形式提供補助，大部份受訪者認爲保費減免比較直接。此外，若想爲保險產品升級，他們認爲也可以隨時運用因保費減免節省的金錢，做法相對靈活。

報告撮要(9)

政府所扮演的角色

- 對於應由政府或私人保險公司管理及營運此計劃，兩方立場的受訪者約各佔一半。
- 支持政府管理的受訪者指出若由政府內部管理及營運，好處包括安全可信、對公眾問責及運作簡單。
- 一些受訪者認爲此計劃不用保險公司/保險代理作爲中介，他們部份曾在保險公司申索償及客戶收費上有不愉快的經驗。
- 支持外判私人保險公司認爲保險公司有市場觸覺；銷售競爭及服務觀念；以及營運效率的優勢。不過，他們強調如果該計劃被外判，政府的監督和規管來保障消費者的利益是非常重要的。
- 對比保險公司/保險代理，部份受訪者認爲政府對市場需要的敏感度較低，不一定能提供良好服務質素。部份受訪者亦認爲若由政府內部營運計劃，成本會較高。

報告撮要(10)

「中價醫院」的概念

- 如有需要，以政府營運部份私家醫院，以較低價錢提供大眾化的私家醫院服務的概念受到大部份受訪者的歡迎。
- 部份受訪者覺得香港基本上需要更多醫院。「中價醫院」在昂貴的私家醫院及長輪候時間的公立醫院中間能提供另類選擇，但須在人力資源、專業質素及醫療設備水平符合標準。他們接受醫院地點較爲偏遠及裝修較爲簡樸作爲節省成本的折衷辦法。
- 少部份受訪者反對或對「中價醫院」 的概念有保留，他們認爲實際上部份醫管局轄下醫院已透過私家病牀提供「中價醫院」質素相等的服務，因此，並認爲沒有必要去推行提供此服務。

受保後對醫管局服務的使用

- 大部份受訪者認爲即使受到計劃或其他途徑的醫療保險保障，他們仍然有機會使用公立醫院服務。
- 他們主要提出以下原因：(1) 在意外或緊急情況時並沒有其他選擇；(2) 部份公立醫院一些治療上享有良好聲譽；(3) 在某些情況下，公立醫院的設備比私家醫院優勝；(4) 某些需要長時間醫治的疾病，例如：癌症，公立醫院的收費較底，支出較有預算。

Findings

– Part 1 –
Attitudes and Experience towards Comprehensive Health Insurance

Attitudes & experience towards comprehensive health insurance (1)

- Participants who were paying for comprehensive health insurance (the “paying” segment) gave the following reasons for taking out the insurance:
  - Prefer using private hospitals and doctors they are familiar with.
  - The hospitalization insurance is part of their life insurance plan.
  - To supplement the insurance benefits from their employers.
  - To protect their family from financial burden.
  - For peace of mind.

Attitudes & experience towards comprehensive health insurance (2)

- Participants were largely satisfied with their purchase and many said they would continue with their coverage.
- As one would expect, those who had made claims felt the premium they paid were well-justified.
- Even those who had not made claims treasured the peace of mind provided by insurance.

"This insurance is well worth it. I had a gastro-endoscopy at a private hospital. It was very expensive, but was all covered." (Younger age, paying OOP, higher-income)

"I have paid the premium for over 10 years. I am happy that I have not made any claims. Insurance is for peace for mind. It's really to protect my children from financial burden if and when I get sick. I am glad I didn't profit from it!" (Older age, paying OOP, lower-income)

Attitudes & experience towards comprehensive health insurance (3)

- However, some participants felt that because they had not made any claims on their health insurance, the premium they paid were for nil. They felt it would be fairer if they could receive partial refund of their paid premium.

> *"It's not worth it. I paid 2-3 thousand a year and have never used it even once." (Younger age, paying OOP, higher-income)*

- A participant cited a claim experience related to exclusion which was note-worthy. His claim was turned down because the associated illness was a pre-existing condition that he had not declared to the insurer when enrolling for the insurance. Unhappy with this, he had since discontinued the subscription for health insurance.

Attitudes & experience towards comprehensive health insurance (4)

- Those who did not have or were not paying for comprehensive health insurance (the “non-paying” segment) gave the following reasons:
  - Their employers provide sufficient coverage as part of their employment benefit.
  - Private hospitalization insurance is too expensive and does not offer enough coverage.

“I am covered by my company. Even if I do not have company coverage, I will not consider paying on my own because it's expensive and I am healthy. For minor problems, I will go to HA. For serious operations, I may consider private hospitals.” (Middle age, not paying OOP, higher-income)

“It’s too expensive. The cheaper kind does not cover much. So it's no protection either.” (Middle age, not paying OOP, higher-income)

Attitudes & experience towards comprehensive health insurance (5)

- Insurance premium rises with age and inflation, so that the protection may not be affordable over time.
- Public hospitals run by Hospital Authority (HA) provide acceptable service anyway.

- For the non-payment segment, there was a common view that health insurance was only worth the money paid when one often got sick and required hospital admission. A lot of participants said that they seldom got sick and expected to stay healthy in the foreseeable future. This perception of risk was particularly apparent for the young participants.

> *"I seldom got sick. On the few occasions when I did get sick, I only went to a clinic, not a hospital." (Younger age, not paying OOP, higher-income)*

- Some mid-age participants covered by employer-provided medical benefits worried that the benefits would lapse when they needed them most in post-retirement life.

Attitudes & experience towards comprehensive health insurance (6)

- A few participants with pre-existing conditions had the experience of subscribing health insurance but were either rejected or scared away by prohibitive premium loading.

> *"I have chronic disease. I wanted to buy hospitalization insurance many years ago but was rejected. HA is my only option because private hospitals are too expensive." (Middle age, not paying OOP, higher-income)*

– Part 2 –
Reactions and Comments on the Hypothetical Scheme

Reactions to the Hypothetical Scheme Plans (1)

- A certain number of participants felt that Plan 1 did not provide adequate coverage, according to their previous hospitalization experience or knowledge about common private hospital charges.

> *"Surgery fee is too low for private hospitals." (Younger age, paying OOP, higher-income)*

> *"This is a very basic coverage. What I have bought is probably much better coverage." (Older age, paying OOP, higher-income)*

> *"MRI coverage is too low. It costs 7-8 thousand." (Younger age, paying OOP, higher-income)*

- Plan 2 was relatively appealing in terms of coverage, but still around one-third of the participants felt it was not good enough.

Reactions to the Hypothetical Scheme Plans (2)

- For both plans, the “paying” segment indicated a slightly higher premium than the “non-paying” segment. This modest difference echoed our observation that price was an important but not an overwhelming factor influencing the decision of the participants to choose insured or not. They were also concerned about value-for-money in relation to their health risks and level of protection being offered.
- There was no distinct systematic difference between participants with chronic disease and those without as far as willingness-to-pay was concerned.
- Compared to the younger and middle age segments, the older segment attached higher price tags for the proposed plans. They appeared to understand well the reality that health risks increased with age.

Ways of Reducing the Premium (1)

- Three ways to reduce premium – “deductibles”, “expensive cases only”, “long-queue cases only” – were proposed to test response (See Appendix 3).
- About two-thirds of participants welcomed the idea of premium discount option. Many of them came from the lower income segment and the older segment (age 50-65). The former appeared to be relatively price-sensitive in general, while the latter was attracted by a more substantial sum of savings from the discount as old-age premium was higher.
- About one-third of participants did not favour the idea of premium discount option. They preferred paying more premium to avoid compromise in the level and scope of protection.
- In terms of perceived attractiveness, “Expensive cases only” coverage was accepted by most participants, followed by “deductible” option and then “Long-queue cases only” coverage.

Ways of Reducing the Premium (2)

- On the option of premium discount through “expensive cases only” coverage, some participants subscribed to the idea because it would protect them from the financial shock of expensive treatments. Chronic disease patients had particularly deep feeling about this.

> *“I have chronic disease. This ‘expensive cases only coverage’ can be a good deal for me because I am paying over 100% premium loading now. This should reduce my premium significantly.” (Younger age, not paying OOP, higher-income)*

- Those who did not favor the idea worried that the treatment they needed would probably not fall in the delineated scope of “expensive cases”.

> *“It’s hard for me to decide unless I know what diseases will be covered under this ‘expensive cases only coverage’” (Middle age, not paying OOP, higher-income)*

Ways of Reducing the Premium (3)

- On the option of premium discount through deductible, some participants felt it was a good way to reduce premium because the deductibles would apply only in case of a claim and the amount was affordable to them.

> *"$15000 is a small amount in the case of hospitalization. I am willing to pay this deductible in exchange for a lower premium." (Older age, paying OOP, higher-income)*

- Some of those who were not receptive to the idea opined that the element of deductible would defeat their purpose of buying insurance.

> *"If the treatment costs less than the deductible, then I will end up paying for everything. What is the point of buying insurance, then?" (Younger age, paying OOP, higher-income)*

Ways of Reducing the Premium (4)

- On the option of premium discount through “long-queue cases only” coverage, some participants found the idea attractive because they could be freed from long waiting time that might result in worsened health condition.

“This ‘long-queue only’ coverage is attractive. If I can get prompt treatment at HA, I don’t think I need to go to a private hospital. Thus, I don't need coverage for ‘short-queue cases’. This option can help keep my premium low. But they need to review the list of long-queue cases regularly.” (Older age, paying OOP, higher-income)

- Some, however, found this option unattractive because they believed HA would schedule a prompt admission if the case warranted it. Therefore in their minds, this option could not add much value to them.

“There is no need for this ‘long-queue only’ coverage because HA will schedule you if you need urgent admission”. (Middle age, not paying OOP, higher-income)

Ways of Reducing the Premium (5)

- The participants also suggested other ways to reduce the premium:
  - Discount for family members: family plan (Many cited the inevitably high premium for old people and the importance of insuring young children)
  - No claim discount
  - Payment from the MPF account of the individual (but a few other participants voiced their displeasure when this suggestion was made)
  - Discount for annual payment or single premium for 10-20 years
  - Loyalty discount for long stay-on with the scheme
  - Referral discount (for both the referrer and referee)
  - Tax deduction (but some pointed out that this could benefit only those who were paying salary tax)
  - Company discount (group discount for employees)

Perception of the Hypothetical Scheme (1)

- Before more key features about the hypothetical scheme plans were unveiled and explained, the participants appeared to be lukewarm in general. The uninsured tended to think that there was no compelling reason to get insured through the scheme. The insured also did not show a strong push to switch to the scheme.
- The attitude towards the hypothetical scheme plans turned more positive after the key features were introduced in details. More of the uninsured expressed willingness to consider buying the hypothetical scheme plans. More of the insured spoke firmly that the plans compared favorably with their current products in terms of coverage, and showed interest to switch to the plans.
- Consistent with higher level of interest, participants generally raised the amount of premium for both hypothetical scheme plan 1 and plan 2 that they considered reasonable. The average increase was about 20%.

Perception of the Hypothetical Scheme (2)

- More specifically, 9 key features of the hypothetical scheme plans were listed out and participants were asked to rank the features by (a) clarity in meaning; (b) effect on attractiveness of the plans.
- At the risk of over-generalization, the responses for (a) and (b) have been aggregated to show the ranking of the 9 features. The ranking together with some related questions and comments are shown in the following table.

Perception of the Hypothetical Scheme (3)

Key scheme features	Clear	Compelling	Common questions / comments
No claim discount	High	High	A fair pricing method
Coverage of pre-existing conditions	High	High	How about illnesses that may be related to some pre-existing conditions?
Guaranteed renewal for life	High	High	But will this element raise my premium?
Coverage of inpatient treatment or surgery at outpatient setting	High	Medium	More choices as day surgery is also covered
Free switch of insurers	Medium	Medium	Will my premium change when I transport?
Packaged benefit limit	Medium	Medium	What if the actual charges are higher than the packaged rate?
Premium loading limits	Medium	Low	How are the limits set?
Standardized insurance terms & coverage	Low	Low	So why will that benefit me?
Premium increment guidelines	Low	Low	How are the guidelines set?

Perception of the Hypothetical Scheme (4)

- “No claim discount” appealed to a full range of participants because it was widely considered fairer to allow one who did not make claim to pay less premium.
- “Coverage of pre-existing conditions” was well received by not only participants with chronic diseases but also other participants. The participants were in general sympathetic towards disadvantaged people and appreciated that the Scheme would take care of these people.
- “Guaranteed renewal for life” was a selling feature as participants generally viewed health insurance as a long-term protection rather than short-term relief. In particular, some were concerned whether they would be rejected by insurers when they turned old and needed protection the most.

Perception of the Hypothetical Scheme (5)

- “Packaged benefit limit” was well received by most of the participants who considered the budget certainty it brought about attractive. Yet a few participants were concerned that it might not compare favourably with itemized benefit structure if the hospitalization lasted longer than normal. Besides, some participants needed more elaboration to comprehend how this innovative feature worked and benefitted them.
- “Standardized terms and coverage” did not receive attention as much as the aforesaid features. Some people found it difficult to comprehend why this element created value, but they appreciated the assurance about insurance service standard that a government scheme should provide.
- “Premium increment guidelines” did not impress extensively as lots of participants did not seem to worry too much about unfair pricing. A few participants pointed out the importance of competition as the best safeguard against unfair pricing.

Ways to Promote the Scheme

- The participants suggested different ways that the government could consider in making the Scheme popular:

Promotion

- Promotion campaign. Get the information out. Make sure people understand.
- Emphasize the plan features in the promotion that make the difference and attract people's attention.

Financial incentives

- Ensure that the premium is reasonable.
- Provide premium subsidies.
- Offer tax deduction (provide relief to the working, tax-payers).
- Offer special discount to the elderly (to alleviate the high premium charged to this segment).
- Offer special discount to low-income people (who can least afford high premiums).

Administrative

- Pay claims promptly. Deliver good service.
- Make it mandatory like MPF through payroll deduction.

- Part 3 –
Attitudes towards Post-retirement Medical Expenditure and Savings Component of the Scheme

Attitudes towards Post-retirement Medical Expenditure

- Most of the mid-age and older-age participants had saving habit for post-retirement living needs, including but not limited to healthcare need. Very few of them set a saving target for healthcare specifically. Some bought life insurance that had a hospitalization insurance rider and a saving component.
- The young-age segment had less tendency/propensity to save, partly due to lower financial ability. Besides, post-retirement healthcare sounded too remote and was not a drive for their saving behavior generally.
- Participants generally did not resist savings as far as income after deduction for living expenses could allow, but were hesitant about being told why and how to save.

Attitudes towards Savings Component of the Scheme (1)

- On the desirability of introducing a savings component to the Scheme, the participants were ambivalent. The spontaneous response from many participants were positive, but when the discussion proceeded to the details, some had second thought about the need for this component and voiced their concerns over the extra financial burden.

"This will be just like MPF! It will take even more out of my paycheck!" (Younger age, paying OOP, higher-income)

"Other insurance companies offer this savings feature too. Why copy them? Part of MPF can be used for future medical expense, why the duplication?" (Younger age, paying OOP, higher-income)

Attitudes towards Savings Component of the Scheme (2)

- Some participants were concerned about the hypothetical age limit of using the savings component. They desired flexibility to withdraw the savings for contingency use at all time.

"Why must I wait until 65 to use this savings? I might get sick before turning 65!" (Younger age, paying OOP, higher-income)

"I can choose among the different products in the market and I don't need to wait until 65 to use it." (Younger age, not paying OOP, higher-income)

Attitudes towards Savings Component of the Scheme (3)

- There were also considerable concerns about the investment return and risks of the savings component. Too conservative an investment strategy might yield too little to catch up with inflation, while too aggressive a strategy would risk loss in capital value.
- A few participants cited the mini-bond incident to explain their cautious attitude towards investment initiatives.

"I need to know its investment return and I don't want to have to wait until 65 to be able to use it." (Younger age, not paying OOP, higher-income)

"Nowadays, there are many saving and investment vehicles, this savings component is not necessary. I'd rather buy bonds!" (Younger age, not paying OOP, higher-income)

Attitudes towards Savings Component of the Scheme (4)

- Notwithstanding the reservation, participants generally welcomed the idea of government incentives to encourage savings and opined that so-doing would increase their likelihood to join the Scheme.

> *"It is attractive only if the government will also contribute to my account." (Younger age, paying OOP, higher-income)*

Ways to Promote the Savings Component

- The participants expressed different ideas that the Government might consider to promote the savings component:
  - Offer a guaranteed return like government bonds. The participants would expect a guaranteed return with minimum risk for their savings component. They wanted to make sure that this money would be at their disposal when they needed it.
  - Remove the restriction on using the fund until reaching age 65. An often-asked question: “What would I do if I need the money for medical expenses before I turn 65?”
  - Contribute in part to the saving. Government (partial) contribution to the savings component would provide the needed incentive.
  - Allow the insured to pass on the unused savings to family members. Another often-asked question: “What will happen to my money (the sum of my contributions) if I die before I have used any of it?”

Desired Forms of Government Incentives (1)

- Most participants opined that the Government should provide some forms of subsidy to encourage people to join the Scheme and relieve their financial burden.
- Subsidy to premium was the most popular form of subsidy among different ideas. On average, the “paying” segment considered that a subsidy equivalent to about one-third of insurance premium was reasonable. The corresponding figure for “non-paying” segment was even higher. To some extent, this high percentage could be interpreted to reflect that there was inherent gap between the use value of health insurance perceived by the non-payers and the payers.
- The idea of tax deduction was proposed by some participants and discussed around the table. It was relatively received by people with middle to higher income, although some of them did not fully subscribe to the idea as it would benefit taxpayers only. People with lower income and without tax burden did not consider the idea attractive to them.

Desired Forms of Government Incentives (2)

- On the timing of subsidy, a majority of the participants (especially the middle and older segments) did not have strong view and accepted the idea of the subsidy being deferred until retirement.

> *"It's fine if the government subsidy is accrued under my account and cannot be used until I retire." (Older age, not paying OOP, higher-income)*

- However, quite some participants (especially among the younger segment) strongly preferred it paid out now.

> *"Setting an age threshold is unrealistic because one might incur medical expenses at any age." (Younger age, paying OOP, higher-income)*

> *"We should be able to use the subsidy as the need arises, and not to wait until age 65." (Younger age, paying OOP, higher-income)*

Desired Forms of Government Incentives (3)

- The participants were also asked whether the subsidy should also take the form of free insurance product upgrade rather than premium discount to standardized product. A majority of participants prefer premium discount as they considered it more straight-forward and attractive to allow free use of saved amount afterwards. There was a notable insight that the savings from premium discount could always allow people to go backward and upgrade the insurance product, but the reverse was not feasible.

"I like price discount. Product upgrade is not meaningful to me!" (Younger age, not paying OOP, higher-income)

"I can buy higher coverage if I can afford it, product upgrade is a poor substitute for discount." (Younger age, not paying OOP, higher-income)

– Part 4 –
Government's Role in the Scheme

The Government's Role (1)

- The participants were more or less equally split on whether the government should manage and operate the scheme internally or outsource to the private insurance companies.
- Those in favor of government management cited the advantages of security/trust, public accountability and simplicity if the government manages and operates the proposed scheme internally.

"The government will be more accountable. They will respond to our complaint." (Middle age, not paying OOP, lower-income)

"The government is more secure. Even the biggest companies failed during the financial crisis, but the government was unaffected." (Middle age, not paying OOP, lower-income)

"The government should do it all and not to outsource. I have had enough trouble with the MPF!" (Older age, not paying OOP, higher-income)

The Government's Role (2)

- Some participants felt that they did not need the insurance companies/agents as middlemen. Some of them did not like the experience they had with insurance companies/agents in claims handling and customer charges.

> *"Insurance companies are slow and reluctant to pay claims."*
> *(Younger age, paying OOP, higher-income)*

> *"I trust the government much more than insurance companies. They showed little transparency in how they charged the customers."*
> *(Middle age, not paying OOP, higher-income)*

The Government's Role (3)

- Those in favor of outsourcing to private insurance companies cited the advantages of better marketing expertise; sales, servicing and competition mindset; as well as operational efficiency. Nevertheless, they stressed that government oversight and regulation to safeguard consumer interest would be paramount if the scheme was to be outsourced.

"I think the government should outsource to private insurance companies. I am very satisfied with my insurance agent." (Older age, paying OOP, higher-income)

"It's better to outsource to private insurance companies. They can utilize existing facilities and staff. This would save money. Otherwise, the government would need to set up a new department at a high cost." (Younger age, not paying OOP, higher-income)

"MPF is a good outsourcing model for the government to follow: the consumers can choose providers and the government will oversee." (Younger age, not paying OOP, higher-income)

The Government's Role (4)

- Some opined that the government was not responsive to market needs and might not deliver good service compared to insurance companies/insurance agents.

> *"Insurance agents are very responsive because they work for commission. The government is not responsive when I need some answers." (Middle age, paying OOP, lower-income)*

- Some said it would be more costly if the government operated the scheme all in-house.

> *"It will be costly for the government to operate this without outsourcing. They would need to set up the system and to hire many staffs." (Middle age, paying OOP, lower-income)*

The Concept of “Middle-tiered” Hospitals (1)

- If needed, the idea of Government operating a number of private hospitals that would provide economy class services at a charge lower than corresponding private hospitals was welcomed by most of the participants.
- The participants generally felt that more hospitals were needed in Hong Kong anyway. “Middle-tiered” hospitals could provide a buffer for the middle class to choose between the two ends of expensive private services and long-queue public services.

> *“To succeed, these hospitals need to cater and appeal to the needs and demands of the middle class.” (Younger age, paying OOP, higher-income)*

> *“Hong Kong needs more medical facilities anyway.” (Younger age, paying OOP, higher-income)*

The Concept of “Middle-tiered” Hospitals (2)

- The support for the idea was conditional upon the premise that the manpower quality and standard of medical facilities was not compromised for the lower charges.
- Most though not all participants who supported the idea accepted less convenient location of hospitals and less expensive amenities if such were needed to keep the charges lower.

“People prefer private hospitals because of their facilities and service so if these proposed hospitals can deliver the same standard of service, then it will work.” (Younger age, paying OOP, higher-income)

“It will be great if this can be done. I am afraid they can't build enough of this kind of hospitals to meet the demand.” (Older age, paying OOP, higher-income)

The Concept of “Middle-tiered” Hospitals (3)

- For the few who resisted or were reserved about the idea, there was a common view that a “middle-tiered” service was actually being provided through private beds in some HA hospitals and that new types of hospitals were not necessary to deliver the same sort of service.

“Actually, there is a wide range in the price charged by private hospitals. Some are cheaper. This idea of "middle-tiered" hospitals is not very clear. This sounds like the subsidized housing projects for people who can't qualify for public housing and can't afford to buy private flats.” (Younger age, not paying OOP, higher-income)

“There is already private patient service at HA. My child was treated at a public hospital as a private patient. The service was very good and was cheaper than a private hospital.” (Middle age, paying OOP, higher-income)

Utilization of HA services after insured

- A majority of the participants indicated that they might still use the services of public hospitals even though they had health insurance coverage through the scheme or other channels. They cited the following reasons :
  - For accident or emergency cases.
  - Some public hospitals are renowned for specific treatments.
  - In some cases, public hospitals have better equipments than private hospitals.
  - In some cases, such as cancer treatment, a prolonged follow-up is needed and this can be done at a public hospital at a much lower cost.

Appendix 1
Participants' Profile

Participants' Profile (1)

- **Total Number of Participants = 89**

- Gender (N=89)

Male	Female
46.1%	53.9%

- Age (N=89)

Aged 20-35	Aged 36-49	Aged 50-65
20.2%	40.4%	39.3%

- Paying Out-of-pocket for Comprehensive Health Insurance (N=89)

Paying Out-of-pocket	Non-paying Out-of-pocket
50.6%	49.4%

Participants' Profile (2)

- With / Without Comprehensive Health Insurance for Non-paying Group (n=44)

With Comprehensive Health Insurance			Without Comprehensive Health Insurance
From Employers	From Family Members	From Both Employers and Family Members	
22.7%	4.5%	2.3%	70.5%

- Household Income (N=89)

Higher Income ($20,000 or above)	Lower Income (Below $20,000)
60.7%	39.3%

- Chronic Disease (N=89)

With Chronic Disease	Without Chronic Disease
31.5%	68.5%

Participants' Profile (3)

- Monthly Premium Paying for Paying Group (n=45)

	Aged 20-35	Aged 36-49 Higher Income	Aged 36-49 Lower Income	Aged 50-65 Higher Income	Aged 50-65 Lower Income	Overall
Average	$304	$336	$346	$544	$335	$373

- Purchasing Channel for Paying Group (n=45)

Directly from Insurance Companies	From the Agents of Insurance Companies	Directly from Banks
80.0%	2.2%	17.8%

- Claim Experience

With Claim Experience	Without Claim Experience
26.7%	73.3%

Participants' Profile (4)

- Occupation

Clerks	**42.7%**
Managers and administrators	**12.4%**
Housewife	**10.1%**
Service workers and shop sales workers	**9.0%**
Professionals	**7.9%**
Plant and machine operators and assemblers	**6.7%**
Elementary occupations	**4.5%**
Retired	**3.4%**
Others	**2.2%**
Associate professionals	**1.1%**

Participants' Profile (5)

- Martial Status (N=89)

Single	Married	Divorce
28.1%	69.7%	2.2%

- Number of Children (n=64)

0 Child	1 Child	2 Children	3 Children	4 Children
10.9%	31.3%	48.4%	6.3%	3.1%

Appendix 2
Discussion Guide

Focus Group Discussion Guide

適用於自行購買綜合住院保險的受訪者：

A. 個人綜合住院保險的經驗、態度和看法 (10 minutes)

1. 請問你而家持有邊一類型嘅住院保險呢？你可唔可以講吓你份保單嘅保障範圍呢？
2. 點解你會買呢類型住院保險呢？
3. 你對於保單嘅保障範圍滿唔滿意呀？你有冇試過索取賠償呢？如果有，你滿唔滿意嚟次索償經驗呢？
4. 對於住院保險嘅保障，你有冇咩建議想俾保險公司呢？

[主持人之後簡單介紹自願參與的輔助醫療融資方案的背景 – 包括建議包含的保險及儲蓄成份的計劃特徵，及政府有可能提供的鼓勵措施。] (SHOW Slide 1)

B. 假設的住院保險計劃的反應及意見 (70 minutes)

[主持人逐一展示兩個假設計劃，並就各個計劃作出介紹及解釋其內容，以及詢問以下問題] (SHOW Slide 2 & 3)

1. 對於呢個假設計劃，你有冇啲咩唔清楚嘅地方呢？
2. 你會唔會考慮從你而家持有嘅住院保險計劃轉移過嚟呢個假設計劃呢？點解會 / 點解唔會呢？**[追問具體原因]**
3. 你認爲呢個計劃嘅保費應該定喺幾多錢先算合理呢？ 或者你最高願意俾幾多錢保費呢？
4. 你會唔會加埋自己嘅子女、配偶或者父母成爲呢個計劃嘅受保人？點解會 / 點解唔會？
5. 依家有額外選擇，即如果肯俾部分索償墊底費（每次入院計），就可以減低保費嘅話，以下有三個選擇，請問你最鍾意邊一個，定係三個都唔鍾意，點解呢？ **(SHOW Slide 4)**
6. 如果呢個計劃可以減低保障範圍至只包括部分昂貴的治療（例如癌症，心臟通波仔），咁你覺得應該會減少幾多保費呢? **(SHOW Slide 5)**
7. 又如果呢個計劃可以減低保障範圍至只包括部分在公立醫院輪候時間較長的手術（例如白內障手術，關節置換手術），咁你覺得應該會減少幾多保費呢? **(SHOW Slide 6)**
8. 請問你有冇其他可以減低保費嘅方法想建議？

[主持人展示假設計劃的各項特徵，並詢問以下問題] (SHOW Slide 7- 9)

9. 對於假設計劃嘅特徵，你有啲咩意見呢？你需唔需要呢啲特徵呢？**[逐項討論，追問受訪者喜歡及不喜歡的地方，他們的喜好以及期望]**
10. 如果假設計劃有齊呢啲特徵，你又願意俾幾多錢保費呢？
11. 喺呢九項特徵入面，有邊三項最吸引到你呢？請你將呢三個項目排次序。
12. 雖然有醫療保險嘅保障，喺咩情況之下你依然會選擇使用公立醫院嘅服務呢？**[追問：預算、質量等方面的考慮]**

13. 你認爲政府應該用乜嘢方式去鼓勵市民購買呢個計劃呢？**[追問：例如減稅，保費資助，退休後保費回贈（呢三項應該係一次性措施定係經常性？），對於長期忠實嘅參加者提供額外獎勵]**
14. 你覺得政府嘅鼓勵措施，會吸引到邊一類人呢？[低風險(年青及健康) vs 高風險(年長及身體較弱)，低收入 vs 高收入]

C. 退休後的醫療使費及相關儲蓄的看法 (20 minutes)

1. 你會唔會繼續購買你而家持有嘅醫療保險，直至退休之後呢？點解呢？
2. 你有冇考慮或者已經開始爲你退休後嘅醫療使費（包括醫療保費）做儲蓄呢？如果有，你會儲起現時人工嘅幾多% (或者大約金額) 作爲你未來嘅醫療使費呢？如果唔會，點解呢？
3. 如果假設計劃有儲蓄成分，你認爲政府應該用乜嘢方式去鼓勵市民購買呢個計劃嘅儲蓄成分呢？**[追問：例如減稅，退休後保費回贈（呢兩項應該係一次性措施定係經常性？），對於長期忠實嘅參加者提供額外獎勵]**
4. 如果假設計劃會有儲蓄成分，以作爲退休後的醫療使費（包括醫療保費），你最關注嘅係咩? **[追問：例如儲蓄規模、儲蓄形式，使用限制、投資風險]**
5. 你覺得呢啲鼓勵儲蓄嘅措施，會吸引到邊一類人呢？[低風險(年青及健康) vs 高風險(年長及身體較弱)，低收入 vs 高收人]
6. 你認爲假設計劃應唔應該有儲蓄成分？定係參加者可以選擇購買其中一項呢? 你自己嘅選擇又係點樣呢？

D. 政府所扮演的角色 (20 minutes)

1. 相對於將服務外判俾私營保險公司，有啲人想由政府直接監管上述嘅假設計劃，你對於呢方面有咩睇法呢？
2. 有人覺得政府應該提供一啲收費較經濟嘅私家醫院服務，讓假設計劃嘅參加者可以選擇使用，你又有咩睇法呢？[主持人備註: 收費較經濟和醫療質素完全無關，只是醫院內之設備如裝修用料，病房空間等較私家醫院遜色]
3. 如果假設計劃係得到政府用某啲方法津貼，你覺得政府應該津貼幾多錢(%或金額)，先會吸引到你去買呢？(無論用咩方法津貼)

適用於非自行購買 / 沒有綜合住院保險的受訪者：

A. 個人綜合住院保險的經驗、態度和看法(10 minutes)

1. 你有冇留意到市面上有邊啲醫療保險產品（尤其是針對住院保障）？可否略略講吓?
2. 你有冇考慮過購買呢啲醫療保險產品呢？點解呢？
3. 你唔購買醫療保險嘅原因係咩呢？**[追問：產品認識，預計的風險，醫管局設施的質量，醫療保險產品的負擔等]**
4. 你有冇曾經購買過醫療保險產品呢？（如答有）點解你中途終止咗保單呢？可否講吓呢份保單嘅保障範圍、保費同服務呢？請問有冇具體嘅例子？
5. 請問有咩因素能夠驅使你去購買(或者再次購買)醫療保險呢？**[追問：身體狀況、收入、保費、所提供的產品，家庭狀況轉變等等。]**

[主持人之後簡單介紹自願參與的輔助醫療融資方案的背景 – 包括建議包含的保險及儲蓄成份的計劃特徵，及政府有可能提供的鼓勵措施。] (SHOW Slide 1)

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2. 有人覺得政府應該提供一啲收費較經濟嘅私家醫院服務，讓假設計劃嘅參加者可以選擇使用，你又有咩睇法呢？[主持人備註: 收費較經濟和醫療質素完全無關，只是醫院內之設備如裝修用料，病房空間等較私家醫院遜色]
3. 如果假設計劃係得到政府用某啲方法津貼，你覺得政府應該津貼幾多錢(%或金額)，先會吸引到你去買呢？(無論用咩方法津貼)

Appendix 3
Focus Group Stimuli

輔助醫療融資方案背景

- 於2009-10施政報告中，行政長官曾蔭權公佈正着手制訂一個自願參與的輔助融資方案，並計劃在2010年諮詢公眾。
- 這個方案會包含保險及儲蓄成分。
- 政府會加以規範及監管，並會動用為推動醫療改革預留的五百億元撥備，提供資助及誘因，令有能力負擔的市民，特別是已有醫療保險保障的人士，可以有更多私營服務的選擇。

假設計劃(一)

住院保障範圍	
病房類別	標準私家大房
「套餐」收費項目（指定病症，例如白內障手術、切除盲腸手術）	
每次入院最高賠償限額	按「套餐」計
非「套餐」收費項目（其他病症）	
住房及膳食費用（每症最多120日）	每日最多$550
主診醫生巡房費（每症最多120日）	每日最多$550
深切治療病房費用（每症最多120日）	每日最多$2,000
手術費（外科醫生費、麻醉師費用、手術室費用合計）	每症最多$50,000
其他專科醫生巡房費	每症最多$2,000
其他住院雜費	每症最多$7,000
入院前及手術後的診治/治療	每症最多$1,800
先進診斷成像測試（例如磁力共震）	每症最多$3,000
病人可獲實際賠償（按以上計算可索償總額）	
首$10,000 / 另$90,000 / 餘額	80% / 90% / 100%
門診服務（額外保障）	
化療（計算80%）	每年最多$150,000
洗腎服務（計算80%）	每年最多$80,000

假設計劃(二)

住院保障範圍	
病房類別	標準私家大房
「套餐」收費項目（指定病症，例如白內障手術、切除盲腸手術）	
每次入院最高賠償限額	按「套餐」計，設較高限額
非「套餐」收費項目（其他病症）	
住房及膳食費用（每症最多120日）	每日最多$700
主診醫生巡房費（每症最多120日）	每日最多$700
深切治療病房費用（每症最多120日）	每日最多$3,000
手術費（外科醫生費、麻醉師費用、手術室費用合計）	每症最多$70,000
其他專科醫生巡房費	每症最多$2,500
其他住院雜費	每症最多$10,000
入院前及手術後的診治/治療	每症最多$2,100
先進診斷成像測試（例如磁力共震）	每症最多$4,000
病人可獲實際賠償（按以上計算可索償總額）	
首$10,000 / 另$90,000 / 餘額	80% / 90% / 100%
門診服務（額外保障）	
化療（計算80%）	每年最多$200,000
洗腎服務（計算80%）	每年最多$100,000

減低保費方法(一)

索償墊底費 (每次入院)	保費減少%
$5,000	20%
$10,000	35%
$15,000	45%

減低保費方法(二)

減低保障範圍	保費減少%
只包括**部分昂貴的治療** (例如癌症，心臟通波仔....)	??

減低保費方法(三)

減低保障範圍	保費減少%
只包括**部分在公立醫院輪候時間較長的手術**，例如: 白內障手術 (三年以上)、 關節置換手術 (四年)、 靜脈曲張切除手術 (一年以上) 、 經尿道前列腺切除術 (一年)	??

假設計劃的特徵(一)

特徵	假設計劃	市面上計劃
統一條款及保障範圍	有	沒有
保障範圍	必須住院的治療 或不須住院的日間手術	大致相同，但部份計劃只保障住院進行的治療
已有疾病的保障（如癌症、哮喘、糖尿病、高血壓、白內障...）	有，在等候期屆滿後(估計1至3年)	個人保險不會受保
保證終身續保	有	約一半保險公司提供
保單轉移	可以(條款不變)	沒有

假設計劃的特徵(二)

特徵	假設計劃	市面上計劃
賠償結構	按套餐計算(就某手術或病例分類)，若無相關套餐亦可逐項費用計算(視乎病症)	逐項費用計算
保費結構	按年齡組別計算，附加保費或會設上限	按年齡組別計算，附加保費不設上限
保費增加方法	參照準則	沒有準則
無索償折扣(NCD)	有(10%，最多30%)，首批參加者可即時享有30%保費優惠	部分保險公司提供

假設計劃的特徵

特徵	假設計劃
統一條款及保障範圍	有
保障範圍	必須住院的治療 或 不須住院的日間手術
已有疾病的保障	有，在等候期屆滿後(估計1至3年)
保證終身續保	有
保單轉移	可以(條款不變)
賠償結構	按套餐計算(就某手術或病例分類)，若無相關套餐亦可逐項費用計算(視乎病症)
保費結構	按年齡組別計算，附加保費或會設上限
保費增加方法	有參照準則
無索償折扣(NCD)	有(10%，最多30%)，首批參加者可即時享有30%保費優惠

End of Report