Final Report

Focus Group Study on Supplementary Healthcare Financing 2010

Prepared for
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Table of Content

Executive Summary

1. Research objectives: to understand what people think of the existing health-care system their own health risk, the two-prong financing strategy and the key concepts and issues of the voluntary supplementary financing scheme.

2. Methodology: The research was implemented through in-depth focus groups study conducted face-to-face in the campus of The Hong Kong Polytechnic University. All recruitment was conducted through random sampling. A total of 40 subjects participated in six sessions of focus group.

3. Data analysis: the Socio-economic data of the participants were collected. All sessions were fully audio-taped and verbatim transcribed. Together with the coding of information, all relevant data can be found in the appendices.

4. Key findings

4.1. Focus group participants maintain high trust level in public hospitals, but worry about the long waiting time, possible quality drop and burdens of self-financed drugs. Private hospitals are instant available and of high quality, but charge high prices and are lack of pricing transparency.

4.2. A large portion of participants purchased private health insurance currently or before, or seriously considering to purchase private health insurance in future. Many have purchased private health insurance including saving elements. They query, however, about the lack of transparency of existing PHI.

4.3. Participants' estimation of premium rates predominantly ranging from HK$1000 to HK$6000 per annual under the new scheme, which may or may not include a saving component. Those carry existing private health insurance are not keen in shifting to the new scheme, still generally adopting a prudent to positive attitude. For those without private health insurance, many also think that they will stick to public services in the future. Burden of contribution is the main concern.

4.4 Participants within all strata contain contrasting views on the introduction of subsidies and incentives. Pros agreed government can attract more scheme participants, encourage self responsibility and provide better protection. Against views worried about “interest transfer”, double subsidy and the regressive nature of reform. The welfare of grassroots may be traded off for the benefits of middle class.

4.5 They also dispute over the nature of subsidy within all strata, on whether it should be equally shared by all or specifically targeted towards the needy. Though, it seems that lower income groups prefer more special care for elderly and existed diseases under the new scheme, while the higher income groups prefer elderly and poor be protected by public services rather than joining the new scheme.

4.6 Most people incline to include saving component in the new scheme. They think that this is crucial for preparing for the future, especially for protections after retirement. But they also worried about the high rate of contribution.

4.7 In sum, participants are relatively positive towards government’s introduction of the new scheme. Some think this can channel excess demand and contribute to better public services. Many think centralized funding should still predominantly be employed in future, but also welcome Hospital Authority, medical school or NGO managed private services, which are thought to promote competition, set up benchmarks and promote pricing transparency. Most people think that extra hospital beds should both be public and private in future, in order to cater different groups and needs.

4.8 There are apparent contrasting views on public option. Pros think that government is non profit and provides more confidence to the public. Against views maintained that government is inefficient and ignorant about the market and should be limited to a regulatory role.

4.9 Concerning major features of the new scheme, coverage of existed diseases and lifelong guaranteed renewal are the main features that attract most attention in the new scheme. However, the respective high premiums and their affordability remain to be key concerns. Discount and no claim bonus are also welcomed by many participants. Package rates do not attract too much attention as expected.

4.10 There are apparent contrasting views on the coverage of maternity services. The increase in cost and issue of fairness are the major concerns.

4.11 There are also general worries about abuses from both the demand-side and supply-side. The worries of supply-side abuses are more substantial. Many people admit the difficulties in monitoring due to knowledge deficiency. The need to strengthen regulation and cost control for insurance companies is also a major concern.

4.12 Many people worry about the inadequate supply of medical professionals after the introduction of the new scheme. They suggest additional resources for the training of new medical professionals, import of mainland professionals and development of Chinese medicine. Many also stressed the importance of prevention, body check and public education.

5. Recommendations on general policy issues

5.1 One major challenge of communicating the new scheme comes from both habitual expectation for “candies” delivered by government, as well as public sentiment about "government business collusion" and "interest transfer". It is suggested that any subsidies and incentives in promoting the new scheme should be indirect rather than direct, long term rather than immediate.

5.2 There are not only worries about public services and grassroot interests being traded off, but also conspiracies about government’s “shifting of burden” to scheme participants. It is advised that subsidies and incentives could be re-conceptualized as "subsidy rebate" in revealing the fact that no double subsidy will occur between the primary safety net and the new scheme.

5.3 It could be explicitly expressed how members of the new scheme can benefit even staying in public services, eg, free from drug formulatory limits, possibility of utilizing Hospital Authority private services. It could also be explicitly projected how much public subsidy Hospital Authority can be saved based on the different assumptions of new scheme participation.

5.4 Due to the general mistrust about the administrative costs and profit margins, more effective regulation of insurance companies should be introduced. The principles and mechanisms of cost containment as well as the accountability and transparency of fund management should be explicitly addressed. An independent regulatory and arbitrating body set up to regulate the scheme should also be included as a policy choice.

5.5 In viewing of the general public mistrust in private health insurance, "public option" should still be included as a policy choice. Concerning the escalating demand and widening gap of supply in medical services, the supply of adequate private hospitals and medical professionals, especially the training of specialists to meet the need of reform should be explicitly addressed.

5.6 Besides the employment of deductibles and co-payment, a saving component together with no claim bonus or discount could also be considered as possible means of demand side control knob. For moral hazards on the supply side, Hospital Authority diagnosis related group cost will provide the crucial benchmark and control knob. Ultimately, an independent body set up to coordinate or purchase private services under the new scheme, as well as the official endorsement of “Q-mark” practitioners could also be included as policy choices.

5.7 In order to cater the new demand, the extension of new private/semi-private services by Hospital Authority, medical schools and public-private partnership hospitals could be included as a policy choice. It should be emphasized that Hospital Authority will only provide such services under full cost recovery, and additional resources will be generated from private services.

6. Recommendations on specific technical issues

6.1 It is strongly suggested that saving component should be incorporated into the new scheme. A limited duration of contribution enabling lifelong protection should particularly be emphasized.

6.2 Discount and no claim bonus is another area of major concern. The rate of bonus should be objectively and transparently determined, thus placed control on the administrative fees and profits of insurance companies.

6.3 Although there will be substantial public demand on government for the loosing of contribution pressure, relatively rational voices requiring subsidies to be more targeted are not uncommon. It should be explicitly addressed that due to the limits of government reserve, priorities of subsidy should have to be made. In general, inclination towards the elderly (and guaranteeing lifelong protection) is more widely accepted, but inclination towards existed diseases may receive potential criticisms. In order to promote personal healthcare responsibility and abuses, these two groups should still bear a substantial loading on their own.

6.4 The financial implications and sustainability of different subsidy models should also be explicitly addressed. Indirect subsidies, whether in form of subsidy by kind (provider of last resort, second safety net) or subsidy by cash (reinsurances, residual insurances) could probably better avoid worries of abuses, induce fewer distributional struggles and receive less public controversies.

6.5 Issues related to package rates, family discount rates, body check and primary care are also highlighted.

I. Introduction

1. The Chief Executive has announced in 2009-10 Policy Address that the Government is working on a voluntary supplementary financing option and planning to consult the public on the proposal in 2010. The first-stage consultation on healthcare reform in 2008 reflects a broad community consensus on the need for the Government to address healthcare financing, but reservations about any mandatory scheme.

2. The 2010 supplementary healthcare financing scheme will be based on voluntary participation, comprising insurance and savings components, standardized and regulated by the Government. The Government will also make use of the $50 billion set aside to support healthcare reform to provide subsidies and incentives to encourage the public to join the scheme.

3. The supplementary healthcare financing scheme aims to:
   i. Improve sustained access to affordable private healthcare through medical insurance, thereby facilitating choice for private healthcare as an alternative to public healthcare;
   ii. Enhance transparency about service standards and price in the private health insurance and healthcare services market, thereby promoting market competition and enhancing consumer protection and confidence.

4. The Research service for supplementary finance for healthcare 2010: In-depth interview/focus group interview is commissioned by the Food and Health Bureau to gauge the views of the general public on supplementary financing reform for preparation for the second-stage of public consultation.

5. Research Objectives

5.1 To understand what people think of the existing health-care system and its perceived problems (in particular existing public healthcare service, private insurance product and private healthcare services);

5.2 To see how people view their own health risk and their perception on risk-pooling and saving for healthcare needs;

5.3 To find out what people think of the two-prong financing strategy – tax-funded public healthcare system, together with supplementary financing through standardized medical insurance and saving plan;

5.4 To understand what people think of the key concepts and issues of the voluntary supplementary financing scheme (including the use of the $50 billion reserve to support healthcare financing reform), and discover how the target groups' age and income profile correlated with their preference.

II. Methodology

1. Research Design

1.1 The research was implemented through in-depth focus groups study. The in-depth focus groups recruited participants to discuss topics according to a pre-agreed discussion guide (Appendix 1).

1.2 The target population was land based non-institutional population of Hong Kong aged 18 or above and resided in Hong Kong but excluding foreign domestic helpers. All recruitment was conducted through random sampling. Computer Assisted Telephone Interviews (CATI) system was used to collect the required information through screening questionnaire. A 13907 total sample (telephone number, with invalid household number) with 16244 dialing records were attempted.

1.3 Those who pass through the screening questions were invited to participate in the in-depth individual interviews or focus group discussions. A total 158 interviewees showed interest in the focus group firstly, and 10 interviewees were successfully re-attempted later. All in-depth focus group interviews were conducted face-to-face in the campus of The Hong Kong Polytechnic University.

1.4 A total of 40 subjects were successfully interviewed within one of the six sessions of focus group interviews. Interviewees covered the following categories, with even distribution among and within each category. A fair share of men and women, and some cases with chronic illness or long-term health care needs were also included:

Group A) Aged 18 to 29, household income between HK$7000 and 19999;
Group B) Aged 30 to 49, household income between HK$7000 and 19999;
Group C) Aged 50 to 64, household income between HK$7000 and 19999;
Group D) Aged 18 to 29, household income over HK$20000;
Group E) Aged 30 to 49, household income over HK$20000;
Group F) Aged 50 to 64, household income over HK$20000.

1.5 All focus groups were moderated by Mr. Chow Sung Ming, the Principal Investigator of the Research Team. All moderators and research assistants were trained and qualified to conduct interview. Training was provided by the Research Team prior to the piloting. Training manual was developed under the agreement of Food and Health Bureau.

1.6 The discussion guide was fully tested in the pilots. Findings of pilot test were documented, with recommendations and necessary amendments will be made to improve the interview process and discussion guide designs. Interviews achieved in the pilot test were not counted as part of the study proper.

1.7 Further details of the research design can be found in the research proposal.

2. Data Collection

2.1 The in-depth individual interviews/ focus group interviews were conducted in Cantonese, according to the spoken dialect of selected respondents. The lengths of interview range from 1.75 to 2 hour, a total of exactly 40 participants have participated in the 6 focus groups:

Group A) 30/7/2010, 7 participants;
Group B) 21/7/2010, 5 participants;
Group C) 10/7/2010, 6 participants;
Group D) 31/7/2010, 9 participants;
Group E) 17/7/2010, 9 participants;
Group F) 10/7/2010, 4 participants.

2.2 Socio-economic data (such as age, sex, martial status, educational and income level, etc.) of the participants were collected (Appendix 2).

2.3 All sessions were fully audio-taped and verbatim transcribed.

3. Data Management Strategy

3.1 Information pertaining to identity of respondents was collected for quality control purposes only, and such information was not be retained upon completion of the interviews.

3.2 All comments from participants were properly edited, coded and validated by more than one analyst and regarded as “confidential” documents after data have been entered.

3.3 The verbatim transcript for six focus groups was prepared and a copy of audio tape will also be delivered to Food and Health Bureau.

4. Methodological Problems Encountered

4.1 Telephone Interview Sampling

There are a number of problems related to telephone interview sampling. It is a particularly resource consuming method with low effectiveness. The successful recruitment rate is extremely low. Furthermore, the personal characteristics of participants are highly contingent and pose difficulties on conducting discussions.

4.2 Lower Age Group

The recruitment of participants aged 18-29 is particularly difficult, partially due to the nature of telephone interview sampling method. It is highly difficult to arrange suitable time slots for focus groups to cater enough participants. Finally, snowball sampling through the original potential participant pool has been employed to supplement the original random sample method.

4.3 Household Income Criteria

It was agreed upon using household rather than personal income as the selection criteria of focus groups. The choice of household income implies both advantages and disadvantages. The case of group F (Aged 50 to 64, over HK$20000) reveals that although their families belong to the higher income groups, participants themselves may either be retired or housewives, and do not possess financial resources for personal disposal.

4.4 Balance of General and Specific Discussions

In order to understand participants' views on of the key concepts and issues of the supplementary financing scheme, more technical details are required to facilitate a meaningful discussion. However, the over concentration on technical details will induce risks of neglecting the big picture. A careful balance in guiding discussion and time allocation is the major challenge of conducting focus groups.

4.5 Tendencies of Side Tracking

Since it is necessary to tap the participants' views on the healthcare system and financing strategies as a whole, there are constant tendencies of side tracking due to the vagueness and broadness of the scope. Participants demonstrated preferences of talking about issues like social insurance, primary healthcare or even Chinese medicine, which may not be directly related to the proposed supplementary financing scheme.

4.6 Paradox of Incentive Provision

There were a large number of cases for which participants seemed to take part in focus groups mainly aiming at the traffic subsidy. Some of them are unable to deliver meaningful and consistent opinion of the topics under discussion. It may be speculated that HK$200 traffic subsidy may be too low to attract enough participants, but too high the subsidy may also incur more participants who are totally financial driven.

4.7 Uneven Knowledge and Participation

Even for participants who might not mainly aiming at the traffic subsidy, there was still a wide gap in background knowledge and level of participation. Participants better equipped will naturally tend to dominate the discussions, while for the others they might feel shy to talk, especially when compare their opinion with others. Though consistently prompted by the moderator, there was still some imbalance of weight concerning the discussed content.

III. Data Analysis

1. Data Analysis Plan

1.1. Identification of key concepts through:

- **Words:** actual words used by participants and meanings of those words; do a frequency count and construct a continuum or category;
- **Context:** the triggering stimulus that provides the background for the tone and intensity of the participants' oral comments;
- **Internal consistency:** trace the flow of the conversation to find out change of position or view points among participants and their reasons;
- **Specificity of responses:** pay attention to responses that are in the first person as opposed to third-person answers;
- **The big idea/picture:** construct the big picture by paying attention to the body language, intensity of comments (by using scaling and index) and other evidence rather than from isolated comments.

1.2. Coding of information

Information unit is the minimal information. It is direct quotes from focus group participants ranging from a phrase, a sentence to a paragraph. By adopting margin coding, each category is represented by an identical series of number and information units are classified into different categories.

1.3. Categorization of information

Specific criteria of allocation of unit to its respective category are set in advance and evaluated continuously to ensure the grouping fits the category. Criteria of the classification are revised and adjusted when there are too many units are placed in a single category; and repetitions (similarities among categories) and incompletion of information. To rectify the situation, similar categories are merged and integrated while categories with too many information are divided into a few subgroups.

1.4. Deliberation of categories

Categorization of information units is done by more than one analyst and reviewed upon three factors: name of the category; criteria of sorting units to categories; and appropriateness of the allocation. When divergence of ideas remains after negotiation, interpretation from other experienced analysts is resorted.

1.5. The coding for six focus group discussion was prepared and delivered to Food and Health Bureau.

2. Socio-economic Background of Participants

2.1 For participants of age 18 to 29 (Group A and D), all of them are unmarried, most of them enjoy higher education level. Many of them also have family members that require long term medication. However, the current enrolment level of private health insurance and coverage of employer insurances is much lower for the family income group HK$7000 to 19999;

2.2 For participants of age 30 to 49 (Group B and E), most of them were married. However, the difference in education level between family income group HK$7000 to 19999 and HK$20000 above is significant. The enrolment level of private health insurance and coverage of employer insurances for the latter group is also much higher. Most participants from both groups do not require long term medication but many of their family members that require.

2.3 For participants of age 50 to 65 (Group C and F), most of them possess lower education level. Quite a number have retired. However, the family income group HK$7000 to 19999 has a lower married rate. Most of both groups do not enrolled in PHI or covered by employer insurances. A significant ratio of participants requires long term medication and so do their family members.

3. Comparisons of Key Themes and Categories across the Groups

3.1. Views on Existing Healthcare System

3.1.1. Group D & E have the highest proportion of people with private health insurance, followed by Group C. Group B & C got more people who have private health insurance before. Group A did not include any participant ever with private health insurance. A few participants from Group D, E & F enjoy employer or civil servant coverage. Group D & E include participants with PHI including saving element, resulting of high premium rate.

3.1.2. Group A, B & C mentioned the affordability of private health insurance. Group B, C, E & F mentions the better protection provided by private health insurance, but group C & D at the same time mentioned the lack of transparency of existing private health insurance. Some participants in group A & D, aged from 18-29, said that they did not need the insurance at the moment.

3.1.3. All groups mentioned the long waiting time as well as the low prices of public hospitals. All groups mentioned the instant availability, and Group A & D mentioned the high quality of services in private hospitals. But group A, C, D & E also mentioned the high price and Group E mentioned the lack of pricing transparency in private hospitals.

3.1.4. The long waiting time of public hospitals is the major push for patients to shift to private services, but the high price of the latter is the major deterring factor. Group A & C mentioned the quality drop of public services, which may be resulted from the shortage and job pressure of the healthcare professionals, while group B, D, E & F mentioned the standard of public services is still high. Group B, C & F also worried that self-financed drugs and treatments brought the patients a large burden.

3.2. Features of the New Scheme

3.2.1. There was a wide range of speculation on the premium of new scheme, the majority falls into $1000 to around $6000 per annual. Group D & E provided a more median estimation. Group A & F obtained some extremely high estimations. Group C suggested a family discount rate of $6000 per family annually.

3.2.2. Participants with private health insurance did not show strong view on shifting to the new scheme. Those without private health insurance mentioned un-affordability, as well as their sticking on public services.

3.2.3. Group B, D, E & F highlighted coverage of existed diseases, but they also queried about the under protection during the waiting period. Group A, C, E & F highlighted lifelong guaranteed renewal. Group A & B highlighted discount and no claim bonus. Group B & D mentioned the low benefit level. Group C highlighted portability. Group B mentioned the better coverage of critical out-patient services but also the escalating premium of elderly. Overall, coverage of existed diseases and lifelong guaranteed renewal attracted most attention.

3.2.4. Package rates were discussed in group A & E but received no clear response from other groups. Both group A & E thought that standardization of the details and charges could help improve transparency, hence the trust on using private services. They also wished the package could cover more types of treatments.

3.3. Additional Protections and Potential Abuses of New Scheme

3.3.1. Group A, B, D & E discussed the coverage of maternity services. Group A & D contained contrasting views on the inclusion of maternity services. Group B generally agreed but group E generally disagreed. The increase in cost is the major concern.

3.3.2. Group A, D & F have contrasting views on potential demand side abuses. Group A mentioned that unnecessary hospitalization may be requested, while group D & F mentioned that hospitals can screen effectively. Preventive measures suggested include blacklisting by group A, free body check by Group A & D, co-payment by group D & E. Group A & D also mentioned that the insurance companies would monitor this closely.

3.3.3. Group A & C mentioned the worry of supply-side abuses, and group E admitted the difficulties in monitoring due to knowledge deficiency. Group D & F put trust on the physicians and insurance company respectively. Group C suggested independent means of checks and balances.

3.4. Government Support and Incentives

3.4.1. All groups preferred government should promote the new scheme in general (even some stressed they may not join). Some thought that this can provide better medical services and some thought this can channel excess demand from public hospitals. Group B participant thought that this cannot channel excess demand cost effectively.

3.4.2. Group B, C, D & F have contrasting views on subsidies and incentives. Pros agreed government can attract more scheme participants, encourage self responsibility and provide better protection. Against views worried about “interest transfer”, double subsidy and the regressive nature of reform.

3.4.3. Promoting measures were widely discussed. Group A suggested that government should provide the last resort. Group B, C & F suggested cash subsidy. And some from group D suggested tax rebate, though this was also criticized as unfavourable to the poor.

3.4.4. Groups A, B, C & E agreed to include saving component. They thought that this is crucial for preparing for future, but also worried about the high rate of contribution.

3.4.5. Group A, C & E thought that the subsidies shall be provided to both the insurance and saving at the same time.

3.4.6. Group A, D & E have contrasting views on public option. Pros thought that government is non profit and provides more confidence to the public. Against views maintained that government is inefficient and ignorant about the market and should be limited to a regulatory role. Alternatively an NGO can take up this scheme. Group B & F voted their trust on public option.

3.5. Target Groups of New Scheme

3.5.1. Young people as the target was suggested by group B & E; elderly was suggested by group B & D; middle class, poor and chronic patients were suggested by group D.

3.5.2. Group A, B & C preferred special care for elderly and existing diseases under the new scheme. Group E & F preferred elderly and poor to be protected by public services, rather than joining the new scheme. Group D worried about the inclusion of existed diseases would put burden on the whole scheme and suggested that individualized premium should be set.

3.6. Priorities of Subsidy

3.6.1. Group A, C, D & F contained contrasting views on nature of subsidy, whether it should be equally shared by all or specifically targeted towards the needy. Group A & B preferred to subsidize elderly, group D focused more on middle class and group E focused more on discount for young people.

3.6.2. To gain trust, group D mentioned clear and standard details in the insurance scheme, group E mentioned transparency and problems of drop out, that may affect the confidence of new scheme.

3.7. Overall Comments and Expectations

3.7.1. Group B, D, E & F suggested centralized funding (some included the introduction of new taxes) should be employed to generate extra revenue. Although Group B & D also agreed to raise medical fees, Group C & E preferred more personal contribution through insurances and savings.

3.7.2. Group B, C, D & F suggested extra hospital beds should both be public and private, in order to cater different groups and needs. Group E focused more on additional private beds to cater future additional and mainland patients. The set up of semi-private services was mentioned in group D & F.

3.7.3. Group C, E & F welcomed Hospital Authority, medical schools or NGO managed private services which were thought to promote competition, set up benchmarks and promote pricing transparency. Group C & E also worried about doctor shortage and negative effects on public services and training.

3.7.4. Group C & D thought that the new scheme can improve current system. But group C & F worried that it will affect quality of public services.

3.8. The Disposal of Additional Resources

3.8.1. If there are extra future resources, Group B, C & E mentioned the training of new medical professionals, import of mainland professionals and development of Chinese medicine. Group E stressed the importance of prevention, body check and public education.

3.8.2. Group B highlighted the issues of clinic services for elderly.

3.8.3. Group C & E emphasized the need to strengthen regulation and cost control for insurance companies.

3.9. The full data analysis report was prepared and delivered to Food and Health Bureau.

IV. Key findings

1. What people think of the existing health-care system and its perceived problems

1.1. As revealed from the above analysis, Hong Kong people still maintain high trust level in public hospitals, but worry about the long waiting time, possible quality drop due to the shortage and job pressure of the healthcare professionals and burdens of self-financed drugs and treatments. These form the major “push” factors which drive people to seek private services.

1.2. The apparent advantages of private hospitals are their instant availability and high quality of services. But the high price and the lack of pricing transparency in private hospitals are the deterring factors. The high price is the major “push” factor which drives people to obtain private health insurance protection.

2. How people view their own health risk and perception on risk-pooling and saving

2.1. A large portion from all strata, probably except the very young ones, have purchased private health insurance (to a lesser extent, cash subsidy schemes) currently or before, or seriously considering to purchase private health insurance in future, especially for those who do not enjoy civil servant coverage. People even enjoying employer insurance also consider purchasing, since they may not be able to enroll after retirement. A few cases even possess 2 to 3 plans of different natures.

2.2. They query, however, about the lack of transparency of existing private health insurance. Affordability is also another major concern, especially for those from the higher age group. Young and mid-age people also worry about potential premium rises in the future.

2.3. A large portion from all strata purchased private health insurance including saving element. This seems to be a major new trend in the existing private health insurance market. The main selling point is it can provide lifelong protection after full contribution (normally last for 10 to 20 years). However, the resulting premium rate is extremely high, ranging from over HK$10000 to over HK$20000 per annual, which are roughly 4 to 5 times higher than normal private health insurance.

2.4. The existing private health insurance including saving element, however, also contains significant drawbacks. “Lifelong protection” is available on the condition of no or low claim. The investment returns and benefit levels are also disproportionally low when compare to the high premium.

3. What people think of the two-prong financing strategy

3.1. Participation and Contribution

3.1.1. Among the focus group participants, for those carry existing private health insurance, they are able to provide more “realistic” estimations of premium rates for the future scheme, predominantly ranging from HK$1000 to HK$6000 per annual, which may already include or not include a saving component.

3.1.2. Those carry existing private health insurance are not keen in shifting to the new supplementary finance scheme, and are generally adopting a prudent to positive attitude. For those without private health insurance, many also think that they will stick to public services in the future. Burden of contribution is the main concern. The possibility of family discount rate is also raised.

3.2. Subsidies and Incentives

3.2.1. Virtually participants within all strata contain contrasting views on whether the government should introduce subsidies and incentives or not, even among the lower income groups. As revealed above, pros agreed government can attract more scheme participants, encourage self responsibility and provide better protection. Against views worried about “interest transfer”, double subsidy and the regressive nature of reform. The welfare of grassroots may be traded off for the benefits of middle class.

3.2.2. Most people incline to include saving component in the new scheme. They think that this is crucial for preparing for the future, especially for protections after retirement. But they also worried about the high rate of contribution. In addition, more people think that, based on the assumption that if government subsidies ever exist, these should be provided to both the insurance and saving at the same time. More people mention cash subsidy rather than tax rebate and provider of last resort.

3.2.3. There are apparent contrasting views on the nature of subsidy within all strata, based on the assumption that if government subsidies ever exist, whether it should be equally shared by all or specifically targeted towards the needy. Though, it seems that lower income groups prefer more special care for elderly and existed diseases under the new scheme, while the higher income groups prefer elderly and poor be protected by public services rather than joining the new scheme. The latter also worry that the inclusion of existed diseases would lay burden on the whole scheme.

3.3. Role of Government and Public Services

3.3.1. Even including those who stressed they may not join the new scheme, people are still relatively positive towards government's introduction of the new scheme. Some think this can contribute to better medical services and some think this can channel excess demand from public hospitals. But one participant also point out that this may not channel the excess demand cost effectively.

3.3.2. There are also apparent contrasting views on public option within all strata. As revealed above, pros think that government is non profit and provides more confidence to the public. Against views maintained that government is inefficient and ignorant about the market and should be limited to a regulatory role.

3.3.3. Predominant number of people think that centralized funding (even including the introduction of new taxes) should still be employed to generate extra healthcare revenue in future. Although at the same time, they may not be against the raising of medical fees and the introduction of personal contributions through insurances and savings.

3.3.4. Predominant number of people also think that extra hospital beds should both be public and private in future, in order to cater different groups and needs. Many people welcome Hospital Authority, medical school or NGO managed private services, which are thought to promote competition, set up benchmarks and promote pricing transparency. But some also worried about the related problems of medical professional shortage and negative effects on public services and training.

4. What people think of the key concepts and issues of the new scheme

4.1. Major Features

4.1.1. Overall speaking, coverage of existed diseases (more from higher income groups) and lifelong guaranteed renewal are the main features that attract most attention in the new scheme. However, the respective high premiums and their affordability remain to be key concerns.

4.1.2. Coverage of existed diseases can benefit more people than existing PHI. But many also queried about the under protection during the waiting period, as well as the burden it may lay on the whole scheme. But individualized premium may be able to solve the problem. Guaranteed renewal, on the other hand, benefits all people who may not enjoy protection after certain age limit under existing PHI, and may not be able to satisfy medical needs after retirement. Less controversy has been induced by guaranteed renewal.

4.1.3. Discount and no claim bonus are another features that attract more attention (more from lower income groups), which are expected to lower premium rates and improve affordability to a certain extent. But some think that the discount rate should further be raised and some suggest further discount rates for families. Others also concern about portability and the better coverage of critical out-patient services, but some may worry about the low benefit level and inability of cost recovery under the new scheme.

4.1.4. Package rates do not attract too much attention as expected. As revealed above, some people think that standardization of the details and charges could help improve transparency, hence the trust in using private services. Some wish the package rates could cover more types of treatment. It seems that people are aware of and concern more on the high price than the pricing system of private hospitals.

4.2. Other concerns

4.2.1. There are apparent contrasting views concerning the coverage of maternity services, even among the young females. As revealed above, the increase in cost and issue of fairness are the major concerns.

4.2.2. There are also apparent contrasting views on the potential demand side abuses. While unnecessary hospitalization may be requested, hospitals are considered capable of screening effectively and insurance companies monitoring closely. Preventive measures suggested include free body check, deductibles and co-payment.

4.2.3. The worries of supply-side abuses are more substantial. Many people admit the difficulties in monitoring due to knowledge deficiency. Some suggest insurance companies can perform the role of monitoring. Others suggest independent means of checks and balances should be developed. Clear and standard details in the new scheme are crucial. The need to strengthen regulation and cost control for insurance companies is also a major concern.

4.2.4. Predominant number of people worry about the inadequate supply of medical professionals after the introduction of the new scheme. They suggest additional resources for the training of new medical professionals, import of mainland professionals and development of Chinese medicine. Many also stressed the importance of prevention, body check and public education, which can be incorporated into the new scheme and effectively reduce the demand for hospitalization.

V. Recommendations

Through in-depth analysis of the research findings above, the Research Team has come up with a number of recommendations which aim at addressing the concerns and worries of the public, as well as reduce the misunderstandings and communication gaps in publicizing the new scheme. It should be noted that the recommendations may not be resulted from the direct comments of the focus group participants, but rather based on secondary analysis and macro policy inferences.

1. General Policy Issues

1.1. Worries of "interest transfer"

1.1.1 As revealed by the research finding, one major challenge of communicating the Supplementary Healthcare Financing Scheme comes from the extremely contrasting and contradictory views on whether the government should introduce subsidies and incentives or not. There are both habitual expectations for “candies” delivered by the government, as well as public sentiment and worries about "government business collusion" and "interest transfer". It is suggested that any subsidies and incentives in promoting the new scheme should be more indirect rather than direct, more long term rather than immediate.

1.1.2 Virtually participants within all strata contain contrasting views on whether the government should introduce subsidies and incentives, even among the lower income groups. In order not to further intensify social divisions and antagonism, which may potentially be harmful to a rational policy debate, subsidies and incentives could first, include policy options of subsidy by kind (in forms of provider of last resort, second safety net) prioritized to subsidy by cash. Second, subsidy by cash could be in form of indirect subsidy, including policy options which are independently managed and disposed from private health insurance schemes themselves (e.g. in forms of reinsurances or residual insurances, etc).

1.2. "Subsidy Rebate"

1.2.1 Though many show positive attitude towards the new scheme, there are also substantial worries on the one hand that public services and grassroot interests may be traded off, on the other hand conspiracies about government's "shifting of burden" towards members of new scheme. It is advised that any subsidies and incentives in promoting the scheme could be re-conceptualized as "subsidy rebate" in revealing the fact that no double subsidy will occur between the primary safety net and the new scheme. Members of the future scheme, if still utilizing public services, will still need to pay the current public service rate same as the non-members. However, Hospital Authority full costs induced will be covered by insurance claims at the same time. This could effectively avoid the public doubts about shifting health resources of grassroots to the middle class.

1.2.2 On the other hand, potential members of the new scheme may query about of the burdens of additional contribution under the new scheme. As claimed by many participants especially for those who do not carry existing private health insurance, they will opt for sticking to the public services in future. It could be explicitly expressed how they can benefit even staying in public services, eg, free from drug formulatory limits, possibility of utilizing Hospital Authority private services.

1.2.3 It could also be explicitly projected how much public subsidy Hospital Authority can be saved based on the different assumptions of new scheme participation. The drop out rate of scheme participants from public services and impact on waiting time for public services will be the major concern. Review and expansion of the drug formulary could also be explicitly promised.

1.3. Regulation of Insurance Companies

1.3.1. As clearly revealed by the research findings, there is general mistrust about the administrative costs and profit margins of insurance companies. They may be considered as drain of public and private resources instead of better coverage and protection. Although the standardized plan and its portability may significantly reduce the problem, more substantial evidences have to be presented (e.g. from the experiences of the newly introduced portable Mandatory Provident Fund). The principles and mechanisms of cost containment as well as the accountability and transparency of fund management should also be explicitly addressed in the consultation.

1.3.2. In addition, an independent regulatory and arbitrating body set up to regulate the scheme should also be included as a policy choice. Consequently, the "voluntary insurance scheme" could be re-conceptualized as "regulated standard insurance". The "voluntary saving scheme" could also be re-conceptualized as "regulated standard saving".

1.4. "Public Option"

There are extremely contrasting views on the desirability of "public option". Although this may not be a prioritized policy choice for the government, in viewing of the general public mistrust in private health insurance regulation, "public option" should still be included as a possible alternative in the provision of private health insurance, reinsurance and residual insurance products.

1.5. Supply and Regulation of Private Hospitals

1.5.1. Predominant number of people worry about the inadequate supply of medical professionals after the introduction of the new scheme. Although the package rates may provide relatively stabilized prices, but more fundamentally, the escalating demand and widening gap of supply in medical services may become the ultimate “black hole” of the whole reform. The opening up of medical market and influx of mainland patients will further intensify the discrepancy. The property market in Hong Kong being “colonized” by mainland customers set a good precedent of potential public distress.

1.5.2. The supply of adequate private hospitals and medical professionals, especially the training of specialists to meet the need of reform should be explicitly addressed. Possible solutions including the training of specialists and medical students abroad, the introduction of foreign medical practitioners on a limited scale, the coverage of scheme participants for hospitals outside Hong Kong and the further promotion and introduction of Chinese medicine, including the establishment of new Chinese medicine hospitals etc. could be explored in future.

1.5.3. There are also general worries about the potential abuses after the introduction of the new scheme. Besides the employment of deductibles and co-payment, a saving component together with no claim bonus or discount could also be considered as possible means of demand side control, as reviewed by the experiences of Medisave in Singapore.

1.5.4. While for moral hazards on the supply side, Hospital Authority diagnosis related group cost will provide the crucial benchmark and control knob. Public-private partnership is also emerging as a gate keeper and potential check for value for money and quality private services. Ultimately, an independent body set up to coordinate or purchase private services under the new scheme, as well as the official endorsement of “Q-mark” practitioners could also be included as policy choices.

1.6. Hospital Authority Private Services

People welcome Hospital Authority and other non-profit managed private services, which are thought to promote competition, set up benchmarks and promote pricing transparency. In order to cater the new demand, the extension of new private/semi-private services by Hospital Authority, medical schools and Public-private partnership hospitals could be included as a policy choice. This is however a double-edge sword which may affect the personnel supply and quality of the original public services. It should be emphasized that Hospital Authority will only provide such services under full cost recovery, and additional resources will be generated from private services.

2. Specific Technical Issues

2.1. Introduction of the Saving Component

2.1.1. As clearly revealed from the research, most people incline to include saving component in the new scheme. it is strongly suggested that saving component should be incorporated into the new scheme. In addition, in order to address the public concern of high contribution rates, limited duration of contribution (e.g. 10 to 20 years) enabling lifelong protection should particularly be emphasized. It should, however, explicitly address the deficiencies of similar products in current private health insurance market, especially related to the high premiums, low returns and low benefit levels, as well as effective means to encounter them (similar to existing Mandatory Provident Fund).

2.1.2. Discount and no claim bonus is another area of major concern. This could be mandatory deposited into the regulated standard saving, rather than delivered for personal disposal. The rate of bonus should be objectively and transparently determined, thus placed control on the administrative fees and profits of insurance companies. These “stick and carrot” can provide means of regulating consumption behaviour and check against moral hazards.

2.1.3. The regulated standard saving should aim at lifelong protection for participants especially after retirement. Participants make excess claims before full contribution can further be protected by reinsurance or residual insurance schemes.

2.2. The 50 Billion Government Reserve

2.2.1. There are apparently contrasting and contradictory views on the nature of subsidies and incentives. Although there will be substantial public demand on government for the loosing of contribution pressure, relatively rational voices requiring subsidies to be more targeted are not uncommon. It should be explicitly addressed that due to the limits of government reserve, priorities of subsidy should have to be made. In general, inclination towards the elderly (and guaranteeing lifelong protection) is more widely accepted, but inclination towards existed diseases may receive potential criticisms. In order to promote personal healthcare responsibility and avoid abuses, as well as enhancing financial sustainability of the scheme, these two groups should still bear a substantial loading on their own.

2.2.2. The financial implications and sustainability of different subsidy models should also be explicitly addressed. Subsidy if equally shared by all may consume the whole reserve in around 10 to 15 years. The effects on later generations (especially for the “Post-80s”) should not be dismissed.

2.2.3. Indirect subsidies, whether in form of subsidy by kind (provider of last resort, second safety net) or subsidy by cash (reinsurances, residual insurances) could probably better avoid worries of abuses, induce fewer distributional struggles and receive less public controversies.

2.3. Package Rates

2.3.1. Package rates can not only improve public confidence in utilizing private service, but should also be considered as an important tool of service regulation. As revealed above, the Hospital Authority diagnosis related group structure, when carefully managed and sufficiently transparent, will provide the crucial benchmark and control knob. However, the effectiveness of Hospital Authority cost containment will be a potential uncertainty.

2.4. Family Discount Rates

2.4.1. As revealed by the research findings 3.1.2, it is recommended that special discounts can be considered to attract enrollment of families as a whole. Current private health insurance only target families with children under 18, and this should significantly be improved. Family discount rates could be considered to boost the enrollment ratio, promote the balance of participation across age groups and reduce adverse selection.

2.5. Body Check and Primary Care

As also revealed from the research 4.2.4, it is recommended that discounts or bonuses for body check and primary care can be considered, not only to attract enrollment, but also improve prevention and public education. Government subsidy (e.g. similar to medial coupon) can also be considered. This will, ultimately, reduce acute situations and hospitalization, thus promoting the sustainability of the whole scheme. The financial implications and sustainability, however, should also be critically considered.

Appendix I

Research service for supplementary finance for healthcare 2010

In-depth interview/focus group interview

Sample proforma of discussion guide (Chinese)

1. 現行制度及需求(15MIN)

1.1 你而家或以前有冇買醫療保險，如果有，每年大概要花幾多錢？
1.2 你對而家香港既私人醫療保險計劃有咩睇法?
1.3 你對而家香港既公立醫院住院服務有咩睇法?
1.4 你對而家香港既私家醫院住院服務有咩睇法?

2. 假設住院保障計劃(30MIN)

2.1 對於呢個假設既新計劃，你覺得有冇唔清楚既地方?
2.2 你認爲呢個計劃既保費每年幾多錢先算合理?
2.3 對於呢個計劃既特徵，你有咩野意見?你需唔需要呢的保障呢?（例如已有疾病的保障、保證終身續保、保單轉移、按套餐價計算等）
2.4 你認爲按套餐價計算收費，會唔會令你對轉用私家服務更有信心呢?
2.5 你認爲應唔應該特別考慮長者或退休人士既需要?
2.6 你認爲應唔應該特別考慮高風險或已有疾病人士既需要?
2.7 你會唔會擔心索償權利會被人濫用（病人、醫生等）?你認爲有冇辦法可以防止濫用?
2.8 你會唔會擔心濫用同埋人口老化呢 D 因素，會令以後既保費普遍大幅增加?你又會唔會擔心以後負擔唔起個人既保費?

3. 對計劃的政策支持／誘因(25MIN)

3.1 整體而言，你會唔會考慮參加或轉個黎假設既新計劃呢? 點解參加或唔參加呢?
3.2 你認爲政府應唔應該採用一 D 辦法，黎鼓勵市民參加呢個新計劃?（扣稅、補貼、退休後保費回贈、長期參加者額獎勵等）
3.3 你認爲呢個計劃應唔應該加入儲蓄成分，黎作爲退休後既醫療使費或保費?政府應唔應該採用一 D 辦法呢鼓勵市民參加儲蓄? 政府應該優先支持保險抑或儲蓄呢?（儲蓄將會主要用响未來既保費上）

3.4 政府已經預留咗 500 億既基金，黎推動上述呢個計劃既實施，你應爲呢的錢應該花响邊方面?

－資助年輕人抑或剩係長者及退休人士?

－剩係資助高風險／已有疾病人士?

－剩係資助低收入人士?

－剩係資助納稅人?

－特別照顧孕婦同埋生仔既支出?

－提供再保險／額外的安全網?

3.5 相對於政府將服務外判俾私人保險公司，你同唔同意政府亦可以直接提供上述呢個新計劃?

4. 整體看法及期望(30MIN)

4.1 根據發達國家既經驗，人口老化會造成整體醫療開支既上升，香港未來十至二十年仍會有 40%至 80%既上升空間，你認爲新增加既資金應該來自邊度?（加稅、加價、保險或儲蓄計劃等）原因係咩野?

4.2 應付人口老化會造成既新增醫療需求，你應爲新增加既醫院病牀應該加响邊度? (SLIDE 3)

4.3 就算有呢個新計劃既保障，响咩野情況下你依然會選擇使用公立醫院既服務（價錢、質量、輪候等）?

4.4 你覺得政府應唔應該鼓勵市場、大學醫學院或醫管局，提供一的較廉價既私人醫療服務?

4.5 你認爲政府推動呢個計劃，係唔係首先要加強監管保險公司同私家醫院，黎增加對消費者既保障? 可以點樣監管呢?

4.6 你贊唔贊成由政府黎推動呢個計劃，鼓勵市民自願購買保險同儲蓄? 對香港社會有咩野好處或壞處?

4.7 除咗用享鼓勵市民購買保險同儲蓄，政府既資源用享其他方面會唔會更加好? 例如直接用响改善公立醫院服務，或者改善疾病預防既工作?

4.8 你擔唔擔心新計劃會影響公立醫院既服務質素? 抑或可以減輕公立醫院既輪候壓力? 你認爲新計劃對唔同階層既市民會有咩野唔同既影響?

4.9 你對香港醫療制度未來既發展，仲有咩野其他睇法?

Appendix II

Research service for supplementary finance for healthcare 2010

In-depth interview/focus group interview

Socio-economic Data of Participants

(Total=40; Missing data=1)

1. 年齡

18-29	16
30-49	12
50-65	11

2. 性別

男	16
女	23

3. 家庭平均月入

HK$7000-19999	15
HK$20000 以上	24

4. 職業

批發、零售、進出口貿易、飲食及酒店業	5
社區、社會及個人服務業	8
金融、地產及商用服務業	8
照顧家庭/退休/沒有工作	11
其他	7

5. 教育程度

小學	2
中學	13
大專	9
大學或以上	15

6. 婚姻狀況

未婚	20
已婚, 有子女	14
已婚, 沒有子女	3
離婚	2

7. 有否購買私人醫保

沒有，不會考慮購買	7
沒有，但會考慮購買	11
有	15
以往有，現時沒有	6

8. 有否長期疾病

有	6
沒有	33

9. 家人有否長期疾病

有	19
沒有	20