

Pilot note

The pilot study was conducted using the same online recruiting as the main study by Qualtrics between the 6/11/2015 and 12/11/2015. One difference between the pilot and main study was the inclusion of a third treatment group. This treatment group was added as an intermediate between Treatment 1 (ancillaries only) and Treatment 2 (ancillaries and hospital combined) used in the main study. The differences in terms of attributes are described below.

Treatment 1	Treatment 2	Treatment 3
Price (4 levels)	Price (4 levels)	Price (4 levels)
	<i>Ancillaries services</i>	
Insurer's copay (2 levels)	Insurer's copay (2 levels)	Insurer's copay (2 levels)
Dental (2 levels)	Dental (2 levels)	Dental (2 levels)
Optical (2 levels)	Optical (2 levels)	Optical (2 levels)
Physical health services (3 levels)	Physical health services (3 levels)	Physical health services (3 levels)
Natural therapies (2 levels)	Natural therapies (2 levels)	Natural therapies (2 levels)
Massage therapy (2 levels)	Massage therapy (2 levels)	Massage therapy (2 levels)
	<i>Hospital services</i>	
	Hospital inclusions (3 levels)	Hospital inclusions (3 levels)
	Excess (2 levels)	
	Hospital services (2 levels)	

The total pilot sample size was 90 respondents. There were 31 respondents assigned to treatment 1 (T1), 34 to treatment 2 (T2) and 25 to treatment 3 (T3).

Quotas for sample representativeness were effective and resulted in a large degree of variation across socio-demographic variables. Selected variables and means are below.

Variable	Mean (survey)	Mean (census/APRA)
Age 25-34	26.7	25.8
Age 35-44	25.6	26.7
Age 45-54	26.7	25.7
Age 55-64	21.1	21.8
Male	48.9	49.3
Degree or higher	30.0	24.4
Married	46.7	52.6
De-facto	17.8	10.7
Employed	65.6	71.3
Managers	18.6	14.4
Professionals	27.1	24.0
Technicians and trades	6.8	13.9
Community and personal services	6.8	8.9
Clerical and admin	22.0	15.7
Sales	8.5	7.0
Machinery operators and drivers	1.7	7.1
Labourers	8.5	8.8
Hospital cover	0.52	0.51
Ancillaries cover	0.49	0.54

*Have used PHIAC/APRA numbers (December 2011) and the 2011 ABS Census for PHI coverage. Since coverage has grown overtime, these figures are probably higher today.

Improvements to the sampling program were implemented in the main survey to ensure even allocation across treatments.

To generate the D-efficient choice sets, SAS was used.

At the time of the pilot study, multinomial logit (MNL) regression was seen as the baseline modelling strategy for the analysis. MNL models were therefore estimated to check the reasonableness of parameter estimates. The choice distributions for each choice scenario were also examined to ensure people were not all selecting a single option.

On the basis of these investigations the following findings emerged:

- For T1, the parameter estimates were reasonable and generally in line with expectations. There were no options that were consistently avoided by participants.
- For T2, the parameter estimates were generally consistent with expectations (i.e. price negative and significant, higher coverage generally viewed favourably). However, the choice sets involved some very unattractive options, one of which was never chosen.
- For T3, the parameter estimates were not consistent with expectations and most parameters were statistically insignificant. These results are discussed further below.

From these results, the following decisions were made between the pilot and main survey.

- The D-efficient choice set used for T1 was retained. While updating the choice set using the pilot estimates may have theoretically improved efficiency, since most variables were already significant in the pilot and the results sensible this choice set was viewed as successful.
- The intermediate combined health insurance treatment (T3) was dropped. One possible reason for the inconsistent results from this treatment was that many hospital features remained fixed across all 8 choice scenarios. This was necessary to prevent extrapolation by respondents as well as adhere to the regulated choice environment. However, it may also have confused respondents or even prompted protest answers. I decided that on balance, the marginal benefit to including an intermediate treatment was not worth the additional financial cost given these unresolved issues. Instead, more budget was allocated to recruiting a larger sample for the two treatments ultimately used.
- The choice sets for T2 were updated using D-efficiency criteria and the pilot coefficients. The main reason for this was that there were some very unattractive options in the original choice set that did not produce much variation in choice. The new choice sets resulted in an increase in relative D-efficiency from 14.75 to 41.02.

MNL results

T1

