



Impoverishment and patients' "willingness" and "ability" to pay for improving the quality of health care in Palestine: An assessment using the contingent valuation method

Awad Mataria^{a,b,*}, Rita Giacaman^b, Rana Khatib^b, Jean-Paul Moatti^{a,c}

^a French National Institute of Medical Research, Unit 379 & Regional Center for Disease Control of South-Eastern France (INSERM U379/ORS), Marseille, France

^b Institute of Community and Public Health, Birzeit University, P.O. Box 154, Ramallah, Palestine

^c Faculty of Economics, University of the Mediterranean, Marseille, France

Abstract

This paper examines the impact of impoverishment on patients' preferences with respect to improving the quality of health care, by focusing on the sudden impoverishment experience that affected the Occupied Palestinian Territory (OPT) since the beginning of the second Palestinian Uprising of September 2000. Two random samples of patients (352 and 353 individuals, respectively) were interviewed about their willingness to pay for improving a set of quality attributes in delivery of primary health care, prior and after the occurrence of this crisis situation, using a contingent valuation questionnaire. Impoverishment did not seem to affect the structure of patients' preferences vis-à-vis some essential quality attributes such as "doctor–patient relationship" and "drug availability". However, preferences toward "luxury" quality attributes, e.g., "geographical proximity" and "waiting time", suffered from both income-dependent and income-independent negative impoverishment effects. We conclude that impoverishment might not only affect individuals' availability of resources but also the ability of certain groups of patients, notably women, villagers and the elderly, to adequately express their preferences toward improving the quality of health care delivery. The issue of how willingness to pay results should be interpreted in the light of our study for policy implications was discussed. The study raises strong doubts about the current policy of introducing patients' cost recovery schemes for funding primary health care in the current crisis situation of the OPT.

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1. Introduction

The early 1980s' international economic crisis substantially aggravated the unfavorable economic trends in many developing countries [1], and signaled the severe deterioration of economic stability in several

* Corresponding author. Tel.: +970 2 2988654/5; fax: +970 2 2951181.

E-mail address: awad@birzeit.edu (A. Mataria).

middle- and low-income states [2]. Many governments responded by implementing stabilization and structural adjustment programs [3], proposed and subsequently demanded by international organizations, e.g., the World Bank [4] and the International Monetary Fund [5]. Hence, these states were obliged to restrict their social expenditures including health care budgets [6], with the risk of compromising the provision of good quality care. Alternative funding avenues, mainly based on challenging the demand-side of the health care market, were promoted to counter-balance the reduction in public resources [7]. The strategy that attracted policy- and decision-makers' most attention consisted of introducing utilization charges, i.e., user fees, paid by the patients at the point of consumption—this is commonly known as *cost recovery* [8,9]. Additional resources were to be used – at least in theory – to improve the quality of delivered care [10,11]. Proponents of this approach usually argue that patients are *willing* and *able* to pay for health care, and evidence in support of this assumption is generally derived from surveys dealing with individuals' attitudes toward seeking care [12,13], as well as, their behavior towards health expenditures [14,15]. Under comparable circumstances, similar policies are being considered for implementation by health care providers in the Occupied Palestinian Territory (OPT). Indeed, implementing cost recovery schemes was listed as one of the strategic objectives in the latest (1999–2003) Palestinian National Health Plan [16, p. 28].

However, pricing decisions have proven to be a difficult area for health care decision-making [17]. Recent experiences demonstrate that without visible and immediate improvements in the quality of care, user fees implementation will cause service utilization to drop [1,18]. Thus, planning user fees on the basis of patients' *preferences* vis-à-vis improving the quality of care is being increasingly considered to help inform policymakers about the social impact of pricing policies, and about the design of socially acceptable and financially sustainable quality improvements [19]. In this context, conventional economic theory provides a useful framework for assessing consumers' *strength of preferences*, including its measurement through monetary units [20].

Different techniques have been developed to assess patients' willingness to pay (WTP) values for various health commodities—the most commonly used being

the *contingent valuation* (CV) [21]. Although CV has been mainly developed and applied within areas of public transport [22,23] and environment [24,25], it is being increasingly used in the context of health care [26,27]. As defined by Klose [28], CV is a hypothetical survey technique used to directly assess the maximum amount of money respondents would be willing to pay to benefit from a defined health/health care commodity.

Although, there is no direct mechanistic relationship between CV and resource mobilization objectives, it is important to note that the current interest in CV surveys for health care in developing countries has been facilitated by the debates raised by the implementation of cost recovery policies [29]. A usual assumption of CV is that individuals who declare *willing* to pay the price should, somehow, be *able* to do so [30]. The relationship between WTP and *ability to pay* (ATP), however, remains a matter of debate. Some economists argue that the two notions should be strongly distinguished: “WTP is not synonymous with ATP, because health expenditures may impose considerable costs on household consumption and investment patterns, and may start a process of asset depletion and impoverishment” [30, p. 220]. Hence, if a patient expresses a WTP for a service, and even, if she/he goes further to pay for it in the real world, such stated and revealed behaviors may not be automatically interpreted as a proof of *affordability*. Payments might be made at considerable social costs obliging the patient to give up essential consumption, such as education, just to be able to acquire the service. Indeed, the notion of affordability involves a third-party value-judgment – usually a societal one – that adds to the equation societal benefits emerging from individual measures.

In this paper, we attempt to complement the above argument and suggest that an absence of stated (or revealed) WTP value may not always be interpreted as a *lack of preferences* or as if the value of the good perceived as nil for the individual. Indeed, when confronted with a severe social and/or economic exogenous shock, such as a rapid impoverishment, individuals may start a process of re-prioritization of what is important and what is not, leading them to underestimate issues in which they were previously expressing relative interest. A conventional interpretation of such phenomenon would be that these changes in individual choices are simply due to alteration in the individuals' structure of preferences, as a result of the

exogenous shock they had to face, leading to a shift in the demand curve and subsequent alterations in stated WTP values. An alternative interpretation may, however, be derived from Amartya Sen's [31] argument with regard to the inability of certain individuals to adequately express their desires and interests under such critical conditions. This latter argument implies that individuals keep their same preferences despite the socioeconomic shock, but are no longer able to express them adequately. The implied claim is that people do not have preferences in the classical sense in which that term is used in economic theory. Instead statements of WTP are better viewed as expressions of attitudes than as indication of preferences. If this is effectively so or not, currently remains a matter of theoretical and empirical debate [32].

Using data on patients' WTP values, elicited through CV, before and after the initiation of a severe impoverishment period in Palestine, we attempt to assess how patients' preferences have been affected with respect to improving the quality of delivered care. We argue that under poverty conditions, individuals may cease to express a WTP for certain aspects of health care for which they were attaching considerable importance before conditions of poverty set in. Furthermore, we test the hypothesis that such attitude cannot be exclusively attributed to a pure income-reduction effect. Indeed, impoverishment may have an effect on both the *nature* and/or the *strength* of patients' preferences vis-à-vis improving health care. By the *nature* of preferences we refer to quality attributes that the patients are interested in ameliorating—this shall be manifested by stating positive WTP values. The *intensity* of preferences involves the extent to which patients “desire” the improvement, as reflected by the magnitude of stated WTP values.

The paper aims to provide policymakers with innovative information related to the type of quality improvements that may better guarantee a successful implementation of financially sustainable, socially acceptable and equitable cost recovery policies—yet, under varied economic environments. It makes use of the sudden and severe impoverishment that has been experienced by the Palestinian population living in the Ramallah District of the West Bank, following the Israeli army reinvasions of September 2000, the escalation of conflict, and the subsequent tight closures, curfews, siege, gradual bantustanization of Palestinian land, and

more recently, the erection of the Separation Wall that divides communities from each other and from the land that they till. These events unfortunately provide a de facto opportunity for a quasi-experimental analysis of the impact of sudden and deep impoverishment on preferences toward health care. In this paper, we use this socioeconomic exogenous shock to assess the impact of these environmental and economic changes, and in particular impoverishment, on patients' preferences with regard to improving the quality of delivered care. The second section includes a presentation of the CV questionnaire and details the econometric and statistical analyses being used. Results are presented and discussed in the third and fourth sections, and are followed by concluding remarks and some recommendations for policymaking.

2. Materials and methods

A CV questionnaire was prepared, tested and administered by pre-trained interviewers on two independent random samples of patients seeking care in two urban, governmental and non-governmental PHC centers situated in the Ramallah district (OPT). Respondents were recruited during July–August 2001 and March 2003, i.e., 9 and 29 months, respectively, from the beginning of the second Palestinian *Uprising*—hereafter, we shall refer to the two study phases as *early-* and *late-uprising* studies. The questionnaire was originally designed to supply local health care providers with complementary information to help develop co-payment schedules that could be used to assist in allocating, and partially funding, health care in Palestine [33]. With the explosion of the second Palestinian *Intifada* (uprising), the questionnaire was re-administered to assess the impact of the concomitant impoverishment conditions on patients' preferences. The *late-uprising* study was preceded by a year of critical impoverishment period, mainly induced by incursions of Palestinian controlled-lands and the subsequent tight closure of the OPT. Respondents were randomly selected amongst patients who just had a medical consultation. Any adult patient exiting from a doctor's examination room was eligible to take part in the study. When the medical consultation demanded to acquire medications, the interview took place after the patient had passed by through the local pharmacy of the center.

2.1. Contingent valuation

Following some introductory information on CV, in general, and on its use in assessing health care quality improvement, respondents were requested to value specified enhancements in the quality of delivered PHC, using four pre-selected quality attributes, e.g., *geographical proximity*, *waiting time*, *doctor–patient relationship* (DPR) and *drug availability*.¹ For this purpose, respondents were first questioned about their perceptions about the current status of each of the attributes using ordinal- and Likert-scaling techniques² (for the corresponding measurement scales, see Appendix A). Respondents were subsequently asked to assess a transition from the status quo level of each of the quality attributes, as perceived by them, to the “optimal” state on the corresponding measurement scale, using a *decomposed valuation scenario* [34] and a *payment card elicitation technique* [21,35]. In contrast to a *holistic valuation scenario* where a commodity is valued as a whole, using a decomposed valuation scenario implies that components of the commodity are valued separately. In a payment card elicitation technique, respondents are asked to reveal their maximum WTP values by selecting it from a list of monetary values presented to them on a card aside. For each specified quality improvement, respondents were asked about the highest extra user fee they would be willing to pay, at every new coming medical visit, to benefit from the specified improvement—the valuation process and the WTP questions are presented in Appendix B.

Respondents perceive the *status quo* level of each of the attributes differently, however, the “optimal” proposed states were the same for all the respondents, e.g., a “Very Close” PHC center, a “Not Long at All” waiting time, being able to stay sufficient time and

receive enough and clear information from the doctor, and being able to always find “All” the prescribed treatment(s) in the center. This implied that different respondents valued different amplitudes of quality improvements, depending on their own current situations. Consequently, WTP results can be used to ascertain the validity, and sensitivity to scope, of the CV instrument, i.e., the aptitude of the method to discriminate between the values of different degrees of the commodity being assessed.

Finally, individual demographic and socioeconomic characteristics, including, gender, age, education (number of formal schooling years completed), marital status, living zone, employment status and household monthly income were collected. For more details about the questionnaire construction and the validity testing of stated WTP values, including, construct and internal validity, see [33].

2.2. Analysis

Uni-, bi- and multi-variate analyses were conducted on the separate, and a pooled, sample(s) from the *early-* and *late-uprising* studies. We first ran univariate analyses on each of the four stated WTP values, to assess the distribution of patients’ answers with respect to the different proposed quality improvements. We also calculated the percentage of respondents not willing to pay for each improvement(s)—those are identified as the *non-contributors*. A significant variation in the number of contributors – those stating positive WTP values – between the *early-* and *late-uprising* studies, may be interpreted as a variation in the *nature* of patients’ preferences. Moreover, a significant variation in the magnitude of WTP values may be interpreted as a variation in the patients’ *strength* of preferences. The bivariate analyses involved comparing stated WTP values according to respondents’ demographic and socioeconomic characteristics. To detect the existence of an impoverishment effect(s), the bivariate analysis was stratified by study phase and Pearson chi-square test was used when statistical significance was desired.

Tobit regression analysis for limited dependent variables [36] was used to detect factors independently associated with patients’ stated WTP values. This was preferred to the more commonly used multi-linear ordinary least square (OLS) regression which fails to account for the qualitative differences between limit

¹ In the *early-uprising* study, respondents were also asked to assess improvements over: *staff attitude*, *meeting the same doctor* and *chance of recovery* quality attributes. The three most frequently cited attributes as the most important for the patients to be improved were included the *late-uprising* study. The *waiting time* attribute was exceptionally included due to changes in the waiting time patterns induced by an obvious reduction in the number of PHC centers’ visiting-patients following the *Intifada*; for details see [33].

² The Likert-scaling technique consists in asking respondents to state whether they “Strongly Disagree”, “Disagree”, “Undecided”, “Agree” or “Strongly Agree” with each item’s contents (see Appendix A). Answers are then coded from 1 to 5 and a DPR-score is calculated by taking the average of respondents’ answers.

observations (with WTP=0) and non-limit ones (with WTP>0). Using OLS estimator when a considerable proportion of the observations for the dependent variable are limited “at zero” may lead to erroneous estimation of the marginal effects of any independent variable on WTP values [37]. This is important because a relatively high number of respondents declared not willing to pay for the specified improvements—varying from 19.5% for the ‘geographical proximity’ attribute in the early-uprising study phase to 56.3% for the ‘drug availability’ attribute in the late-uprising study phase. However, few respondents gave reasons indicating a potential “protest” answer to the “Why?” question. Moreover, the number of respondents who declared they were not willing to pay for all the four attributes – valued separately – was remarkably low (9 respondents out of 352 (2.5%), for the early-uprising study phase and 25 out of 353 (7%), for the late-uprising study phase). This means that most of those who declared they were not willing to pay for one quality attribute were not giving a similar systematic answer for the other attributes. Thus, and based on these two considerations, all stated “zero” values were included in the analysis.

Tobit regressions were carried out for WTP values stated for improvement over each of the quality attributes—as dependent variables. Explanatory variables introduced in each model included individuals’ assessment of quality attributes’ status quo level and a set of respondents’ demographic and socioeconomic characteristics. In order to detect the existence, the nature and the intensity of any impoverishment effect on patients’ preferences with respect to improving the quality of delivered care, a binary variable indicating the phase of the study, i.e., *early-* or *late-uprising*, was also introduced into the model.³ This was followed by an assessment of all possible interactions between, on the one hand, the study phase, and on the other hand, respondents’ demographic and socioeconomic characteristics and the level of quality improvements. The interaction terms allow us to understand the fac-

³ The major changes in the study environment in the late-uprising phase consist in the severe economic crisis and the increase of the poverty level. However, other features are also considerable and are susceptible to play a role in influencing patients’ preferences. These include the tight closure of the OPT through installation of checkpoints all around the cities and between villages leading to extremely difficult circulation conditions.

tors whose effects on WTP varied following impoverishment. Each of the Tobit regression analyses was followed by the Ramsey RESET test to assess eventual misspecification of residuals⁴ [38]. WTP values were assessed in New Israeli Shekel (NIS). During the *early-* and *late-uprising* studies, US\$ 1 was equivalent to 4.20 and 4.75 NIS, respectively. Therefore, to adjust for NIS depreciation, patients’ WTP values from the *late-uprising* study were reduced by a coefficient of 0.884. Descriptive analyses were conducted using the computer software SPSS release 9 for Windows; and econometric analyses were carried out using Stata release 7.0 for Windows [39].

3. Results

3.1. Sample characteristics

An equal number of respondents were interviewed during the two study periods (352 and 353 individuals, respectively, accepted to participate). The response rate was significantly higher in the *late-uprising* study (78%) compared to the *early-uprising* phase (61%). This might be due to the continuous increase in the unemployment level following the *Intifada*, making patients having more time to spend at the PHC center with marginal value of time being highly decreased; and the reduction in the number of respondents frequenting urban PHC centers coming from distant areas – due to continuous closures and difficulties in transportation – who are usually in hurry to go back home. Overall, 54.5% of the sample was recruited in the governmental PHC center and 45.5% in the NGO PHC center. In 80.4% of the cases, the respondent was the patient her/himself, while in the remaining cases, mainly where the consulting patient was a child, the accompanying person answered the questions. The majority of respondents were middle-aged, married housewives living in rural zones. Most of the patients had some form of health care insurance coverage (81.5%), for the most part a governmental insurance scheme (>95%). More than half of respondents received the service free

⁴ The test is based on augmented regression including squares and cubics of the fitted values. The auxiliary augmented model is: $y = X\beta + \alpha_1\hat{y}^2 + \alpha_2\hat{y}^3 + \varepsilon$. The test of specification error is then a joint test of $\alpha_1 = \alpha_2 = 0$. H_0 : there is no misspecification; H_1 : there is a misspecification.

of charge—these included almost all patients coming to the governmental PHC (>98%) and 14.4% of patients coming to the NGO PHC center. Respondents' demographic and socioeconomic characteristics, as well as, respondents' perceptions of the service's quality status quo level are summarized in Table 1—the results are also stratified between the two study periods.

3.2. Quality perception

More than 60% of respondents reported that the PHC center they were attending at the time of the interview was located “Very Far” or “Far” from their homes, with no significant differences between the early- and late-*Intifada* studies. One-third of respondents reported that they waited “Very Long” or “Long” before meeting the doctor, and more frequently in the *early-uprising* study. However, the difference in responses between the two periods was not significant. A significant difference was detected in the patients' assessment of the *Doctor–patient relationship* (a higher DPR-score signifies that the patient is more satisfied), with respondents seeming to be more satisfied by the doctors' practice in the *late-uprising* period. Finally, more respondents were able to find their prescribed medications in the pharmacy of the center in the *late-uprising* phase. These significant – apparently quite paradoxical – improvements in the perceived quality of the status quo may be related to some modifications of the clientele. After the start of the *Intifada*, the number of patients coming to the health centers from distant areas has decreased due to financial and geographical accessibility problems, logically leading to a decrease in the patient density and an improvement of the DPR (see Table 1). Likewise, massive regional and international drug donations that have occurred during the *Intifada* may have contributed to a better “*drug availability*”. Multivariate econometric analysis will of course allow us to take into account these changes in clienteles between the two periods.

3.3. Willingness to pay values

Patients' WTP values for improving each of the four quality attributes are summarized in Table 2. The results suggest that the improvement attracting the patients the most, in both study periods, is having a closer PHC center to their domicile. In contrast, the least at-

tractive attribute in the *early-uprising* study was found to be the reduction in the *waiting time* before meeting the doctor and the *DPR* in the *late-uprising* study (this should be an expected result given the tangible improvement in this attribute during the *late-uprising* study). For the four quality attributes, patients' WTP values significantly diminished in the *late-uprising* study in comparison to the *early-uprising* study; the reduction was significant at 0.05 level for three of the attributes and at 0.10 level for the waiting time attribute.

In order to assess variations in the *nature* of patients' preferences, we examined the number of patients who declared being willing to pay to benefit from the specified improvements (the number of contributors). A significant reduction in the number of late phase contributors compared to early phase contributors was noticed for the *geographical proximity* and the *DPR* attributes. No significant reduction in the number of respondents stating positive WTP values was detected for the *waiting time* and *drug availability* attributes. However, this particular result does not take into consideration the variations in the sample's demographic and socioeconomic characteristics and the amplitude of quality improvements proposed to the respondent in exchange of the user fee increase. This was considered in the multivariate analyses elaborated below.

3.4. Factors associated with stated WTP values

The four Tobit regression analyses (Table 3) suggest the existence of a strong and highly significant association between stated WTP values for the different quality improvements and the amplitude of the corresponding amelioration. Respondents living “Very Far” or “Far” from the center were willing to pay more than those living at closer distances to benefit from a “Very Close” PHC center.⁵ Similarly, being those benefiting the most from reducing the waiting time

⁵ Estimated regression coefficients from the Tobit model can be manipulated to express the marginal effects of the corresponding independent variables on stated WTP values, see [40,41]. Indeed, two effects can be decomposed: (1) an effect representing an increase (or decrease) in the WTP values stated by respondents whose WTP is greater than zero and (2) an effect representing a change in the probability of stating a positive WTP value by respondents who declare they are not willing to pay for the improvement. Results of such decomposition are not presented in this paper and for an example the reader is referred to [33].

Table 1
 Status quo quality perceptions and respondents' socioeconomic and demographic characteristics

	All sample N (%) / mean (±S.D.)	Early-uprising N (%) / mean (±S.D.)	Late-uprising N (%) / mean (±S.D.)	p-Value
Geographical proximity				0.441 ^a
Very Far	297 (42.4%)	142 (40.8%)	155 (43.9%)	
Far	144 (20.5%)	72 (20.7%)	72 (20.4%)	
Average	165 (23.5%)	97 (27.9%)	68 (19.3%)	
Close	72 (10.3%)	31 (8.9%)	41 (11.6%)	
Very Close	23 (3.3%)	6 (1.7%)	17 (4.8%)	
Waiting time				0.151 ^a
Very Long	130 (18.6%)	70 (20.0%)	60 (17.1%)	
Long	108 (15.4%)	58 (16.6%)	50 (14.3%)	
Average	176 (25.1%)	86 (24.6%)	90 (25.7%)	
Not Long	135 (19.3%)	71 (20.3%)	64 (18.3%)	
Not Long at All	151 (214.6%)	65 (18.6%)	86 (24.6%)	
DPR (score: [1,5])	3.36 (±1.16)	3.00 (±1.20)	3.72 (±1.00)	<0.0005
Drug availability				0.001 ^a
All	484 (74.6%)	251 (76.3%)	233 (72.8%)	
Some	128 (19.7%)	49 (14.9%)	79 (24.7%)	
None	37 (5.7%)	29 (8.8%)	8 (2.5%)	
Gender (female)	498 (71.0%)	251 (72.1%)	247 (70.0%)	0.529
Age (years)	38.6 (±15.3)	36.2 (±13.9)	41.0 (±16.1)	<0.0005
Education (formal schooling years)	9.1 (±4.7)	9.2 (±4.6)	9.1 (±4.7)	0.984
Marital status (married)	563 (80.3%)	277 (79.6%)	286 (81.0%)	0.636
Employment (direct money-earner ^b)	237 (33.9%)	108 (31.1%)	129 (36.5%)	0.130
Living zone				<0.0005
% City	174 (28.8%)	60 (17.2%)	114 (32.3%)	
% Village	488 (69.6%)	270 (77.6%)	218 (61.8%)	
% Refugee-camp	39 (5.6%)	18 (5.2%)	21 (6.0%)	
Reason for the medical visit				< 0.0005
% Chronic disease and condition	218 (30.9%)	83 (23.6%)	135 (38.2%)	
% Acute infection and common illnesses	401 (56.9%)	226 (64.2%)	175 (49.6%)	
% Pregnancy	50 (7.1%)	15 (4.3%)	35 (9.9%)	
% Emergency	8 (1.1%)	7 (2.0%)	1 (0.3%)	
% Others	28 (4.0%)	21 (6%)	7 (2%)	
Insurance status (insured)	571 (81.5%)	263 (75.6%)	308 (87.3%)	<0.0005
User fee co-payment (free)	421 (60.1%)	188 (54.0%)	233 (66.0%)	0.001
Household monthly income (NIS) ^c				0.001
≤1000 NIS	204 (29.6%)	86 (25.3%)	118 (33.7%)	
]1000–2000] NIS	261 (37.8%)	133 (39.1%)	128 (36.6%)	
]2000–3000] NIS	134 (19.4%)	66 (19.4%)	68 (19.4%)	
]3000–4000] NIS	53 (7.7%)	28 (8.2%)	25 (7.1%)	
]4000–5000] NIS	22 (3.2%)	15 (4.4%)	7 (2.0%)	
>5000 NIS	16 (2.3%)	12 (3.5%)	4 (1.1%)	
Brut sample size (response rate)	1031 (68.4%)	578 (60.9%)	453 (77.9%)	<0.0005
Sample size (net)	705	352	353	

^a “Very Far”/“Far” categories, “Very Long”/“Long”, “All”/“Some” are tested against the rest of the sample.

^b The category of “Direct money-earners” includes: independents (ex., shopkeepers, traders, etc.), employees (governmental and non-governmental) and workers. “Not direct money-earners” includes housewives, unemployed, retired and others.

^c NIS: New Israeli Shekel. During the *early*- and *late-uprising* studies, US\$ 1 was equivalent to 4.20 and 4.75 NIS, respectively; respondents selected among intervals of amplitude of 500 NIS.

Table 2
Patients' stated WTP values stratified by study phase

Quality attribute	WTP (All)		WTP Early-uprising		WTP Late-uprising		p-Value for difference in means
	Mean (±S.D.)	No. (%) contributors	Mean (±S.D.)	No. (%) contributors	Mean (±S.D.)	No. (%) contributors	
Geographical proximity	8.24 (±13.92)	542 (77.3)	9.52 (±16.93)	280 (80.5)	6.98 (±9.97)	262 (74.2)	0.016
Waiting time	4.04 (±7.25)	406 (58.0)	4.51 (±8.77)	209 (59.7)	3.58 (±5.29)	197 (56.7)	0.088
DPR	5.17 (±11.73)	398 (56.9)	7.55 (±15.32)	246 (69.9)	2.74 (±5.27)	152 (43.7)	<0.0005
Drug availability	5.80 (±8.77)	481 (73.0)	6.64 (±10.13)	238 (72.6)	4.95 (±7.07)	243 (73.4)	0.013

before meeting the doctor to minimum, patients currently waiting “Very Long” or “Long” before meeting the doctor were willing to pay the highest user fee increments to benefit from a “Not Long at All” waiting time. The results also suggest that when the respondent is less satisfied from her/his relationship with the doctor, as assessed by the calculated DPR-score, she/he was willing to pay more to spend longer time with the doctor to benefit from more information about her/his medical problem and the prescribed treatments ($p < 0.01$). Finally, patients who did not find any of their prescribed medications in the center were willing to pay more than those who found “Some” or “All” of their medications, to be always able to find them in the pharmacy of the center. Although, the coefficients had the expected sign and order, they were not significant. This might be due to a problem in the framing of the valuation question for this attribute. Indeed, respondents were asked about their WTP values to be “Always” able to find their prescribed medications in the center; therefore, even those who found their prescribed medications in the center at the moment of the study were willing to pay significant amounts to be “Always” able to find them. A better question framing that considers the number of times the patients find their prescribed medications in the center might lead to more robust results.

Females were willing to pay less than males to benefit from improvements over the *geographical proximity* attribute ($p < 0.05$). Differences were not significant for the other attributes. In the local context, females usually have less control over household resources, which may explain their lower stated WTP values. Similarly, elderly patients were willing to pay less than younger patients for the various quality improvements; this was significant for the *geographical proximity* and the *waiting time* attribute ($p < 0.01$). Given that the elderly may well use the opportunity of a visit to the PHC center to socialize and meet people, especially in periods where curfew, closures and siege could only have exacerbated their isolation, their lack of interest for reducing waiting time may be understandable. Except for the *geographical proximity*, no significant differences were detected between the WTP values stated by respondents with different marital status. Neither the level of education of the patient nor her/his employment status appeared to play a role on the magnitude of stated WTP values. Direct money-earners (independents,

Table 3
Factors associated with stated WTP values (Tobit regression analysis)

Independent variable	Geographical proximity	Waiting time	DPR ^a	Drug availability
Constant	5.714 (10.906)	14.269 (9.637)	18.145 (7.118) ^{***}	9.484 (5.437) [*]
Study phase	−27.697 (12.75) ^{**}	−13.793 (8.459) [*]	−2.795 (10.417)	−7.098 (7.561)
Geographic proximity				
Very Far	16.792 (6.855) ^{**}	−	−	−
Far	13.019 (7.008) [*]	−	−	−
Average	13.961 (6.817) ^{**}	−	−	−
Close	9.778 (5.533) [*]	−	−	−
Waiting time				
Very long	−	8.677 (2.281) ^{***}	−	−
Long	−	5.386 (2.445) ^{**}	−	−
Average	−	1.688 (2.327)	−	−
Not Long	−	1.942 (2.308)	−	−
DPR (DPR-score)	−	−	−3.160 (0.843) ^{***}	−
Drug availability				
None	−	−	−	2.085 (2.380)
Some	−	−	−	1.772 (1.936)
Gender (female)	−6.106 (2.925) ^{**}	1.484 (2.040)	3.281 (2.435)	0.280 (1.889)
Age (years)	−0.281 (0.104) ^{***}	−0.187 (0.072) ^{***}	−0.075 (0.082)	−0.073 (0.066)
Education (schooling years)	−0.411 (0.282)	−0.047 (0.188)	−0.072 (0.227)	0.274 (0.182)
Health Status ^b	0.708 (0.868)	−1.387 (0.601) ^{**}	−0.969 (0.713)	−0.471 (0.575)
Monthly income (500 NIS)	0.671 (0.454)	0.513 (0.303) [*]	0.782 (0.359) ^{**}	0.150 (0.290)
Marital status (not married)	−4.469 (2.458) [*]	−1.541 (1.674)	0.055 (1.923)	0.365 (1.574)
Employment (not earner)	−3.833 (2.794)	−2.495 (1.925)	−5.504 (2.280) ^{**}	−1.042 (1.834)
Living zone				
Village	10.281 (3.242) ^{***}	0.157 (1.889)	−1.674 (2.234)	−1.935 (1.801)
Refugee-camp	2.989 (5.426)	0.935 (3.491)	1.796 (4.027)	0.642 (3.323)
Reason of the visit (acute)	−9.691 (2.892) ^{***}	−3.706 (2.000) [*]	−0.113 (2.365)	−1.942 (1.861)
Provider (NGO)	5.998 (2.211) ^{***}	1.512 (1.561)	3.066 (2.211)	−1.245 (1.524)
Study phase × independent variables interactions				
Geographical proximity ^c				
Very Far	1.567 (5.654)	−	−	−
Far	3.188 (5.936)	−	−	−
Average	2.398 (5.668)	−	−	−
Waiting time				
Very long	−	−6.196 (3.249) [*]	−	−
Long	−	−2.092 (3.252)	−	−
Average	−	−0.387 (2.999)	−	−
Not Long	−	−1.462 (3.074)	−	−
DPR (DPR-score)	−	−	0.449 (1.194)	−
Drug availability				
None	−	−	−	2.485 (4.595)
Some	−	−	−	−3.162 (2.459)
Gender (female)	1.284 (4.096)	−4.647 (2.840) [*]	−8.066 (3.509) ^{**}	−2.409 (2.632)
Age (years)	0.307 (0.136) ^{**}	0.131 (0.096)	−0.017 (0.115)	0.082 (0.087)
Education (schooling years)	0.623 (0.388) [*]	0.161 (0.265)	−0.195 (0.328)	−0.188 (0.252)
Health Status	−0.918 (1.221)	1.872 (0.846) ^{**}	0.550 (1.043)	0.381 (0.809)
Monthly income (500 NIS)	0.759 (0.664)	0.188 (0.446)	−0.119 (0.554)	0.329 (0.429)
Marital Status (not married)	7.400 (3.525) ^{**}	1.685 (2.439)	1.341 (2.934)	−0.195 (2.273)
Employment (not earner)	5.812 (3.721)	2.332 (2.568)	6.145 (3.147) ^{**}	0.661 (2.438)

Table 3 (Continued)

Independent variable	Geographical proximity	Waiting time	DPR ^a	Drug availability
Living zone				
Village	−8.390 (4.209)**	−1.071 (2.522)	0.254 (3.088)	2.396 (2.373)
Refugee-camp	1.105 (7.085)	−2.099 (4.693)	−3.946 (5.704)	−0.745 (4.412)
Reason of the visit (acute)	9.650 (3.761)***	4.502 (2.610)*	−2.341 (3.209)	0.552 (2.412)
Provider (NGO)	−1.635 (3.351)	2.926 (2.305)	−1.891 (3.175)	0.912 (2.319)
No. of observations	590	589	585	546
No. of censored observations ^d	135	259	253	141
Log likelihood	−1988.92	−1400.13	−1468.23	−1621.25
Probability > χ^2	<0.00005	<0.00005	<0.00005	0.0710
RESET Ramsy's test (Pb. > F)	0.140	0.881	0.435	0.679

^a DPR score; range [1,5].

^b Health status: 1, excellent to 5, poor.

^c (Phase × close) variable was excluded from the model due to a convergence problem.

^d No. of censored observations = no. of observations with WTP value = 0.

* $p < 0.10$.

** $p < 0.05$.

*** $p < 0.01$.

employees, workers, etc.) – again those who usually control household income – had a tendency to declare higher WTP values compared to non-direct money-earners (housewives, students, unemployed, etc.), this was significant for improving the DPR attribute.

The living zone of the patient played a role only on her/his stated WTP value for the *geographical proximity* attribute. Respondents living in rural zones declared higher WTP values to have a closer PHC center available to them. Respondents with higher income were willing to pay more to benefit from improvements over the four quality attributes. This was significant at the 0.05 and 0.01 levels, respectively, for the *waiting time* and the *DPR* attributes. It seems that even the poorest respondents were willing to pay substantial amounts to benefit from improvements over the *geographical proximity* and the *drug availability* attributes. In general, respondents coming to the center for an acute or common illness were willing to pay less than those more frequently come to the center due to a chronic condition—this was significant for the *waiting time* and the *geographical proximity* attributes ($p < 0.01$ and 0.10, respectively). One should note here that patients in the acute/common illness category usually have a better mobility capacity than those with chronic diseases. Finally, patients recruited from the NGO PHC center were willing to pay more to improve the *geographical proximity*, *waiting time* and *DPR* attributes,

and less for the *drug availability* attribute, compared to those attending governmental facilities. However, this was only significant for the *geographical proximity* attribute. Drugs' prices in NGO PHC are usually set at 10% above their cost price; consequently, paying an extra user fee to have all the prescribed medications be available in the NGO PHC local pharmacy would raise the cost of medications to a level close to prices in private pharmacies. Hence, although patients in NGO PHC center appeared to be more interested in improving quality, this was not the case for the *drug availability* attribute.

3.5. Impoverishment effect

When a binary variable indicating whether the respondent was recruited during the *early-* or *late-uprising* study was introduced into the model – to assess impoverishment impact on WTP values – it appeared to have a statistically significant negative effect with regard to the *geographical proximity* ($p < 0.05$) and *waiting time* ($p < 0.10$) attributes—results are adjusted for the quality variables and the respondents' demographic and socioeconomic characteristics. A likelihood ratio test⁶ suggested that a model with all the

⁶ Tobit (X_i) → log likelihood (L0); Tobit ($X_i, D_i, DiXi$) → log likelihood (L1), $i = 1$ to k . The likelihood ratio test (LR) = 2 (L1 – L0) ~ Asymp. $\chi^2 (k + 1)$.

possible interaction terms between the “study phase variable” and “quality level, demographic and socioeconomic variables” explains the best the distribution of the stated WTP values, compared to a model without the phase variable or with the phase variable and without the interaction terms. Therefore, the former was retained as the model of choice and the results are presented in Table 3. The negative pure impoverishment effect on the *geographical proximity* and *waiting time* attributes remained significant in the presence of the interaction terms ($p=0.015$ and 0.017 , respectively), which would indicate a real variation in patients’ stated preferences with respect to these two quality attributes following the impoverishment shock. In other words, the reduction in patients’ WTP values was not only due to an income reduction effect but also due to a change per se in patients’ assessment of the value (importance) of these two attributes for them. On the reverse, no significant associations were found between impoverishment and patients’ stated WTP values for improvements over the *DPR* and the *drug availability* attributes.

Interaction terms suggest that women’s WTP values for improving the *waiting time*, *DPR* and *drug availability* attributes were more negatively affected by impoverishment than men’s WTP values—this was significant at 0.01 and 0.05 levels, respectively. Although not significant, the interaction term for the Gender variable was also negative for the *drug availability* attribute. Consequently, an equivalent general increase in user fees would penalize females more than males, even if the user fee increments were accompanied by equivalent quality improvements. Elderly patients were willing to pay more in the second study phase to have a “Very Close” PHC center; this was significant at 0.05 level. Certainly, elderly patients represent a category of the population particularly affected by, and highly sensitive to, the difficult circulation conditions in the OPT caused by curfews, checkpoints and closures.

In the pooled sample, patients living in rural zone were willing to pay more than patients living in urban zone to benefit from closer PHC center ($p < 0.01$); however, in the *late-uprising* study, and in comparison to the *early-uprising* study, villagers’ WTP values were strongly negatively affected ($p < 0.05$). An opposite effect was demonstrated with respect to WTP values to improve *drug availability* and the *DPR*—here,

villagers were willing to pay more for these attributes in the *late-uprising* study compared to the *early phase* however differences were not significant. Respondents suffering from an acute condition or visiting the center due to a common illness had a tendency to be willing to pay more, in the second study phase compared to the first, to have a closer PHC center where they could wait much less time before meeting the doctor—this was significant at 0.01 and 0.10 levels, respectively.

The results suggest that patients with higher income levels tended to be willing to pay even more in the second study phase compared to the first phase, to benefit from a better quality, however, the results were not significant. Being more educated in the second study phase had a positive effect on the *geographical proximity* attribute. Respondents of the category of non-direct money-earners (housewives, unemployed, etc.) were willing to pay more in the *late-uprising* study, compared to the early phase, to benefit from a better *DPR* ($p < 0.05$). Indeed, those are the ones who move the least and cross-checkpoints infrequently (to access work, etc). Thus, probably to avoid any un-necessary and risky displacements for the purpose of seeking health care, they were willing to pay more in the *late-uprising* study to benefit from a good *DPR*. Patients with low perceived health status were willing to pay more in the *late-uprising* study phase compared to the early one to reduce waiting time. Finally, respondents who were waiting “Very Long” before meeting the doctor, and those who were only able to find some of their prescribed medications in the center, were willing to pay less in the second study phase, compared to the first, to have each of the corresponding quality attributes improve. The former group seem to be willing to somehow withstand the “Very Long” waiting period in order not to pay more for the service; and the latter seem to have accepted the available quality level – even when non optimal – also in order to avoid extra payments.

4. Discussion

In this paper, we addressed the question of the impact of an adverse variation in patients’ ATP on their preferences vis-à-vis improving the quality of delivered care. The sudden and severe impoverishment

experience that gripped the OPT following the explosion of the second Palestinian *Intifada* and the subsequent quasi-permanent closures of the Palestinian lands was used as a quasi-experimental context. A strong relationship was demonstrated between impoverishment and modifications in patients' preferences (as expressed by their stated WTP values). The results suggest that the value of improvements in secondary, or relative "luxury", quality attributes, e.g., *geographical proximity* and *waiting time*, seem to have been the most negatively affected by the substantial decrease in patients' incomes. On the contrary, patients' preferences for essential tangible quality attributes, e.g., *drug availability* and *doctor–patient relationship*, appeared not to have been affected by patients' impoverishment.

A conventional interpretation of our results would state that the economic shock due to the *Intifada* and the subsequent rapid impoverishment of the Palestinian population have provoked a shift in respondents' demand curve which has not surprisingly affected characteristics of health care that can be viewed as luxury goods. The most important result of our multivariate regression analyses was however that the variation in patients' preferences with respect to some of the quality attributes could not be fully explained by the decrease in patients' ATP. A negative impoverishment effect remained significant even after adjusting for patients' demographic and socioeconomic characteristics, including income, and thus, adjusting for the loss of available income between the two periods of observation. This clearly suggests that an impoverishment shock, as the one related to the crisis situation created by the *Intifada*, may have a multi-dimensional effect that goes beyond the direct impact of the reduction in available income, and may alter the structure of individual preferences itself (shift in the demand curve). We first discuss this multi-dimensional impoverishment impact and its association with patients' demographic and socioeconomic characteristics. Following, we attempt to develop the discussion further and provide arguments about how CV results should be interpreted in the light of our study. We conclude by discussing the implications of our results on public policy decisions with regard to financing health care services in developing countries, in general, and in the context of the OPT in particular.

Impoverishment by itself seems to have multi-dimensional consequences that might promote modifications in patients' perceptions and preferences, resulting in a re-adjustment of individual and family expenditure prioritization schemes. When confronted with severe impoverishment conditions, patients tend to discount certain health care quality aspects for which they were attaching more importance before impoverishment conditions set in. It appears that, under impoverishment conditions, certain groups of patients downplay and adapt their expectations to the most basic quality components, and consequently, tend to weaken their ability to fully express their desires and preferences. This multi-dimensional impact of an impoverishment shock may yet be interpreted in the conventional framework of a shift to the demand curve due to a complex exogenous shock. It, however, suggests that the alternative framework advanced by Amartya Sen may be quite relevant to analyze this phenomenon [31]. Sen's notion of "capabilities" is an attempt to go beyond conventional "welfarist" approaches by taking into account the inability of certain groups of people to "desire", and consequently, to "express" all their preferences in an adequate manner. Our results are quite coherent with the idea that the severe impoverishment shock due to the *Intifada* in Palestine, patients might have started to adapt their expectations and behaviors and self-limit their preferences. It should be mentioned that this effect may not only concern shocks related to political crisis and war situations, as in the case of the *Intifada*, but also other types of events like major epidemics—the HIV/AIDS epidemic in some sub-Saharan countries being a typical example [42].

Russell [30] has argued that, being willing, and able, to pay for a commodity does not automatically imply being able to *afford* the latter, mainly because the social opportunity cost of the payment may be too high to be socially acceptable. In a similar vein, our study may complement Russell's argument using Sen's theory about the inability of certain groups of individuals to manage to desire adequately [31]: an absence of WTP may not always be interpreted as an absence of value for the individual. The main message of our study can be formulated as follows. Not being willing to pay for a commodity does not automatically imply the absence of preferences for the latter. This is because, under certain conditions, patients experience a

change in their perceptions of what is achievable and what is not, and adapt their expectations to the realities and constraints of their lives. As a result, they might become no longer able to express all their preferences in an adequate manner, given particular life conditions.

Such interpretation of our results in the line suggested by Sen work would also be inline with previous studies conducted in the area of economic psychology, where it was suggested that elicited monetary values could be better understood as expressions of attitudes rather than as indications of economic preferences [32]. This has been sometimes alluded to using the term ‘money illusion’ [43]. The latter has been defined [43] as the tendency to think in terms of *nominal* rather than *real* monetary values. The authors [43] argue that people often think about economic transactions in both nominal and real terms, and that money illusion arises from an interaction between these representations, which result in a bias toward a nominal evaluation. These considerations have for long been features distinguishing economists’ versus psychologists’ approaches and methods of reasoning about the elicitation of people’s preferences [44]. Although the more conventional interpretation of our results in terms of demand shift cannot be totally excluded, in this study we bring some additional indication that statements of WTP may better be viewed as expressions of attitudes rather than as direct indication of preferences.

In addition, our results suggest that the consequences of impoverishment affected primarily the most vulnerable groups within the population, e.g., women, the elderly and village dwellers. WTP values stated by these subgroups of individuals were those most negatively affected by impoverishment. Women in the local context usually have little control on household resources, perhaps explaining their higher sensitivity to impoverishment conditions. As for elderly patients, it is important to note that in Palestine, the absence of social security benefits and safety nets translate into a *de facto* arrangement where older people by necessity must rely on family financial resources, as well as, social assistance and support for survival. In this particular instance, it seems that the elderly have re-prioritized access as more important than even the cost of service by exhibiting significantly higher WTP values than other groups in the *late-uprising* study phase,

in order to benefit from a PHC center located closer to their domicile. This is probably due to the impossibility of travel conditions, especially for the elderly, often requiring travel on dirt paths and walking substantial distances (siege and closures) under the fear of being stopped or shot at with tear gas, sound bombs, rubber bullets, and even sometimes, live ones.

Villagers were especially hard hit by the sharply deteriorating political conditions, forced joblessness and prolonged unemployment—many lost their jobs (in nearby Palestinian cities or in Israel) and access to the land that they till to live [45]. This had significantly reduced their WTP values for improving quality attributes like the *geographical proximity* of the PHC center. However, villagers were also especially affected by road closures and siege, resulting with almost total isolation and sudden lack of access to basic services. These circumstances, and especially the problem of inaccessibility to health services which are located in cities and town centers, ironically, but understandably, explain why villagers in this study reported higher WTP values in the second study phase compared to the first for improving the *drug availability* quality attribute. Having experienced this severe lack of access to basic health care, these villagers were willing to pay more than what they were willing to pay previously in order to ensure that their medications are always available at the PHC center and thus not have to face having to visit the center again or look for these medications elsewhere in these trying times—this result is adjusted for socioeconomic and demographic characteristics and the extent of quality improvement. Finally, patients with lower school qualifications were also more negatively affected by impoverishment conditions. This is manifested in their most basic prioritization of the quality improvements that were proposed to accompany the user fee increase, downplayed to the minimal level of being willing to pay more just to have drugs available at the PHC center or to be able to meet the doctor for a sufficient time.

Contingent valuation studies have been mainly developed and applied in the context of publicly financed health care systems of developed countries, and with the purpose of contributing to the monetary valuation of health gains for cost–benefit analysis (CBA) of alternative programs. It is of utmost importance to interpret CV results with caution [46],

mainly when applications are to be extended from economic calculus (a normative perspective) to attain positive economic objectives, e.g., demand assessment and price elasticity estimation [19]. Even in the normative context of CBA, it has been argued that WTP values should be weighted if patients' preferences are proven to be not equivalently distributed amongst the poor and the rich [20]. In the context of demand assessment for pricing purposes, it has been also argued that a proper integration of the issues of payments' *affordability* must be taken into account. *Affordability* is usually defined as a variant of ATP requiring certain external value judgments about income distribution [47]. Our study strongly suggests that in addition to affordability, individuals' *capabilities to desire adequately* and express preferences should also be taken into account while interpreting WTP data. In particular, as shown by the impact of the *Intifada* on the Palestinian population, the process of impoverishment may affect such capabilities to express preferences in certain vulnerable groups a lot more significantly than in the rest of the population.

It is worth mentioning that other elicitation techniques (e.g., conjoint analysis), and its currently most commonly used variant in the area of health economics, namely, the Choice Experiments (CE) methodology [48–52], could have been a good alternative to CV for the purpose of our study. The CE technique focuses on choices made by the respondents between different scenarios, set-up using pre-selected attribute modalities, and based on the modalities. The chosen attributes to characterize the program are varied to their values (or scale) and individuals are told to tick their one preferred scenario. The process is then repeated, intra- and inter-individuals, with new attributes' values. If one of the attributes was the cost (i.e., a monetary attribute), regression analyses as the logit or probit provides coefficients for a division representing marginal rates of substitution (or trade-offs) interpreted as WTP values for the non-monetary attributes, or just trade-offs between the other attributes. The CE technique is currently developed and used in transport, environmental and, more recently, health economics. This technique may help bringing greater clarification between alternative interpretations of an observed shift in preferences following major shocks, like the case of the *Intifada*.

Our study shows that under severe impoverishment conditions, patients' WTP values for improving the quality of delivered care diminish steeply. Given that quality improvement is known to be an unavoidable dimension in determining patients' reaction to price variation [1], using complementary financing mechanisms based on mobilizing private resources (e.g., cost recovery policies) under exacerbated poverty conditions, shall critically penalize health care users, and mainly the most vulnerable amongst them. Other financing mechanisms based on more efficient allocation of public resources amongst the different public sectors should be promoted as an alternative to assure equitable health care utilization.

5. Conclusion

Impoverishment might catalyze a series of both income-dependent and income-independent modifications in patients' preferences vis-à-vis improving the quality of delivered care, especially, with respect to some quality improvements that may be considered less "essential". Being unwilling to pay for a commodity should not be spontaneously, and "naively", interpreted as an evidence of a lack of preferences for the former. Under severe impoverishment conditions, particular groups of patients might accommodate their realities and adapt their preferences to the extent that they become unable to express them adequately. Indeed, although some patients might express preferences for certain aspects of quality improvements, and be willing to pay a substantially extra amount of money to benefit from them under relatively "favorable" economic circumstances, patients might be forced to adapt their preferences in a process that takes into consideration what is achievable in the face of other essential priorities if "unfavorable" economic conditions set in. Our study suggests that under severe impoverishment shocks, the use of direct cost recovery mechanisms, and the introduction of user fees, as complementary means of financing health care, may have many unintended negative consequences for social welfare. We conclude that contrary to some a priori beliefs that they are exclusively an ad hoc tool to legitimate cost recovery policies and reduction in public delivery of health care, CV studies may indeed be carried out in a more "value-neutral"

approach. Such approach implies a clear awareness that CV provides policymakers with valuable information about health care values, from the users' perspective, which are sensitive to the economic and social environment. This should assist in activating rigorous, and continuous, planning of health care financing which explicitly takes into consideration these variations in the social and economic environments, equity and the social welfare of the population.

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Appendix A

Selected quality attributes and their corresponding measurement scales

Sr. no.	Attribute	Measurement scale
1	Geographical proximity	Very far, Far, Average, Close, Very close
2	Waiting time	Very long, Long, Average, Not long, Not long at all
3	Doctor–patient relationship (DPR): being able to discuss her/his problem with the doctor and receive sufficient information about her/his health state and the prescribed treatment(s)	Multi-item Likert-scaling; range: [53] (continuous). Items: 1. I stayed sufficient time with the doctor 2. The doctor explained to me my health problem 3. The doctor explained to me how to use the prescribed treatment 4. The doctor explained to me what I should do to prevent (or not to complicate) my health problem in the future 5. The information was clear and sufficient
4	Drug availability: being able to purchase the prescribed treatment(s) at the center	All, Some of them, None

Appendix B

The four partial WTP valuation questions:

<p>Would you be willing to pay any amount of money (even small amounts like 1, 2, 3 or 4 NIS) more than what you already pay in order to ...</p>	<p>◆ benefit from a PHC center similar to this one and located “Very close” to your home?</p>	<p>◆ Yes →</p>	<p>What is the maximum amount of money that you would be willing to pay, extra to what you currently pay, in order to ...</p>	<p>◆ have a PHC center “Very close” to your home</p>	<p>knowing that this extra amount of money will be paid at every coming visit? →</p>	<p>Payment card</p>
	<p>◆ wait a period you estimate “Not long at all” before meeting the doctor?</p> <p>◆ be able to stay sufficient time with the doctor to discuss with him your health problem, receive sufficient and clear information about your disease and the prescribed treatment(s)?</p> <p>◆ be able to find the prescribed treatment(s) “always” available in the center?</p>			<p>◆ have a PHC center with a “Waiting time” that you estimate as “Not long at all”</p> <p>◆ be able to stay sufficient time with the doctor to discuss with him your health problem, receive sufficient and clear information about your disease and the prescribed treatment(s)</p> <p>◆ be able to find the prescribed treatment(s) “always” available in the center</p>		
		<p>◆ No →</p>	<p>Why?</p>	<p>...</p>		

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