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March 2011

No 2011/02

Newcastle Discussion Papers in  
Economics: ISSN 1361 - 1837

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### ***Abstract***

*This paper adds to the monetary valuation ‘tool-kit’ by demonstrating (a) the role of experiments as ‘learning’ devices in valuation studies, by allowing respondents to understand the intuition behind the value elicitation terms we (as economists) use in our surveys, and (b) the feasibility of eliciting robust Willingness-to-Accept (WTA) for policy making. Resulting data sets appear plausible and well behaved.*

### **1. Introduction**

It is well-known that in many environmental valuations it would be theoretically – and arguably ethically – more appropriate to elicit WTA compensation measures than Willingness-to-Pay (WTP) to avoid measures, for example in natural resource damage assessments, on-going environmental pollution or chronic health effects (see Knetsch 1990 for further consideration of this issue). However, the well-documented problems associated with WTA means that it is rarely adopted, particularly in policy applications. These include the elicitation of implausibly large values and the so-called WTA/WTP gap (see Horowitz and McConnell, 2002 for a systematic review of experimental and field findings). Economic theory predicts that the gap should be small, except in certain circumstances, although the empirical evidence is mixed (Shogren et al., 1994; Bateman et al, 1997; Plott and Zeiler, 2005; List, 2003; Loomes et al, 2009). While this paper takes this gap as its point of departure, we do not focus on it. Instead, we note that a necessary condition in making a judgement about the magnitude of the WTA measure itself or the size of the WTA/WTP gap is robust and reliable measures of both WTP and WTA. Arguably, a wide body of experience exists in respect of WTP, in contrast to WTA. The latter is the main concern of this paper and provides the focus for the reported empirical work and subsequent discussion.

Table 1 is illustrative of the dilemma facing a researcher when faced with judging the reliability of a set of WTA responses. While the comparison comes with a sizeable caveat

attached, given the differing samples, health states and procedures, nevertheless the differences are quite arresting. Mean and median WTA are significantly larger for Subsample 1 (students; non-serious injury) and the multiplier for the 1 week to 3 months mean values is 14 for Subsamples 2 and 3 (case studies: Sections 2/3; non-serious health complaints) but 24 for Subsample 1. Taking these responses at face value, how might we judge the reliability of the WTA responses from Subsample 1? The first point is that a demand revealing mechanism was not used so the possibility exists that responses were simply strategically overstated, as would be predicted. Alternatively, respondents may simply have misunderstood or misinterpreted what is meant by minimum WTA, or both.

**Table 1 Example WTA Responses**

	Subsample 1		Subsample 2		Subsample 3	
	1 month	3 Months	1 month	3 Months	1 month	3 Months
	£	£	£	£	£	£
Mean WTA	175	4807	130	1932	106	1555
Std. Dev	208	8614	189	2866	133	2400
Median WTA	100	2000	50	750	50	600
n	58		155		155	

The potential for the latter confound to be at play is, we conjecture, high. Most people have much more experience on the buying, rather than the selling, side of the market. When we do sell, the most common situations are those in which people make a decision as to whether or not they will accept an offered price for a particular good. Far less common are situations where a consumer ponders at length the minimum s/he would accept to sell something. Indeed, arguably a more likely scenario is to wonder about the maximum s/he can obtain for the item being sold. We conjecture that because of the natural psychology of the task, often coupled with an unfamiliar non-marketed good (e.g. environmental protection, changes in health), it is likely that at least some of the ‘excessive’ discrepancy noted in the literature is caused by peoples’ ‘misinterpretation’ of what is actually meant by ‘minimum WTA’, particularly given the one-shot, non-reflective nature of most empirical estimation exercises. Indeed, even if they are given the opportunity to revise their answers at the end of the exercise, respondents in a valuation study have nowhere near the flexibility and chance for

reflection that is typically involved in a real-life sale. For example, failure to sell your car can almost always be followed up by reducing your asking price and re-entering the market.

Therefore, in this paper we devise a mechanism to control for the two potential confounds by teaching respondents, prior to the health valuation questions, what economists mean by a minimum WTA and the potential consequences of over or under bidding, using a demand-revealing elicitation question. We use an incentivised, incentive-compatible selling task followed by the hypothetical valuation, invoking the idea of ‘rationality spillover effects’ (Cherry et al 2003). The potential for incentivised teaching experiments to convey the intuition behind a relatively complex concept prior to a hypothetical choice task has been demonstrated by Seested Nielsen et al (2010). In their case, the emphasis was on conveying the nature of the valued (changes in life expectancy) as opposed to conveying the essential nature of the elicitation question.

The teaching experiment in this study was based on the Plott and Zeiler (2005) mechanism which has been shown to generate theoretically predicted results (no discrepancy) in the context of lottery tickets, implying the mechanism was understood by respondents and the incentives were clear. While the instructions had to be adapted slightly to make them suitable for members of the public, this was not at the cost of significant structural changes to the task. The purpose of this mechanism was to reinforce the strategic incentives for truthfulness in WTA, stripping out any misguided strategic effects that could inflate the WTA measure.

Both data sets (stomach complaint and throat complaint) appear plausible, consistent and well-behaved. The WTA responses are broadly comparable between the conditions. A t-test, at a 5% level, cannot reject the hypothesis that for each time period the mean is the same for both conditions. The 1 week response is approximately equal to 1 day’s pay for the average worker in the UK. Further, respondents increased their WTA values broadly in proportion to the increase in the time (our measure of severity) that they had to endure the symptoms. The median responses show a similar pattern.

The remainder of the paper is as follows. Section 2 details our empirical methods. Section 3 reports our results. Finally, Section 4 concludes.

## **2. Methods**

Considering the elicitation of respondents' "true" minimum WTA, at a minimum, this requires that respondents should be familiar with this and have at least an intuitive understanding of the possible consequences of offering anything other than their minimum WTA in any valuation exercise. This was the main objective of the study protocol described below, which was based on an incentivised experiment to provide respondents with the information and opportunity to learn about WTA followed by a subsequent hypothetical WTA valuation for stomach and throat complaints. In what follows, we outline the main content of the protocol<sup>1</sup>, which was backed up and supplemented by use of visual aids, aide memoirs and question-and-answer sessions to check for (mis)understanding and help respondents retain the key features of the elicitation method. The protocol was developed, tested and refined on approximately 40 respondents prior to implementation in order to help improve our instructions and explanations, to maximise respondents' understanding.

Respondents (8-12 per session) took part in an introductory discussion, followed by the teaching experiment incentivised by the opportunity of entering a draw<sup>2</sup> for a prize of £10, finishing with a series of hypothetical valuation questions. These are summarised in Table 2 and discussed in detail below. Regarding the latter, the sample was split to counteract any order effects in the data – 50% answered stomach followed by throat while the other 50% encountered them in reverse order. Duration was also switched i.e. one week/one month/three months and three months/one month/one week within both health problems.

### *Introductory session*

The initial session was designed to introduce and provide respondents with the opportunity to practice with the concepts in a group discussion. We began by introducing the term "reserve price" as a substitute for the term 'minimum WTA' in both the experiment and hypothetical survey to follow through the example of selling a flat. Next, the respondents were split into two groups and were asked to discuss a 'reserve price' i.e. the minimum they would accept to 'sell' a teddy bear (which they were given and told that they 'temporarily' owned for the purposes of the discussion). The main purpose of this session was to introduce the notion of an external sealed bid, but it also served to reinforce the lessons beginning to be learned in the previous discussion about what is meant by minimum WTA and tease out any preliminary misunderstandings that may otherwise confound their future responses. Their answer was

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<sup>1</sup> Full protocol and materials are available on request.

<sup>2</sup> Resulting in an expected value which ranged, dependent upon group size, from £0.42 to £1.00

compared to a pre-determined sealed bid in a second price auction mechanism, mirroring the demand-revealing structure that would be used throughout the experiment and hypothetical valuation scenarios.

**Table 2 Experimental Design: Optimal WTA Responses**

Stage	Purpose
<b>1 (Hypothetical): Selling a Flat, Discussion</b>	Introduce idea of preset selling amount (reserve price), true values, dangers of over/underbidding, second price auction rules
<b>2(Hypothetical): Selling a Teddy, Discussion</b>	Reinforce idea of preset selling amount (reserve price), true values, dangers of over/underbidding, second price auction rules; introduce and demonstrate the role of the (secret) sealed bid within the second price auction
<b>3 (Real): Selling a Draw Entry Ticket, Experiment</b>	Experience of selling using the mechanism, elicitation of minimum WTA in an incentivised context
<b>4 (Hypothetical): Health Valuation, WTA Survey</b>	Elicitation of monetary values from respondents with an understanding/intuition of the economic meaning of ‘minimum WTA’.

Once respondents’ answers and the sealed bid had been compared, there followed discussion of why it is always best to be truthful, as the experimenter explained at some length the possible undesirable consequences of over- or under-bidding i.e. in the case of the former there is a danger that you keep the item rather than sell it (if the sealed bid came in between your ‘true value’ and your inflated stated reserve price) while in the case of the latter there is a danger you sell the item for less than it is worth (if the sealed bid comes in between).

Respondents were given a “memory jogger” (Appendix 1a) summarising the key concepts, and recorded their answers in response books, which had an identical layout to the to those in the later experiment and survey.

### *Teaching experiment*

The teaching experiment was based on the Plott and Zeiler (2005) mechanism which has been shown to generate theoretically predicted results (i.e. no WTA/WTP gap) in the context of financial lottery tickets, implying the mechanism was understood by respondents and the incentives were clear. While the instructions had to be adapted slightly in order to make them clearly comprehensible to members of the public, this was not at the cost of significant structural changes to the task. The purpose of this mechanism was to provide the strategic incentives to give truthful WTA responses. As noted earlier, drawing on the evidence of “spillovers” from incentivised to hypothetical rounds in Cherry et al (2003) the basic aim of the financial experiment was that the lessons learned by respondents, with respect to the truthful answers would be carried forward into the subsequent health valuation questions.

Participants were given two tokens which could be used to gain entry to a prize draw. There were two rounds. In each round, participants recorded their ‘reserve price’ (minimum WTA to sell the token and forego entry into the draw) in the knowledge that this would be compared to a sealed bid in an envelope, already randomly selected from a box of 100 bids ranging from £0.01 to £1.00 and visible at the front of the room. If his/her ‘reserve price’ was lower than or equal to this sealed bid they sold the token but received the higher (or equivalent) sealed bid. If higher, s/he did not sell the token and it was put into the draw.

Through these preliminary rounds, we ensured that the respondents had full information, supported by a memory jogger handout (Appendix 1a), as well as extensive practice with the mechanism and experience of how truthful bidding is the way to secure the best outcome. Respondents were also familiar with the terminology, rules, and response book and as such were well prepared to answer the health valuation questions.

### *Health valuation questions*

The health valuations were elicited for two health states (Figure 1a and 1b) over three time durations. First, the general scenario was presented. This involved asking the respondent to imagine they had a health complaint that was self limiting, but that a treatment was available that could immediately remove all of the symptoms. Recall that this scenario was developed with input, from the beginning, with members of the public and this version was judged to be credible and workable in the field. The full text, for the Stomach Complaint (an identical text

was used for the throat complaint) is in Appendix 2, a summary is provided here<sup>3</sup>. Throughout, the respondents were supported with a memory jogger (Appendix 1b), extensive explanation, and the opportunity to ask for clarification. Similarities to earlier rounds were highlighted, as were the context-specific consequences of misguided strategic bidding. This, coupled with the experience from the earlier rounds, gives us confidence that most of our subjects had the best possible understanding of the mechanism used, and hence that we minimised the extent of under- and over-bidding that could have arisen from misunderstanding or strategy, or from the habit of “seeking a good deal” (Brown, 2005).

### Figure 1a Stomach Complaint

The symptoms are:

- a) You will have some **slight discomfort whilst eating**;
- b) You will have **some pain in your stomach** at certain times in the day;
- c) You will feel **slightly ‘under the weather’**;
- d) Your normal daily activities will be otherwise **unaffected**.

The problem is **self limiting**, i.e. will go without any treatment after this period of time.

### 1b Throat Complaint

The symptoms are:

- a) You will have a **slight sore throat**;
- b) You will have **some difficulty talking**;
- c) You will feel **slightly ‘under the weather’**;
- d) Your normal daily activities will be otherwise **unaffected**

The problem is **self limiting**, i.e. will go without any treatment after this period of time.

Next, the subject was told why they could not immediately receive the treatment i.e. this was because of a problem with supply, resulting in a shortage, so that some people would be

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<sup>3</sup> This might be thought of as analogous to the more familiar ‘budget constraint reminder’ in a WTP study

unable to have the treatment and would be given a predetermined amount of money as compensation for having to put up with the symptoms. The respondent was further asked to assume that the compensation amount was not yet known by the doctor, who would therefore ask the respondent for his/her minimum WTA (explained as being analogous to the 'reserve price' in the previous exercises) to forgo the treatment. The doctor would then compare the stated amount with the preset amount and, from this, decide whether the person would receive the treatment or not. More specifically, if the respondent's stated sum was less than or equal to the preset amount then the respondent would receive the latter amount as compensation, rather than the treatment. If, by contrast, the stated amount exceeded the preset sum then the respondent would receive the treatment, rather than the compensation. In the WTP version, the treatment would be administered only if the respondents' stated willingness to pay was sufficient to cover the preset cost of the treatment. In this way, the structure of the health valuation questions exactly matches that of the questions in the earlier learning experiment. The doctor's unknown price works as the sealed bid in earlier rounds, and the same consequences of over and under-bidding apply. All of these similarities were pointed out to the respondents, and they were given a memory jogger that looked almost identical to that used in the learning experiment, to maximise the spillover effects.

At this stage, the symptoms were described, emphasising in particular the non-serious nature of the symptoms was understood (to maintain the assumption of substitutability between income and health). The respondent was then asked to decide, with the help of a card sort similar to that used by Carthy et al (1998), their minimum WTA. Following this, respondents filled in a demographics questionnaire, and then the session finished with the prize draw from the incentivised learning round.

### **3. Results**

Experimental sessions which each involved between 5-12 participants were carried out during September 2009 in Newcastle-upon-Tyne. A convenience sample (n=155) was drawn from the local community by a market research firm. The summary demographics are presented in Table 3.

**Table 3      Sample Demographics**

<b>Indicator</b>	<b>North East England</b>	<b>Study sample</b>
Male/Female	52/48	40/60
Mean Age (years)	37.8	36.9
Household Size	2.3	2.6
Home ownership (incl. those with a mortgage) (%)	52.9	69
Job Classification (%):		
Employed (unskilled/semi skilled) & middle level employee	41	42
Professional & self-employed	32	32
Unemployed & retired & full time student	27	26

### 3.1 Aggregate results

The mean and median responses for each decision that respondents made, after removing three high value outliers, are presented in Table 3.

**Table 2. Mean and Median Responses.**

	<b>WTA Stomach</b>			<b>WTA Throat</b>		
	<b>1 week</b>	<b>1 month</b>	<b>3 months</b>	<b>1 week</b>	<b>1 month</b>	<b>3 months</b>
Mean (Std. Deviation)	130.75 (189.61)	579.39 (1280.10)	1932.77 (2886.67)	106.31 (133.25)	522.25 (1001.44)	1555.32 (2400.07)
Ratio to 1 week	1	4.43	14.78	1	4.91	14.63
Median	50.00	250.00	750.00	50.00	200.00	600.00
Ratio to 1 week	1	5.00	15.00	1	4.00	12.00

Both data sets (health states) appear plausible, consistent and well-behaved. The WTA responses are broadly comparable between the two conditions. A t-test, at a 5% level, cannot

reject the hypothesis that for each time period the mean is the same for both conditions. The 1 week response is approximately equal to 1 day's pay for the average worker in the UK. The "ratio to 1 week" represents the values for 1 month and 3 months divided by the value for 1 week and shows that respondents increased their WTA values broadly in proportion to the increase in time that they had to endure the symptoms. The median responses show a similar pattern. As a further consistency test, we reiterate the reduction in the 1 to 3 month multiplier (compared to an 'uninformed' sample) alluded to in the Introduction.

#### 4.2 Regression Analysis

Table 4 presents the results of a tobit regression, to account for the spikiness of the data, a result of the card-sort procedure. This permits us to assess the economic and/or psychological meaningfulness of the WTA responses.

We regressed each respondent's WTA against socio-demographic variables collected after the survey and the results are shown in the tables below. The duration represents the period that the complaint would last and is highly significant, as the duration is recorded in periods of 1 week the coefficients represent how much respondents would accept per week of 'suffering'.

Gender is not significant but Age is: as people get older they would require a higher level of compensation. Having had some Further Education and also a higher level job are significant and positively impact WTA for the Stomach Complaint but only Job Type has an impact for the Throat complaint. Finally, where people had previously suffered from one of the complaints, this increased their WTA.

**Table 4 Regression Analysis**

<b>Tobit Regression WTA Stomach condition</b> N=363 LR Chi <sup>2</sup> (8) = 74.46 Prob > Chi <sup>2</sup> = 0.00 Pseudo R <sup>2</sup> = 0.012 Log Likelihood = -3127.99	<b>Coefficient</b>	<b>Standard error</b>	<b>t</b>	<b>P&gt; t </b>
<b>Independent variable</b>				
Duration	140.88	17.80	7.91	0.00
Gender	196.86	170.04	1.16	0.25
Age	12.40	6.03	2.06	0.04
Number in Household	131.57	81.80	1.61	0.11
Further Education	452.03	190.31	2.38	0.02
Job Type	212.14	113.89	1.86	0.06
Experience of the complaint	344.35	173.70	1.98	0.05
Perceived current health state	94.23	150.91	0.62	0.53
Constant	-2133.38	586.48	-3.64	0.00
<b>Tobit Regression WTA Throat condition</b> N=366 LR Chi <sup>2</sup> (8) = 72.88 Prob > Chi <sup>2</sup> = 0.00 Pseudo R <sup>2</sup> = 0.011 Log Likelihood = -3148.61	<b>Coefficient</b>	<b>Standard error</b>	<b>t</b>	<b>P&gt; t </b>
<b>Independent variable</b>				
Duration	107.83	14.00	7.70	0.00
Gender	97.32	133.70	0.73	0.47
Age	8.28	4.92	1.68	0.09
Number in Household	72.41	63.90	1.13	0.258
Further Education	-29.82	151.06	-0.20	0.84
Job Type	400.42	89.37	4.48	0.00
Experience of the complaint	399.42	136.03	2.94	0.01
Perceived current health state	321.32	117.92	2.72	0.01
Constant	-2255.13	440.12	-5.12	0.00

**4. Discussion and Conclusions**

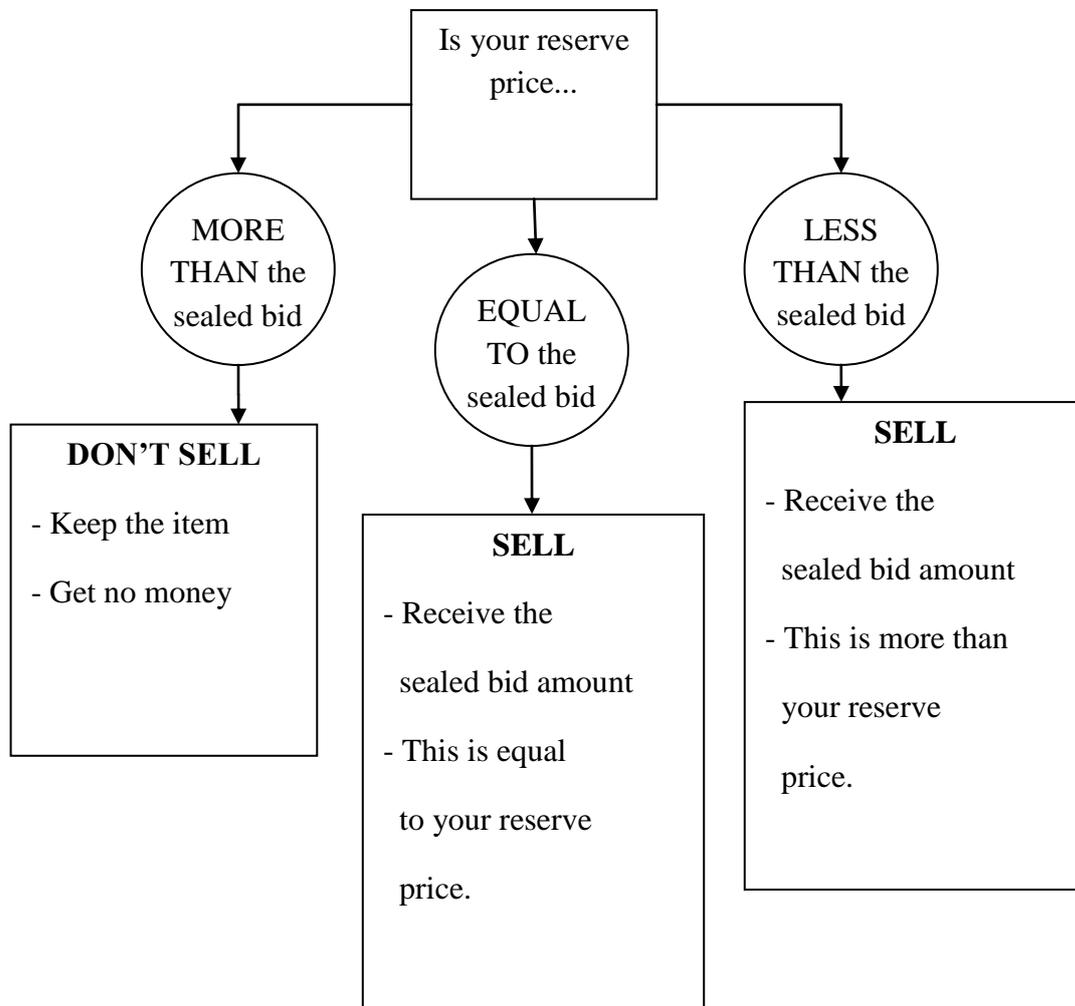
We have employed a methodology that utilises the Plott and Zeiler (2005) mechanism to capture experimental spillover effects to obtain plausible and well-behaved WTA responses. As noted at the beginning of this paper, there is often a mis-match between the desirability of WTA for benefit-cost policy analysis and the actual use of WTP-based values. A major stumbling block to date has been the absence of a practical mechanism that can be shown to generate plausible and defensible values. As such, this paper provides a much needed empirical option to monetary valuation studies. Although based in health, the procedures are clearly transferable to all public sector domains and, in addition, provide further evidence of the potential for incorporating economic experiments into valuation surveys, in this instance as a teaching device to enhance respondent understanding of our economic terms that survey designers - including ourselves - persist in using in our questionnaires.

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## Appendix 1a MEMORY JOGGER (TEACHING EXPERIMENT)

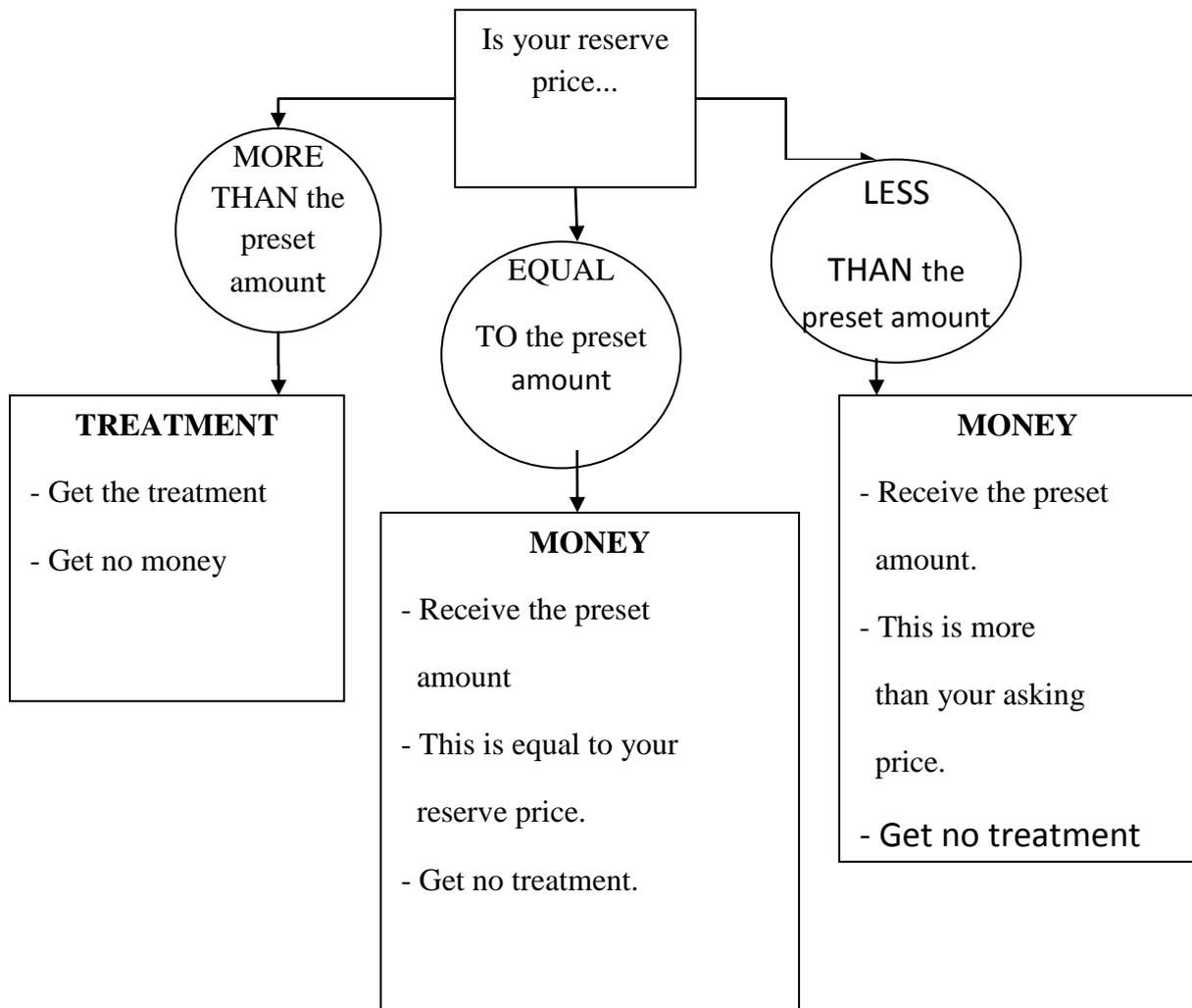
### The bidding process:



### The key points:

1. Once you have recorded your reserve price, the **RULES OF THE GAME DETERMINE** if you sell or not. You cannot choose.
2. If you sell, you receive the **SEALED BID AMOUNT**, not your reserve price.
3. There's **NO POINT UNDERSTATING** what you'd accept
  - **HAVE TO SELL** at a price you think is too lowThere's **NO POINT OVERSTATING** what you'd accept
  - **CANNOT SELL** at a price you'd like to accept

## Appendix 1b MEMORY JOGGER (HEALTH VALUATION)



### The key points:

1. Once you have told your doctor your reserve price, the rules determine whether or not you get treatment or money.
2. If you receive any money, you receive the PRESET AMOUNT, not your reserve price.
3. There's NO POINT OVERSTATING what you'd accept
  - GET THE TREATMENT when you would prefer the money.There's NO POINT UNDERSTATING what you'd pay.
  - GET THE MONEY when you actually think recovery is worth more to you.

## Appendix 2 Health Valuation Scenario (Stomach Complaint)

### 3. HEALTH.

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- Now we will move to the next part of today's session, which concerns decisions over different health scenarios. The results from this part of the session will be reported through to decision makers and may influence government policy. The previous experiment was important because you now have a clear idea of what we mean by the term minimum willingness to accept which will be used in the following questions and also why it is unwise to **ask too much or too little for something**.

#### QUESTIONS 4 AND 5

- I want you to imagine that you have a health problem. You visit your doctor who tells you that if left alone the problem will heal by itself in a given period of time. However there is a treatment that is available that will remove all of the symptoms immediately. There is one slight problem. The manufacturer is temporarily unable to make enough and it has been decided that the best way to cope with this problem is to ask those who will **not be treated** to accept money for putting up with the symptoms.

This amount has already been decided. Let's call it the preset amount. However, it has not yet been released to your doctor. But he will get it later today.

The system that is in place is as follows. You must let your doctor know what is the lowest i.e. the minimum amount that you would accept to 'put up with the symptoms' associated with your problem. Let's call it your 'reserve price'. Later today your doctor will compare your reserve price with the preset amount to see whether you value recovery from the illness more than the money on offer, so he can make the right decision for you about whether you get the money or the treatment.

If your reserve price is less than or equal to this preset amount, you will receive money but will have to put up with the symptoms. The nice part is you will receive the preset amount rather than your reserve price.

If your reserve price is higher than this preset amount, you will be put forward for the treatment but will not receive any money

**Remember, if you ask too much you may not be eligible for the money as the preset amount may be lower than your reserve price.**

**If you ask too little you may get the money and not receive the treatment, even if you would prefer the treatment as the preset amount is too low for you.**

So the preset amount works just like the sealed bid in the earlier questions.

**ASSISTANT: HAND OUT THE HEALTH MEMORY JOGGER (wta)**

***[OVERHEAD 4: MODERATOR GO THROUGH OVERHEAD]***

The first health problem that I want you to consider is a stomach complaint. The symptoms that you will suffer are:

- a) You will have some slight discomfort whilst eating;
- b) You will have some pain in your stomach at certain times in the day;
- c) You will feel slightly 'under the weather';
- d) Your normal daily activities will be otherwise unaffected.

The problem is self limiting, i.e. will go without any treatment after a period of time. These symptoms are written in your response book.

We are going to ask you about three different periods of suffering, 1 week, 1 month and 3 months.

Please turn to Question 4(a) in your response book. You are asked for the amount that is your minimum willingness to accept for not having the treatment and suffering the symptoms associated with these effects if they lasted 1 week.

The key things to remember are that **you only receive the preset amount**. Also, if you ask too much you may not be eligible for the money and if you ask too little you may get the money and not receive the treatment, even if you would prefer it. You can use your memory jogger to remind you of this.

I am interested in the minimum amount you think you would be willing to accept. To help you decide, I will ask you to sort some cards. ....