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Stated Preferences for Public Provision of Services: Experimental Evidence from Latin America*

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Abstract

We study how individuals in six Latin American countries value public versus private provision of education and healthcare using a survey experiment. Respondents were randomly assigned to vignettes that vary income, service quality, and provider type. Reported service quality is the main driver of choices: the probability of selecting a private provider roughly doubles when reported quality of the public option falls from 80 to 20 percent, while income has a smaller effect. Higher institutional trust lowers the likelihood of switching to private providers but does not affect willingness to pay once individuals choose private provision.

JEL codes: D12, H42, I21, I18, O54.

Keywords: Stated preferences; Willingness to pay; Public versus private provision; Service quality; Latin America

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1 Introduction

The mix of public and private provision of essential services, such as education and healthcare, is a core issue in policy debates. Differences in access, cost, and quality shape individual choices and affect how societies organize and finance service delivery, particularly in developing countries with uneven state capacity. This paper examines three questions. First, whether lower public service quality increases private take-up and willingness to pay for a private option. Second, how income shapes private demand relative to quality. Third, whether institutional trust reduces opting out from public provision, particularly when public quality is low. These margins matter because they distinguish private take-up driven by deficiencies in public service quality (potentially addressed through service improvements) from private take-up driven by income (related factors that operate independently of quality and require different policy responses).

We implement a harmonized randomized survey experiment in six Latin American countries. Using vignette-based choice scenarios, we randomly vary service quality, hypothetical income, and the default service provider. Survey experiments have been used to estimate willingness to pay for higher-quality education, healthcare, and infrastructure [Berlinski and Busso, 2016; Burkhardt and Chan, 2017; Wu et al., 2022; Wiese and Eriksen, 2024]. While this literature shows that citizens value quality improvements, it is largely based on single-country studies or specific sectors, limiting evidence on how preferences for public versus private provision vary across institutional contexts. We contribute to this literature in two ways. First, we provide new harmonized, multi-country evidence of preferences for public and private provision of education and healthcare, in settings where comparable revealed-preference variation is difficult to obtain. Second, by experimentally varying service quality and hypothetical income while assigning the service provider, we separate quality-driven demand from income-related opting out and abstract from selection into observed service arrangements. This yields comparable estimates of how quality, income, and institutional

features shape preferences across policy domains. [1]

Evaluations of public services depend not only on observed performance, but also on institutional trust, which shapes how information about quality is interpreted. In Latin America, trust in government remains low even as citizens rely heavily on public provision of essential services [Keefer and Scartascini, 2022]. While existing work suggests that perceptions of quality and satisfaction may be self-reinforcing [Van de Walle and Bouckaert, 2003; OECD, 2017], the implications for service choice in the region remain understudied. We contribute to this literature by examining how institutional trust interacts with experimentally varied service quality in shaping choices between public and private provision.

2 Data and Methods

We measure stated preferences for public services using randomized hypothetical choice scenarios. Stated-preference survey experiments are standard in applied economics when outcomes depend on beliefs, perceptions, or counterfactual evaluations that are difficult to study using revealed-preference data [Schläpfer, 2017; Stantcheva, 2023]. While direct comparisons between stated and revealed preferences remain limited, available evidence indicates that stated-preference designs track real-world behavior along relative trade-offs and marginal responses, even if levels may differ [Hainmueller et al., 2015; Carlsson and Martinsson, 2001; Harrison and Rutström, 2008; DellaVigna and Pope, 2018]. In this context, implementing an incentivized or revealed-preference design would have required randomizing access to public versus private services of different quality across countries, raising substantial practical and ethical constraints.

Intervention. Each participant i in country c received a prompt or vignette about schools

[1] We thank the referee for prompting us to clarify the merits of the experimental design. By randomizing service quality, income, and provider assignment, survey experiments allow researchers to disentangle quality-driven demand from income-related opting out while abstracting from endogenous selection into public or private provision—an identification challenge that is difficult to address with observational or revealed-preference data. See Stantcheva [2023] for a broader discussion of the role of survey experiments in identifying mechanisms and preferences.

and, immediately afterwards, one about hospitals. These sectors were selected because they represent distinct but comparable areas of social service delivery. In most countries, a large share of the population already relies on both public and private options. Examining them jointly allows us to assess whether preferences for public versus private provision are sector-specific or reflect broader attitudes toward state versus market provision.

The prompt used to present the school scenario read: *Suppose you have just started a new job with a salary of X_{ic}, and that, for this reason, you must move to another neighborhood. Your son/daughter could attend a P_{ic} school in that neighborhood, where Z_{ic}% of students reach the minimum level in mathematics on the national educational quality tests. Would you leave him/her in this P_{ic} school, or would you look for an alternative P'_{ic}?*." Participants who chose the private option were then asked: "*How much would you be willing to pay per month for a private school?*"

The prompt used to present the hospital scenario was similar. It read: *Suppose you have just started a new job with a salary of X_{ic}, and it happens that your son/daughter feels unwell and needs to go to a hospital. You could go to a P_{ic} hospital near your home, where Z_{ic}% of patients treated at this hospital report being satisfied with their care. Would you take him/her to be treated at this P_{ic} hospital, or would you look for an alternative P'_{ic}?*." Participants who chose the private option were then asked: "*How much would you be willing to pay for a medical consultation?*"

The experiments manipulate a vector of three attributes $\{X_{ic}, Z_{ic}, P_{ic}\}$. First, an income level X_{ic} is set to correspond to a nominal value equal to the wage earned by either the second or fourth quintile within each country's wage distribution (according to the previous year's household survey). This captures contrasts between lower-middle- and upper-middle-income households, which account for most of the variation in the demand for private provision in Latin America while keeping the interpretation straightforward. Second, a service quality Z_{ic} is defined at 20% or 80% performance rates. These values were selected to create a clear and interpretable gap between low- and high-quality services within realistic bounds based

on national assessments of educational achievement and patient satisfaction. The third is the nature P_{ic} of the default provider, which could be either public or private, and, by construction, P'_{ic}, which is defined as the opposite category.

Randomization. This design yields eight treatment groups, summarized in Table 1, which were randomly assigned to participants. The treatment offered in the school prompt was the opposite of that offered in the hospital prompt. To minimize order and contrast effects, the design used a fixed sequence with treatment characteristics reversed across vignettes. In robustness checks, we confirm that responses to the second vignette do not differ systematically from those to the first, conditional on treatment assignment.

Table 1: Experimental Treatment Groups: Vignette Design

Group	School Vignette			Hospital Vignette		
	Income	Institution	Quality	Income	Institution	Quality
1	Q2	Public	20%	Q4	Private	80%
2	Q2	Public	80%	Q4	Private	20%
3	Q4	Public	20%	Q2	Private	80%
4	Q4	Public	80%	Q2	Private	20%
5	Q2	Private	20%	Q4	Public	80%
6	Q2	Private	80%	Q4	Public	20%
7	Q4	Private	20%	Q2	Public	80%
8	Q4	Private	80%	Q2	Public	20%

Note: Each respondent was randomly assigned to one of eight groups combining three experimental factors per vignette: (i) whether the institution was public or private, (ii) income level (quintile 2 or 4), and (iii) service quality (20% or 80%). Each vignette is about either a school or a hospital, and all respondents answered both.

Outcomes. We study stated preferences for public or private provision of education and healthcare using two primary outcomes. The first is an indicator for *choosing a private provider*, equal to one if the respondent selects a private option, either by remaining with it when it is the default or by switching to it when the default is public. The second is the *willingness to pay* for the private service among participants who selected the private option, expressed in constant 2019 dollars.[2]

[2]Nominal values were converted from local currency to 2019 purchasing power parity (PPP) USD. The

Estimation. Let x_{ic}, z_{ic}, and p_{ic} be binary indicators for being assigned to the high-quality, high-income, and private-default conditions, respectively. We estimate: $Y_{ic} = \alpha + \theta' T_{ic} + \gamma' S_{ic} + \lambda' G_{ic} + \phi_c + \varepsilon_{ic}$, where Y_{ic} denotes the outcome of individual i in country c, ϕ_c are country fixed effects, and $T_{ic} = \{x_{ic}, z_{ic}, p_{ic}, x_{ic}z_{ic}, x_{ic}p_{ic}, z_{ic}p_{ic}, x_{ic}z_{ic}p_{ic}\}$.[3] Random assignment ensures that ε_{ic} is uncorrelated with T_{ic}. We include behavioral control variables (G_{ic}) and socio-demographic variables and attrition controls (S_{ic}), described in table notes. We report adjusted means obtained from predicted outcomes for each treatment cell, holding other covariates at their observed values, which correspond to $E[Y_{ic}|T_{ic}]$. The omitted category is the public default, low income, and low quality vignette. The estimation, consistent with our research design, is fully factorial ($2 \times 2 \times 2$).

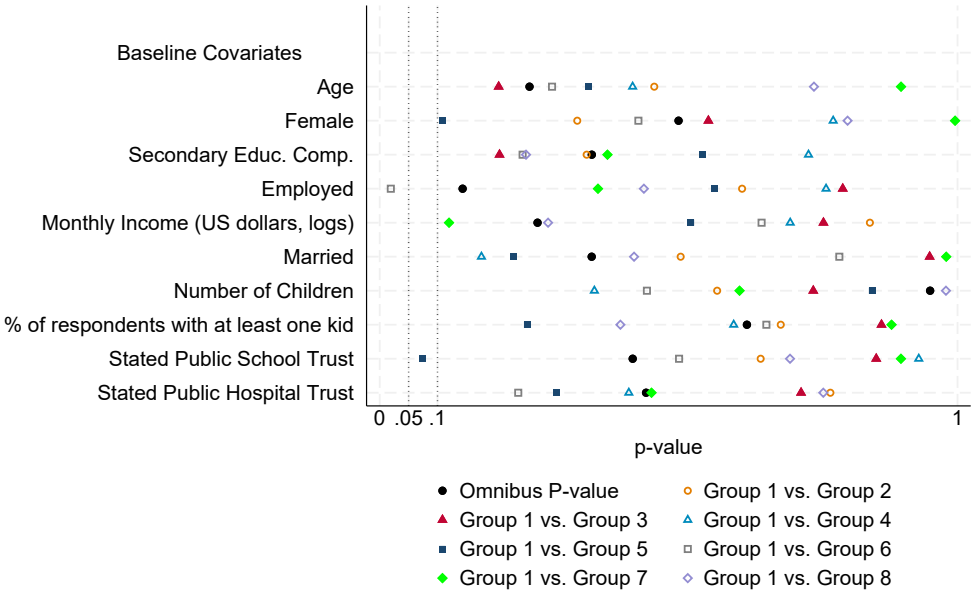
Sample. The experiment included 7,229 individuals, corresponding to approximately 150 participants per treatment group in each country. Participants were recruited through a professional online panel provider using established sampling procedures [Rivers, 2006]. The provider's data collection strategy allowed recruitment from both rural and urban areas across multiple regions within each country. The median survey completion time was 35 minutes, longer than a typical online survey but shorter than standard laboratory or lab-in-the-field experiments. To ensure data quality, we restrict the analysis to respondents who completed the full experimental protocol. All participants within a treatment group received identical instructions. In terms of composition, the sample broadly resembles nationally representative household surveys in each country. Average age, gender composition, marital status, and employment rates are similar, although participants are somewhat more educated on average and report having more children. Additional details on the sampling algorithm, descriptive statistics by country, and comparisons with official household surveys are reported in Appendix A.

question was open-ended. The average willingness to pay for a private school was \$138.50 (\$167.10 standard deviation), and \$90.6 for a private hospital (\$228.60 standard deviation). Approximately 0.34% of respondents reported being willing to pay zero for a private school, and 0.4% did so for a private hospital.

[3]We estimate linear probability models (OLS) for binary outcomes to facilitate the interpretation of interaction terms and predicted marginal effects.

Balance. Figure 1 reports the p-values of null tests of equality between mean characteristics for participants assigned to each of the eight treatment groups. In all but two cases, we fail to reject the null hypothesis at conventional significance levels. These results indicate that randomization was implemented successfully and that observable characteristics are not systematically correlated with treatment assignment. A joint F-test of equality of mean baseline characteristics across all eight treatment groups fails to reject the null hypothesis ($p = 0.96$).

Figure 1: Pre-treatment Balance



Notes. This figure reports pre-treatment balance tests for baseline observable variables across the eight treatment groups. Each point corresponds to the p-value from a test of equality of means for a given variable. Black circles report the omnibus p-value from a joint test across all eight groups. Colored markers report pairwise tests comparing group 1 to each other group. Solid markers denote comparisons with odd-numbered groups (3, 5, 7), and hollow markers denote comparisons with even-numbered groups (2, 4, 6, 8). Marker shapes identify the comparison: circles (group 2), triangles (groups 3 and 4), squares (groups 5 and 6), and diamonds (groups 7 and 8). Colors are used solely to visually distinguish overlapping markers. Vertical dashed lines at 0.05 and 0.10 indicate conventional significance thresholds. Baseline observable variables are listed on the y-axis.

3 Quality, Income, and Public–Private Service Choice

Table 2 reports the main results. Columns (1) and (3) use a binary indicator equal to one if the respondent chooses the private option, while Columns (2) and (4) report willingness to pay for that private service. Each row corresponds to one of the eight experimental groups. The estimates are shown in two panels, although all coefficients are obtained from a single

regression model.[4]

Table 2:
Marginal Effects of Service Quality, Income, and Provider Type on Choices and Willingness to Pay

	School		Hospital	
	Chooses Private	Willingness to Pay	Chooses Private	Willingness to Pay
	(1)	(2)	(3)	(4)
Panel A: Public Default				
[1] Public × Low Income × Low Quality	0.440	121.6	0.382	81.1
	[0.015]	[8.0]	[0.015]	[12.3]
[2] Public × Low Income × High Quality	0.201	155.0	0.096	132.5
	[0.015]	[11.7]	[0.015]	[24.6]
[3] Public × High Income × Low Quality	0.485	154.4	0.588	87.9
	[0.015]	[7.6]	[0.015]	[9.9]
[4] Public × High Income × High Quality	0.200	175.9	0.179	101.1
	[0.015]	[11.8]	[0.015]	[18.2]
$H_0 : [1] = [2]$	0.000	0.018	0.000	0.062
$H_0 : [3] = [4]$	0.000	0.126	0.000	0.526
$H_0 : [1] = [3]$	0.039	0.003	0.000	0.667
$H_0 : [2] = [4]$	0.967	0.209	0.000	0.305
Panel B: Private Default				
[5] Private × Low Income × Low Quality	0.281	121.5	0.241	80.1
	[0.015]	[10.0]	[0.015]	[15.5]
[6] Private × Low Income × High Quality	0.468	103.5	0.366	89.9
	[0.015]	[7.7]	[0.015]	[12.6]
[7] Private × High Income × Low Quality	0.310	139.8	0.351	81.0
	[0.015]	[9.4]	[0.015]	[12.8]
[8] Private × High Income × High Quality	0.522	156.7	0.589	99.9
	[0.015]	[7.3]	[0.015]	[10.0]
$H_0 : [5] = [6]$	0.000	0.154	0.000	0.623
$H_0 : [7] = [8]$	0.000	0.155	0.000	0.244
$H_0 : [5] = [7]$	0.176	0.183	0.000	0.963
$H_0 : [6] = [8]$	0.014	0.000	0.000	0.534
Observations	7229	2630	7229	2522
Socio-demographic	Yes	Yes	Yes	Yes
Other games	Yes	Yes	Yes	Yes

Notes. This table presents ordinary least squares estimations of the marginal effects of being assigned to the private school/hospital group, being assigned to the high-income group, and being assigned to the high-quality group on choosing a private school/hospital and the willingness to pay for the private service. Socio-demographic controls include participants' age, gender, employment status, log of monthly income adjusted for PPP in 2019, marital status, number of children, and dummies for high school completion, having imputed income, and being in the top 50 percentile of earners. Other behavioral controls include an individual's contribution in the public goods game and their risk aversion lottery choice. Regressions include country fixed effects. Standard errors are displayed in squared brackets. For each default–income and default-quality cell, we report the p-value from a test of equality of the marginal effects across quality and income levels respectively, shown immediately below each corresponding panel.

Preferences for public versus private provision respond sharply to perceived service quality. Holding income and default provider fixed, the probability of choosing a private option

[4]Appendix Table B.1 reports the corresponding OLS estimates. Romano–Wolf stepdown p-values are used to adjust for multiple hypothesis testing across outcomes and interaction terms; the main conclusions of this section are unchanged.

roughly doubles when the public service quality declines from 80% to 20%, in both education and healthcare.[5] Within each default–income cell, differences in private take-up across quality levels are statistically significant at the 1% level in both sectors. Willingness to pay also responds to public service quality, but less systematically. In education, respondents assigned to low-quality public schools report willingness to pay for private schooling about 20% higher than those assigned to high-quality schools; in healthcare, the corresponding difference is smaller, at roughly 5%. These effects are statistically significant only in the public–low-income treatment cell, indicating that quality-driven valuation responses are concentrated among lower-income respondents facing poor public options.[6]

Income effects are smaller and less systematic than those associated with service quality. Assignment to the higher income quintile increases the probability of choosing a private option and, in some cases, willingness to pay. These effects are most pronounced in healthcare, where higher income significantly increases private take-up across treatment cells, though it does not have a systematic effect on willingness to pay. In education, income effects are more limited: higher income increases private take-up and willingness to pay only in the public–low-income and private–high-income cells.

The default institution also matters. Participants assigned to a public default are more likely to switch, particularly when public quality is low, whereas those initially offered a private service exhibit higher overall willingness to pay, even after controlling for income and quality. This asymmetry is consistent with framing effects and reputational priors favoring private provision, in line with widespread perceptions of higher quality and reliability of private schools and hospitals in the region.[7]

[5]The share of participants choosing a private option—either by remaining with it when assigned as the default or by switching from a public option—was 36.38% in the school scenario and 34.89% in the hospital scenario.

[6]Willingness to pay for higher-quality education and healthcare services increases by 12.1%–22.4%, respectively, consistent with estimates in the literature.

[7]Country-specific estimates are available upon request. Effect sizes vary across settings, but the qualitative patterns—stronger responses to quality than to income and lower private demand among high-trust respondents—are similar across countries.

4 Institutional Trust and Demand for Public Services

Table 3 examines how institutional trust moderates preferences for public versus private provision.

Table 3: Heterogeneous Marginal Effects: Stated Institutional Trust

	School				Hospital			
	Chooses Private		Willingness to Pay		Chooses Private		Willingness to Pay	
	Low IT	High IT	Low IT	High IT	Low IT	High IT	Low IT	High IT
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Panel A: Public Default								
Public × Low Inc. × Low Qual.	0.533	0.313	108.1	148.7	0.428	0.333	67.9	103.9
	[0.021]	[0.022]	[7.2]	[20.6]	[0.021]	[0.020]	[15.4]	[20.7]
Public × Low Inc. × High Qual.	0.281	0.090	159.1	142.4	0.132	0.058	155.2	64.2
	[0.021]	[0.022]	[9.9]	[38.9]	[0.021]	[0.020]	[27.9]	[49.5]
Public × High Inc. × Low Qual.	0.554	0.393	149.9	161.2	0.700	0.473	91.0	82.8
	[0.021]	[0.021]	[7.2]	[17.8]	[0.021]	[0.020]	[12.1]	[17.3]
Public × High Inc. × High Qual.	0.280	0.093	173.5	190.9	0.254	0.084	107.2	56.9
	[0.021]	[0.022]	[10.1]	[37.3]	[0.020]	[0.021]	[19.4]	[43.9]
Panel B: Private Default								
Private × Low Inc. × Low Qual.	0.337	0.197	123.0	114.0	0.306	0.175	77.3	80.3
	[0.021]	[0.022]	[9.1]	[25.5]	[0.021]	[0.020]	[18.3]	[28.4]
Private × Low Inc. × High Qual.	0.558	0.347	103.7	108.5	0.435	0.290	89.2	88.8
	[0.021]	[0.022]	[7.1]	[19.2]	[0.021]	[0.020]	[15.3]	[22.0]
Private × High Inc. × Low Qual.	0.374	0.231	144.9	132.6	0.426	0.264	75.9	95.8
	[0.021]	[0.021]	[8.8]	[22.9]	[0.021]	[0.020]	[15.1]	[23.5]
Private × High Inc. × High Qual.	0.612	0.396	156.2	155.7	0.666	0.503	90.0	117.3
	[0.021]	[0.022]	[6.7]	[18.0]	[0.021]	[0.020]	[12.2]	[17.1]
Observations	4169	3060	1840	790	3780	3449	1578	944
Socio-demographic	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Other games	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Notes. This table presents ordinary least squares estimations of the heterogeneous marginal effects of being assigned to the private school/hospital group, being assigned to the high-income group, and being assigned to the high-quality group on choosing a private school or hospital. High and low trust are assigned based on whether participants' self-reported institutional trust falls above or below the median on public schools and hospitals, respectively. Socio-demographic controls include the individuals' age, gender, employment situation, log of monthly income adjusted for PPP in 2019, marital status, number of children, and dummies for high school completion, having an imputed income, and being a top 50 percentile earner. Other behavioral controls include player's contribution in the public goods game and their risk aversion lottery choice. Regressions include country fixed effects. P-values testing for the equality of coefficients of Standard errors are displayed in squared brackets.

Respondents were classified as having low or high trust in public schools or hospitals depending on whether their self-reported trust score (1–10) fell below or above the sample median.[8] Across all settings, individuals with higher institutional trust are consistently less

[8]Classifying respondents into high and low stated trust facilitates interpretation. As a robustness check, we also estimate the full model interacting each attribute with continuous trust, including linear and quadratic terms (Appendix Table B.2). Results are unchanged: higher trust consistently reduces the

likely to choose private options; particularly when quality is low.[9] Willingness to pay conditional on choosing a private service shows no systematic difference between trust groups. Point estimates across both school and hospital settings are similar, and their confidence intervals overlap, suggesting that trust influences the decision to remain in or exit public systems rather than the valuation of private alternatives. In other words, individuals who trust public institutions are more likely to stay within them, but once they opt for private provision, their willingness to pay is comparable to that of low-trust respondents.

5 Conclusion

Perceived service quality is the main determinant of preferences for public versus private provision of education and healthcare, dominating income effects. Institutional trust further moderates choices by reducing exit from public provision when quality is low, without affecting willingness to pay once private provision is chosen. These patterns are consistent across sectors. Together, the results imply that strengthening public provision requires visible improvements in service quality and credibility, supported by transparent information and accountability mechanisms; policies focused only on financial access are unlikely to shift preferences.

probability of switching to private providers, with the effect strongest when the default option is low quality. Continuous marginal effects mirror the median-split patterns.

[9] See Appendix Table B.3.

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Online Appendix

A Data

A.1 Fieldwork

Fieldwork was carried out in Argentina, Brazil, Chile, Colombia, Mexico, and Peru using sample matching to draw a sample from a panel of respondents provided by Netquest, a commercial panel provider.

The Latin American Public Opinion Project (LAPOP) programmed the survey instrument on the Qualtrics platform and designed each sample using Integrated Public Use Microdata Series (IPUMS) census data. Netquest sent out batches of invites, relaying back to LAPOP which panelists had responded. LAPOP then re-matched panelists to unfilled target sample slots. This cycle was repeated several times, until the target sample was approximately filled. Up to 20 matches were sent out at the same time in one "batch". The highest number of matches was performed in Brazil, where 143 matches were required to achieve the desired sample size.

At the conclusion of fieldwork, responses were weighted to population using post-stratification weights.

A.2 Background Data

An agreement with LAPOP enabled us to access the profiles of potential respondents. LAPOP was responsible for designing the sample and deploying the online survey questionnaire across the six Latin American countries. From the Netquest panel, LAPOP drew random target samples, stratified by region and, where available, urban/rural status, from census microdata in IPUMS. LAPOP then matched Netquest panelists to each member of the target sample to achieve a matched sample. This process was repeated until more than 90% of the target records had been matched; the resulting sample was then post-stratified

on several characteristics to more accurately approximate the census population.

A.3 Sample

Table A.1: Sample Descriptive Statistics

	Mean	Weighted Mean (age-gender-education)	Weighted Mean (Household Surveys)
	(1)	(2)	(3)
Age	40.03	40.07	39.97
Female	0.52	0.52	0.52
Secondary Educ. Comp.	0.83	0.79	0.51
Married	0.58	0.60	0.57
Number of Children	2.00	2.05	1.44
% of respondents with at least one kid	0.62	0.64	0.33
Employed	0.63	0.62	0.69

Notes. This table shows the average pre-treatment characteristics of all individuals who completed the entire survey. Column (1) shows the unweighted average and column (2) shows the weighted average of individuals from our survey. Column (3) shows the average characteristics of individuals from household surveys. For the purpose of comparing levels of income across countries, we use estimates of monthly income converted to US dollars using the purchasing power parity (PPP) conversion factor for private consumption 2019 from the World Bank.

Table A.2: Sample Descriptive Statistics by Country

		Mean	Weighted Mean (age-gender-education)	Weighted Mean (Household Surveys)		Mean	Weighted Mean (age-gender-education)	Weighted Mean (Household Surveys)
		(1)	(2)	(3)		(4)	(5)	(6)
Age	Argentina	42.29	42.47	42.09	Colombia	38.91	38.77	39.05
Female		0.51	0.52	0.52		0.54	0.53	0.52
Secondary Educ. Comp.		0.82	0.72	0.65		0.75	0.65	0.61
Married		0.55	0.58	0.56		0.60	0.60	0.57
Number of Children		2.31	2.43	1.48		1.91	1.96	1.41
% of respondents with at least one kid		0.61	0.66	0.32		0.66	0.68	0.29
Employed		0.65	0.61	0.63		0.68	0.67	0.70
Age	Brazil	40.11	39.94	39.94	Mexico	39.72	40.02	39.26
Female		0.50	0.52	0.53		0.54	0.52	0.53
Secondary Educ. Comp.		0.82	0.81	0.31		0.83	0.75	0.44
Married		0.59	0.60	0.51		0.62	0.67	0.61
Number of Children		1.77	1.78	1.32		2.00	2.07	1.47
% of respondents with at least one kid		0.56	0.56	0.26		0.66	0.70	0.36
Employed		0.62	0.62	0.65		0.56	0.54	0.72
Age	Chile	41.68	41.17	41.57	Peru	37.51	38.07	41.04
Female		0.52	0.52	0.53		0.51	0.51	0.51
Secondary Educ. Comp.		0.81	0.81	0.71		0.98	0.97	0.71
Married		0.61	0.61	0.52		0.53	0.53	0.55
Number of Children		1.97	1.98	1.38		2.02	2.05	1.53
% of respondents with at least one kid		0.65	0.64	0.38		0.60	0.62	0.41
Employed		0.61	0.61	0.63		0.64	0.64	0.74

Notes. Each panel shows the average pre-treatment characteristics of individuals who completed the entire survey for each country. All panels show unweighted and weighted average of individuals who completed our survey in columns (1) and (2) and (5) and (6) respectively. Columns (3) and (6) shows the average characteristics of individuals from household surveys. For the purpose of comparing levels of income across countries, we use estimates of monthly income converted to US dollars using the purchasing power parity (PPP) conversion factor for private consumption 2019 from the World Bank.

B Additional Results

Table B.1:
Effects of Service Quality, Income, and Provider Type on Choices and Willingness to Pay

	School		Hospital	
	Chooses Private	Willingness to Pay	Chooses Private	Willingness to Pay
	(1)	(2)	(3)	(4)
Panel A: Main Effects				
High Quality	–0.239***	0.224**	–0.286***	0.121
	[0.022]	[0.113]	[0.021]	[0.146]
	{0.004}	{0.096}	{0.004}	{0.096}
High Income	0.045**	0.337***	0.206***	0.111
	[0.022]	[0.088]	[0.021]	[0.084]
	{0.048}	{0.004}	{0.004}	{0.044}
Private Default	–0.159***	–0.026	–0.141***	0.053
	[0.022]	[0.102]	[0.021]	[0.106]
	{0.004}	{0.753}	{0.004}	{0.689}
Panel B: Two-Way Interactions				
High Income × High Quality	–0.046	–0.036	–0.123***	–0.074
	[0.031]	[0.159]	[0.030]	[0.183]
	{0.331}	{0.833}	{0.004}	{0.331}
High Quality × Private Default	0.426***	–0.398***	0.411***	–0.145
	[0.031]	[0.152]	[0.030]	[0.181]
	{0.004}	{0.020}	{0.004}	{0.422}
High Income × Private Default	–0.016	–0.110	–0.097***	–0.091
	[0.031]	[0.141]	[0.030]	[0.136]
	{0.725}	{0.725}	{0.004}	{0.725}
Panel C: Full Interaction				
High Quality × High Income × Private Default	0.070	0.324	0.237***	0.264
	[0.044]	[0.211]	[0.042]	[0.228]
	{0.327}	{0.327}	{0.004}	{0.327}
Observations	7229	2630	7229	2522
Control mean	0.438	4.281	0.382	3.751
Control S.D.	0.496	1.250	0.486	1.121
Socio-demographic	Yes	Yes	Yes	Yes
Other games	Yes	Yes	Yes	Yes

Notes. This table presents ordinary least squares estimations of the effects of being assigned to the private school/hospital group, being assigned to the high-income group, and being assigned to the high-quality group on choosing a private school or hospital and the log willingness to pay for the private service. Socio-demographic controls include participants' age, gender, employment status, log of monthly income adjusted for PPP in 2019, marital status, number of children, and dummies for high school completion, having imputed income, and being in the top 50 percentile of earners. Other behavioral controls include an individual's contribution in the public goods game and their risk aversion lottery choice. Standard errors are displayed in squared brackets. Romano-Wolf multiple hypothesis p-values are displayed in braces.

Table B.2:
Marginal Effects of Stated Institutional Trust on Choices and Willingness to Pay Across Treatments

	School		Hospital	
	Chooses Private	Willingness to Pay	Chooses Private	Willingness to Pay
	(1)	(2)	(3)	(4)
Panel A: Public Default				
Public × Low Income × Low Quality	–0.014	–43.2	0.014	–13.5
	[0.025]	[12.7]	[0.021]	[18.1]
Public × Low Income × High Quality	–0.041	–10.7	–0.011	–25.1
	[0.025]	[14.7]	[0.021]	[23.0]
Public × High Income × Low Quality	–0.060	–35.3	0.027	–11.1
	[0.024]	[11.6]	[0.021]	[16.3]
Public × High Income × High Quality	–0.086	–2.7	0.002	–22.7
	[0.025]	[14.4]	[0.022]	[21.7]
Panel B: Private Default				
Private × Low Income × Low Quality	0.032	–34.7	–0.025	9.3
	[0.025]	[14.2]	[0.022]	[20.1]
Private × Low Income × High Quality	0.005	–2.1	–0.050	–2.3
	[0.025]	[12.8]	[0.021]	[17.8]
Private × High Income × Low Quality	–0.014	–26.7	–0.011	11.6
	[0.024]	[13.5]	[0.021]	[18.4]
Private × High Income × High Quality	–0.040	5.8	–0.036	0.1
	[0.026]	[12.6]	[0.021]	[15.9]
Observations	7229	2630	7229	2522
Socio-demographic	Yes	Yes	Yes	Yes
Other games	Yes	Yes	Yes	Yes

Notes. This table presents ordinary least squares estimations of the marginal effects of stated trust on public schools or hospitals on choosing a private school or hospital and the willingness to pay for the private service. Socio-demographic controls include participants' age, gender, employment status, log of monthly income adjusted for PPP in 2019, marital status, number of children, and dummies for high school completion, having imputed income, and being in the top 50 percentile of earners. Other behavioral controls include an individual's contribution in the public goods game and their risk aversion lottery choice. Standard errors are displayed in squared brackets. p<0.10, ** p<0.05, *** p<0.01.

Table B.3: Tests of Equality of Marginal Effects by Institutional Trust

	School		Hospital	
	Chooses Private	Willingness to Pay	Chooses Private	Willingness to Pay
	(1)	(2)	(3)	(4)
Panel A: Public Default				
Public × Low income × Low quality	0.000	0.008	0.000	0.173
Public × Low income × High quality	0.000	0.403	0.004	0.126
Public × High income × Low quality	0.000	0.274	0.000	0.722
Public × High income × High quality	0.000	0.561	0.000	0.410
Panel B: Private Default				
Private × Low income × Low quality	0.000	0.878	0.000	0.934
Private × Low income × High quality	0.000	0.755	0.000	0.887
Private × High income × Low quality	0.000	0.676	0.000	0.634
Private × High income × High quality	0.000	0.673	0.000	0.191
Observations	4169, 3060	1840, 790	3780, 3449	1578, 944
Socio-demographic	Yes	Yes	Yes	Yes
Other games	Yes	Yes	Yes	Yes

Notes. This table reports p-values from tests of equality of marginal effects between individuals with high and low institutional trust. Each p-value corresponds to a Wald test of the null hypothesis that the marginal effects reported in the adjacent columns of Table 3 are equal within a given combination of default assignment, income level, and service quality. High and low institutional trust are defined based on whether participants' self-reported trust in public schools or hospitals lies above or below the median, respectively. All tests are based on a pooled regression with interactions between institutional trust and the assignment variables, controlling for the same socio-demographic and behavioral covariates and including country fixed effects as in Table 3.