UC Berkeley PhD Program in Health Policy, Job Market Candidates, 2021

Claire Boone Health Economics https://claireboone.github.io/ cboone@berkeley.edu	*Discretion in clinical decision-making* Many clinical decisions must be made with poor or limited information. In these cases, discretionary decision-making – an understudied input to quality healthcare – is highly important. In my job market paper, I study how providers behave when diagnosing and treating hypertension, a potentially deadly disease where false positive test results are common. I find that providers round some patients' test results below the diagnostic threshold, using their discretion to turn a positive test for hypertension into a negative. Using bunching estimation to quantify this behavior at the clinic level, I estimate that up to 62% of patients expected to be just above the diagnostic threshold are instead just below it. Thresholds are widely used in medicine, yet their potentially distortional effects on provider behavior have not been previously quantified. Using the fact that in Chile patients are assigned a public primary care clinic based on their home address, I examine the impact of this clinical discretion with data from >600,000 visits. Providers adhere to clinical practice guidelines similarly across clinics. Yet, at high discretion clinics, patients who are assigned a negative test result are 9-44% less likely to be hospitalized for heart attack or stroke within 1 year. These results indicate provider discretion leads to better sorting of patients with respect to the diagnostic threshold. This appears to be partly achieved using heuristics: among patients with identical test results, those with characteristics representative of high cardiovascular risk are less likely to be sorted below the diagnostic threshold. I conclude that in a setting with poor information, heuristic thinking can be beneficial to clinical decision-making. My dissertation focuses on using behavioral economics to understand and improve health services delivery. The two other papers use quasi-experimental methods to evaluate the effects of sending text-message visit reminders to patients living with chronic diseases. Using large administrative datasets, we provide estimates of the causal effects of nudging at scale on both supply and demand-side outcomes.	*Committee:* Paul Gertler Ziad Obermeyer Jon Kolstad Ulrike Malmendier	*Geographical preference:* Open (United States, global) *Job preference:* Academic or semi-academic research (health system, research institute)

David Contreras-Loya Health Economics https://www.dcloya.com davidcon@berkeley.edu	*Managerial Practices and Altruism in Health Care Delivery* Management influences firm performance in various industries. This suggests that improving business performance through better management in health care can result in productivity gains in countries with low and varied quality of care. I report results from a field experiment of a large and comprehensive management consulting intervention designed to improve business management and care delivery in the Kenyan private health sector. I find large improvements in management practices and structural quality that translated into better business performance in terms of increased investment, patient load, higher prices, increased revenue, lower unit costs and higher profits. However, better management and structural quality did not translate into improved process (clinical) quality. In fact, the intervention reduced correct clinical case management of patient care by 8% (p-value < 0.001). Consistent with the theory that demand is quality inelastic, I also find that patients did not notice the fall in quality and that demand did not fall. From a supply-side perspective, it was optimal for profit-maximizing firms to lower quality and raise prices. I examine this further by measuring provider-specific preferences with a modified dictator game: I show that the pure profit-maximizers were the ones that reduced correct clinical case management, while charging 30% more than the least altruistic providers outside the intervention. Altruistic providers in the program did not lower quality or raise prices.	*Committee:* Paul J. Gertler Stefano Bertozzi Ziad Obermeyer Aprajit Mahajan	*Geographical preference:* United States, Canada, Europe *Job preference:* Academic with teaching, academic or semi-academic research department or institution

Maria Dieci Health Economics https://mariadieci.com/ dieci@berkeley.edu	*Patient vs. provider incentives for malaria care in Kenyan pharmacies: A cluster randomized controlled trial* Malaria afflicts 190 million people in sub-Saharan Africa each year, with children, pregnant women, and the poor bearing the brunt of the burden. Nearly all deaths and serious illness are preventable through available, effective, and inexpensive medication, and clinical guidelines clearly recommend testing prior to treatment. Despite this, most malaria cases are undiagnosed, resulting in a gap between treatment and need: missed diagnoses result in avoidable illness, and over-prescription of antimalarials can lead to drug resistance. Most malaria patients seek care at pharmacies, where I hypothesize that the mismatch between diagnosis and treatment reflects a misalignment of patient and provider incentives. In my dissertation, I investigate how realigning patient and provider incentives to diagnose suspected malaria cases prior to treatment can improve malaria case management. Building on prior work on the impact of subsidies for rapid diagnostic tests (RDTs) and malaria treatments, I test whether targeted incentives for RDTs and first-line antimalarials only to malaria-positive cases will improve treatment targeting through increasing test result adherence. Using a cluster randomized trial design in 140 pharmacies in malaria-endemic zones in Kenya, I randomize patient discounts and pharmacist performance incentives and compare their effectiveness and cost-effectiveness to the status quo standard of care. Pharmacies were randomized to a status quo control group or one of three treatment groups using a digital malaria case management tool: (1) patient discounts for RDTs and first-line antimalarials conditional on a positive test; (2) pharmacy incentives for selling RDTs to diagnose fevers and for selling first-line antimalarials conditional on a positive test; and (3) patient discounts and pharmacy incentives for RDT use and first-line antimalarial use for confirmed malaria-positive cases. This design allowed us to evaluate the impact of two part incentive structures as well as to examine the causal effect of targeting that incentive to the patient (demand-side) or the provider (supply-side). Preliminary findings from ~80 sites suggest that subsidies and incentives for diagnostic testing significantly increase usage of testing and may nudge malaria positive individuals to purchase high quality antimalarials and improve treatment targeting. Data collection is ongoing until early 2022, and analysis is in progress.	*Committee:* William H. Dow Paul J. Gertler Lia C.H. Fernald Jonathan Kolstad	*Geographical preference:* United States *Job preference:* Academic with teaching, academic or semi-academic research department or institution, postdoctoral fellowship

Lakshmi Gopalakrishnan Population Health Sciences https://www.lakshmigopalakrishnan.com/ glakshmi@berkeley.edu	*Gender norms as a social determinant of health and well-being in South Asia* Gender norms are upstream determinants of gender inequality and affect health through differential exposures, health-related behaviors, and access to care, reinforcing and reproducing gender inequalities with adverse health implications. My dissertation examines the role of inequitable gender norms and their associations with physical and mental health outcomes among young married women in South Asia. • Paper 1 uses a hierarchical random effects logistic regression model to examine the longitudinal association of community-level collective gender norms on physical and sexual intimate partner violence among newly married young women in India (Working paper available upon request). • Paper 2 studies the longitudinal association between women eating last in the household and their depression scores using a survey of newly married women in Nepal. I also explore whether the effects of eating last on depression differed in households who are food insecure versus food-secure households. • Paper 3 uses a nationally representative panel dataset of married women from India to examine the association between fertility and empowerment measures, including intrahousehold decision making, mobility, and financial autonomy.	*Committee:* Stefano Bertozzi Julianna Deardorff Patrick Bradshaw	*Geographical Preference:* United States *Job Preference:* Global health organizations (for profit/non-profit), funding agencies, academic research institute / academic with teaching or semi-academic with research emphasis in global health