Research Statement

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I am an applied microeconomist specializing in health and labor economics. One strand of my research examines risky health behaviors—e.g., smoking, drug use, and poor diets and sedentary lifestyles contributing to obesity— which are a major source of preventable deaths. My work quantifies their costs and consequences and evaluates interventions to reduce them. A second strand focuses on the design of social insurance, with an emphasis on paid sick leave—one of the largest social insurance programs, covering a substantial share of the labor force and involving sizable public expenditure.

The Long Term Consequences of the Opioid Epidemic. The opioid epidemic—a staggering increase in mortality from drug overdoses—has contributed to the longest sustained decline in life expectancy in the U.S. since 1915. I study how the crisis has altered economic and social structures, and has reshaped the political landscape of communities.

"*Republican Support and Economic Hardship: The Enduring Effects of the Opioid Epidemic*"—with Carolina Arteaga, forthcoming at the *Quarterly Journal of Economics*—is the first paper to establish a causal link between the opioid epidemic and the political realignment of the Republican and Democratic parties. We show that the communities that endured increases in mortality and reliance on public transfer programs became increasingly aligned with the Republican Party: exposure to the crisis increased the share of votes for Republicans in House, presidential, and gubernatorial elections. The paper also introduces a new source of within-state variation in exposure to the crisis. Our proposed design captures critical within-state urban–rural and demographic heterogeneity that characterizes opioid exposure across communities.

In "*Demographic Divergence: The Legacy of the Opioid Epidemic*"—with Carolina Arteaga and Stephen Classen—we show that the opioid epidemic contributed to growing regional divergence across U.S. communities. Areas more exposed to the epidemic experienced significant relative population declines 10 and 20 years after the onset of the crisis. By 2010, areas more exposed to the epidemic experienced 1.2 p.p. lower population growth per one–standard-deviation increase in exposure; by 2020, this effect was 2.5 p.p. While direct mortality from drug-induced deaths contributed to this declined, changes in migration patterns emerge as the main driver of local demographic adjustment. A one–standard-deviation increase in exposure led to a 4% increase in out-migration rates by 2010, which persisted thereafter. Exposure to the opioid epidemic also increased fertility among unmarried women, women in their late twenties, and those without a college degree. While these fertility responses account for only a small share of overall population changes, they have contributed to the growing divergence in family formation patterns.

This work has been presented at leading conferences such as the *NBER Summer Insti-*

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tute and Spring Meetings, and cited in the *2024 CEA Economic Report of the President*. Other scholars have leveraged our instrument to study the crisis' effects on homelessness, crime, innovation, municipal finances, and household composition.

The Health and Economic Costs of Weight Bias.[1] Obesity rates have risen sharply worldwide, posing major public health challenges. Despite its prevalence, there remains a troubling lack of understanding regarding the causes and consequences of obesity. This gap is reflected in the tendency to overemphasize individual behavior and to promote stigmatizing views of fat individuals. My research aims to systematically measure the prevalence and costs of weight-based discrimination, assess its impact on health and economic outcomes, and explore potential interventions to reduce weight-related inequalities.[2]

In the health care setting, we aim to document the prevalence of weight bias among physicians and estimate its impacts on patient health. Two empirical challenges arise: selection of patients to physicians and measuring weight bias. To address selection, we exploit the quasi-random assignment of patients to primary care physicians in Ontario. To measure views, we will analyze over 600,000 anonymized electronic medical records from the University of Toronto's UTOPIAN network, linked to administrative health data. Using machine learning and natural language processing tools, we plan to detect implicit and explicit sentiment toward higher-BMI patients in physician notes. Leveraging this measure, we will then estimate causal effects on quality of care and patient health.

For the education arm of this agenda, we have partnered with the New York City Department of Education (NYCDOE). Crucially, the NYCDOE collects student biometric data that can be linked to administrative records. We plan to construct two complementary measures of bias. First, leveraging rich administrative data, we will estimate teacher-specific bias based on past teacher–student interactions. Second, we will conduct an original survey, inviting middle and high school teachers to complete the weight-related Implicit Association Test—a computer-based tool developed by social psychologists to measure implicit bias.[3] Using these measures, we will examine how exposure to biased teachers impacts student outcomes. Lastly, we aim to evaluate the effectiveness of an anti-fat bias training program for teachers. Similar trainings have reduced weight stigma among health professionals, and evidence from related domains suggests that increasing teachers' awareness of their biases can reduce disparities in grading and expectations. We have identified potential partners for program design, and the NYCDOE has expressed strong interest in evidence-based interventions to address weight-related inequalities.

This work will expand our understanding of health disparities and the formation of

[1] My collaborators are Carolina Arteaga and Román Andrés Zárate (University of Toronto).

[2] Weight bias—or weight-based discrimination—refers to prejudice against fat individuals, rooted in cultural narratives that depict them as lazy, unintelligent, or lacking self-discipline. These biases operate implicitly and explicitly. I use the term "fat" as a neutral descriptor, following the framing advocated by fat justice movements.

[3] The weight IAT measures the strength of associations between the concepts of thin and fat and the attributes (good and bad) and stereotypes (e.g., athletic, clumsy).

human capital in addition to providing novel estimates of biased views and their health and economic costs. To date, we have secured access to the data described above and funding totaling approximately $87,500. We plan to field a pilot study during the upcoming academic year.

Smoking. Governments can preserve population health by implementing policies that directly restrict the availability of unhealthy products or raise the time costs of using them. In particular, tobacco regulation has been a major component of health policy in both developed and developing countries. My paper *"Tobacco Consumption Habits in Argentina: Causal Evidence from a New Regulation"* (Reject & resubmit at *Journal of Health Economics*) assesses the effectiveness of antismoking nonprice policies in low- and middle-income countries, where 80% of tobacco smokers worldwide live. Unlike other studies on the effects of nonprice policies in the context of middle- and low-income countries, my paper employs an identification strategy that provides causal estimates of the impacts of this policy on smoking, drinking, and health outcomes.

Social Insurance. Social insurance programs offer valuable protection against a broad range of risks that can harm individuals' well-being. The welfare benefits generated by this protection may be partially offset when individuals change their behavior in response to program incentives. The optimal design of social insurance involves balancing the value of risk protection against the costs associated with behavioral responses to coverage. A large body of literature has modeled these trade-offs in the contexts of unemployment, disability, retirement, healthcare, and work-related injury risks. My paper, "*On the Design of Paid Sick Leave: A Structural Approach,*" extends this literature by studying the optimal design of paid sick leave.[4]

This paper is the first to propose a theoretical framework for designing paid sick leave and quantifying the welfare gains from its implementation. I build a model in which workers trade off the utility of time off against the consumption loss from taking sick leave. The social planner chooses the parameters of a paid sick leave contract to maximize aggregate welfare, taking into account workers' behavioral responses and production externalities that arise when diseases are contagious and health shocks to a worker negatively affect their co-workers' productivity. Using this framework, I show that the presence of production externalities alters the welfare effects of behavioral responses. These responses can be welfare-improving–i.e., by curbing contagious diseases and reducing production externalities–and do not necessarily make insurance provision more expensive. In the empirical application, I leverage rich administrative data from the Chilean paid sick leave system to estimate the optimal contract parameters and provide novel estimates of the welfare gains from its implementation.

I have presented this paper at prestigious university seminars, including the *University of Wisconsin-Madison,* the *University of Michigan,* and the *University of Western Ontario*.

[4]These programs provide income replacement for workers who suffer from short-term impairments caused by non-work-related sickness (e.g., common flu).