

How Do Household Energy Transitions Work?

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2024-01-07

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Abstract

Introduction

Methods

Results

Conclusions

Brief summary of what we did.

Introduction

China is deploying an ambitious plan to transition up to 70% of all households in northern China to clean space heating, including Beijing. To meet this target the Beijing municipal government announced a two-pronged program that designates coal-restricted areas and simultaneously offers subsidies to night-time electricity rates and for the purchase and installation of electric-powered, air-source heat pumps to replace traditional coal-heating stoves. The program is being rolled out on a village-by-village basis; however there is uncertainty as to when villages will receive the program. The variability in when the policy is applied to each village allows us to treat the roll-out of the program as a quasi-randomized intervention. Households may also be differentially affected by this program due to factors such as financial constraints, preferences and social capital, and there is uncertainty about whether and how this intervention may affect indoor and outdoor air pollution, as well as health behaviors and health outcomes.

Specific Aims and Overarching Approach

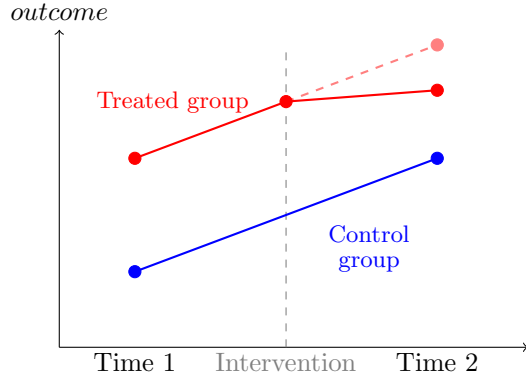
This study builds on three data collection campaigns in winter 2018/19, winter 2019/20, and winter 2021/22, as well as a partial campaign in winter 2020/21 (CIHR-funded) with the following specific aims:

1. Estimate how much of the policy's overall effect on health, including respiratory symptoms and cardiovascular outcomes (blood pressure, central hemodynamics, blood inflammatory and oxidative stress markers), can be attributed to its impact on changes in PM2.5;
2. Quantify the impact of the policy on outdoor air quality and personal air pollution exposures, and specifically the source contribution from household coal burning (Previously Aim 3);
3. Quantify the contribution of changes in the chemical composition of PM2.5 from different sources to the overall effect on health outcomes (Previously Aim 2).

Study Design and Methods

- Field equipment
- DiD schematic
- Mediation DAG

To understand how Beijing’s policy works we used a difference-in-differences (DiD) design (Callaway 2020), leveraging the staggered rollout of the policy across multiple villages to estimate its impact on health outcomes and understand the mechanisms through which it works.



The DiD design compares outcomes before and after an intervention in a treated group relative to the same outcomes measured in a control group. The control group trend provides the crucial “counterfactual” estimate of what would have happened in the treated group had it not been treated. By comparing each group to itself, this approach helps to control for both measured and unmeasured fixed differences between the treated and control groups. By measuring changes over time in outcomes in the control group unaffected by the treatment, this approach also controls for any unmeasured factors affecting outcome trends in both treated and control groups. This is important since there are often many potential factors affecting outcome trends that cannot be disentangled from the policy if one only studies the treated group (as in a traditional pre-post design).

The canonical DiD design (Card and Krueger 1994) compares two groups (treated and control) at two different time periods (pre- and post-intervention, Figure X). In the first time period both groups are untreated, and in the second time period one group is exposed to the intervention. If we assume that the differences between the groups would have remained constant in the absence of the intervention (parallel trends assumption), then an unbiased estimate of the impact of the intervention in the post period can be calculated by subtracting the pre-post difference in the untreated group from the pre-post difference in the treated group.

However, when multiple groups are treated at different time periods, the most common approach has been to use a two-way fixed effects model to estimate the impact of the intervention which controls for secular trends and differences between districts. However, recent evidence suggests that the traditional two-way fixed effects estimation of the treatment effect may be biased in the context of heterogeneous treatment effects (Callaway and Sant’Anna 2021; Goodman-Bacon 2021)

Data Analysis

Total Effect

To estimate the total effect of the policy we used a DiD analysis that accommodates staggered

Mediation Analysis

To describe the causal mediation analysis we can represent the total effect with the following equation, noting that we simplify the DiD equation above by dropping the error terms and using X as a generic term to capture the village fixed effects (V_j), time fixed effects (Pj) and other covariates (Z_{jt} and X_{ijt}) that, as noted above, we assume are sufficient to estimate the total effect:

$$E[Y|T, X] = \beta_0 + \beta_1 T + \beta_2 X$$

where β_1 represents the impact of the intervention T and X represents a vector of pre-treatment covariates sufficient to estimate the total effect without bias. After estimating the total effect, we will estimate the controlled direct effect (CDE), which gives the effect of the intervention on outcomes through pathways other than the proposed mediator (i.e., the “direct” path $T \rightarrow Y$ in the DAG (Figure ?) above), after setting the mediator to a specific value. The CDE can be derived after estimating the following equation:

$$E[Y|T, X, M] = \gamma_0 + \gamma_1 T + \gamma_2 M + \gamma_3 TM + \gamma_4 X + \gamma_5 W$$

Noting that γ_3 allows for interaction between the exposure and mediator, the CDE is estimated as: $\gamma_1 + \gamma_3 MT$. In the absence of interaction between the exposure and the mediator (i.e., $\gamma_3 = 0$) the CDE will simply be γ_1 , i.e., the effect of the policy holding M constant. For a valid estimate of the CDE we must account for confounding of the mediator-outcome effect, represented by W in the equation above. In our example this might include changes in cooking behavior, diet or tobacco smoking, or indoor temperature. Baseline measures of both the outcome and the proposed mediators will help to reduce the potential for unmeasured confounding of the mediator-outcome effect (Keele et al. 2015). In addition to estimating the CDE , we may also be interested in measures of how much of the of the policy’s impact may be due to its impact on the mediator. One potential way of estimating this is to subtract the CDE from the TE and express this as a proportion (sometimes called the “proportion eliminated”), i.e., $PE = [TE - CDE(m)]/TE$ or, using the two equations above, $(\beta_1 - \gamma_1)/\beta_1$. In our example this corresponds to the proportion of the total effect of the CBHP policy on blood pressure that could be eliminated if we were to fix $PM_{2.5}$ at a certain value $M = m$.

Results

Description of study sample (Table)

- Study flowchart of participants (Figure)
- Description of PM measurements (Figure)
- Uptake of the policy (Sankey energy use Figure)
- Impact of ‘treatment assignment’ on coal use (Figure? Table?)

Aim 1

- Impact of policy on PM mass (Figure)
- Table of CDEs (Central SBP, Central DBP, FeNO, Respiratory outcomes, inflammatory markers), mediated by indoor PM (CDEs for personal and outdoor in SI)
- Table for multiple mediation analysis for BP

Aim 2 (was Aim3)

- Figure of source contributions (6 or fewer components)
- Source contributions by treatment status
- DiD for source contributions to PM

Aim 3

- Table of mediated health effects by source contribution (coal and biomass)

Discussion and Conclusions

Other relevant results (Tables or figures in SI) - Temperature - Heating room - Well-being

Implications of Findings

To come...

Data Availability Statement

To come...

Acknowledgements

To come...

References

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Appendices

About the authors

Other publications

Other papers that have been published.(Li et al. 2022a; Li et al. 2022b; Sternbach et al. 2022)