Brendon Andrews

Northwestern
Economics

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Fields

Research: Health Economics, Economic History, Applied Microeconomics

Teaching: Health Economics, Microeconomics, Econometrics

Education

Ph.D., Economics, Northwestern University, 2022 (anticipated)
Dissertation: *Markets for American Physicians, 1880-1914*
Committee: Joel Mokyr (Co-Chair), David Dranove (Co-Chair), Joseph Ferrie

M.A., Economics, Queen's University (Kingston, Canada), 2015

Hon. Bac. of Social Sciences, Specialization in Economics (summa cum laude), University of Ottawa, 2013

Fellowships & Awards

Social Sciences and Humanities Research Council of Canada
Doctoral Fellowship, 2016-2020 ($80,000 CAD)
Northwestern University Graduate Fellowship, 2020-2022
Queen's Graduate Award, 2013-2014
University of Ottawa: Silver Medal, Department of Economics Plaque, Merit Scholarship, Jacques Henry Memorial Scholarship, Joseph Patrick and Eileen Marie Mulroy Memorial Scholarship in Economics

Competitive Grants

Economic History Association Exploratory Travel and Data Grant, 2021 ($2,500)
Graduate Research Grant, 2021 ($2,000)

Teaching Experience

Teaching Assistant, Northwestern University
PhD Introduction to Econometrics, 2017
MBA Healthcare Economics, 2018
MBA Competitive Strategy and Industrial Structure, 2020

Teaching Assistant, Queen's University
Introductory Statistics, 2013-2014

Student Mentor, University of Ottawa, 2012-2013

Consulting

Competition & Antitrust Economics, Charles River Associates (Toronto)
Associate, 2014-2015; Consulting Associate, 2015-2016

Conferences

50th Annual Conference of the Illinois Economics Association: "Quality and Reputation in Markets for Physician Services: Historical Evidence from a Shocking Report", oral presentation, 22 Aug 2021.
53rd Annual Conference of the Canadian Economics Association: "The Impact of

Physician Supply on Mortality: Evidence from Early Twentieth Century America", oral presentation, 1 June 2019.

50th Annual Conference of the Canadian Economics Association: "On Contagion and the Demand for Health", oral presentation, 5 June 2016.

Research Assistance *Amélie Petitclerc, Dept. of Medical Social Sciences, Feinberg School of Medicine, 2018.*
Andrew Sharpe, Centre for the Study of Living Standards, Ottawa ON, 2011-2013.

Refereeing International Journal of Health Economics and Management

Job Market Paper *"Reporting versus Reputation: Physician Quality and the Flexner Report of 1910" (sole-authored)*

If patients can be persuaded to switch between licensed providers on the basis of authoritative opinions, policy-makers can harness such reporting as an additional tool to implement incentives for high-quality care. I employ the landmark Flexner Report (1910) medical school evaluations to show that reputations are a primary threat to effective reporting. This historic report did not target specific physicians, but ruthlessly disparaged the quality of American medical schools and recommended the vast majority be closed. I show that doctors who recently entered a local geographic market and who attended poorly-reviewed schools – not just the recent graduates thereof – were about three times more likely to experience practice failure after the report's release. Heightened practice failure implies that perceived quality and expected demand fell by enough to compel market exit. I therefore capture monumental shifts in the viability of recent entrants' physician practices immediately after the release of weak negative signals. Expert recommendations have considerably less impact when providers have established themselves in a market – no impact on practice failure can be detected. These heterogenous effects imply that policy-makers are unlikely to dramatically alter consumer demand with quality information when trust and reputation are important market features – a strategy which targets existing relationships may be more powerful.

Working Papers *"Ambiguity in Cost-Effectiveness Analysis" (sole-authored)*

In some countries, cost-benefit analysis [CBA] or cost-effectiveness analysis [CEA] are mandated for policymaking. While these tools are often used interchangeably, the theoretical implications of ambiguous settings for decision-making have not been adequately explored, especially in a healthcare technology evaluation context. Ambiguity arises when decision-makers cannot form priors over unknowns, and is distinct from uncertainty. I show that even when CBA and CEA produce equivalent policy recommendations in unambiguous settings, and CBA accurately measures welfare, the unadjusted use of CEA does not typically maximize welfare under certain statistical decision rules. Regulators attempting to combine sensitivity analyses by minimizing maximum regret or applying a Bayesian prior over CEA ratios will sometimes be too conservative. This may be an undervalued feature of CEA when evaluations are subject to industry participation and favorable bias. Intuitively, the disagreement occurs due to the non-linear distortion in the value of benefits introduced by CEA. I propose adjusted ratios which more accurately reflect CBA under different decision rules, but urge healthcare evaluators to explicitly model the impact of novel technologies on social welfare. Embracing ambiguity and explicitly selecting a decision rule to combine information will allow regulators to specify a set of possible choices for the monetary value of benefits, eliminating a main argument in favor of CEA.

Works in Progress *"Physician Rebellions: Health System Policy and Consultations with Homeopaths" (sole-authored)*

Physician rebellions against management policies are commonplace, pose more of a risk to healthcare acquisition and affiliation agreements than regulators, and are often

accompanied by appeals to patient welfare. Due to coordinated action and anonymous surveying, little is known about which doctors oppose policies, and disentangling profit-seeking and altruistic motivations is difficult. In 1884, the entire regular medical profession in New York was publicly surveyed concerning whether to repeal a ban on consultations with homeopaths – who treated the wealthiest patients. I model consumer choice between regular & homeopathic health systems, which in this era were quite high-risk and approximately equivalent to a placebo, respectively. Under the status quo policy, regular doctors had access to high-quality consultations with capacity-constrained specialists, but homeopaths did not. I show that this ban produces additional volume for some regular physicians, and that specialists have a strong profit motive to repeal the ban during emergency situations. Using conditional choice models, I show that differences in votes cast are strongly influenced by economic incentives. Regulators should therefore be hesitant to accept the policy claims of activist physicians, who may attempt to block welfare-increasing policies.

Languages English (native), French (basic survival; intermediate research reading)

References

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