

The impact of vaccine lotteries on COVID-19 vaccination rates: Evidence from Poland

Bachelor Thesis

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1 Introduction

2 Background

2.1 Literature review

2.1.1 Incentives in public health

Governments are facing public health challenges at every corner. But how can they motivate people to live healthier lives? Behavioural economics can offer several ways to influence the decisions of individuals, probably the least severe form are nudges.

Nudging is a concept mainly brought to the public through the work of **thaler_nudge_2008empty citation**. They define a nudge as an intervention that “alters people’s behavior in a predictable way without forbidding any options or significantly changing their economic incentives” (p. 6). Nudging can be applied in various ways, it is however often connected to lifestyle topics, such as nutrition and diet. For example, in an experiment in Denmark (**friis_comparison_2017**), the aim was to promote the consumption of vegetables in the setting of a self-serving buffet, which included salad and other dishes in large bowls. As a nudge, the food environment was changed by arranging green plants and herbs around the food bowls. In a second experiment, salad was pre-portioned into smaller take-away bowls. The results showed that the intake of energy from vegetables of the participants can be increased by pre-portioning the salad. Although many studies evaluating the impact of nudges find positive effects of the respective interventions, these results should be interpreted with caution, since a lot of studies, including **friis_comparison_2017empty citation**, were conducted in the lab and may therefore not be reproducible in a real-world setting (**ledderer_nudging_2020**).

Besides nudging, policymakers could try to change economic incentives. Governments have been using taxation as a means of influencing the behaviour of individuals for a long time, for example in alcohol and tobacco policy. Both in developed and developing country, it has been shown that raising prices leads to reduced consumption of tobacco (**yeh_effects_2017**; **immurana_effects_2021**).

Beyond taxation, policymakers could also use other financial incentives to motivate changes of individual behaviour to tackle public health challenges, such as (small) cash payments or lotteries. There have been many studies evaluating such possible schemes, typically using randomised control trials. Several meta-analyses found that such incentives can be successful in inducing behaviour changes. For example, **giles_effectiveness_2014empty citation** evaluated 16 studies on

issues such as smoking cessation, health screenings, physical activity and vaccinations. The authors found that financial incentives are more effective than no intervention at encouraging healthy behaviour. This finding is also confirmed by **mantzari_personal_2015empty citation**, who evaluated 34 studies and additionally concluded that this effect is stronger for the most deprived individuals, thereby possibly reducing health inequalities.

There is also some literature on lotteries as an incentive in public health, apart from COVID-19 vaccine policy. **bjorkman_nyqvist_incentivizing_2018empty citation** find that the introduction of a lottery program reduced HIV incidence in Lesotho. Lotteries can also successfully increase cycling and walking activity (**ciccone_using_2021**; **patel_randomized_2018**) and participation in chlamydia screenings (**niza_vouchers_2014**).

2.1.2 Incentives to increase COVID-19 vaccination rates

In march 2020, when the COVID-19 pandemic struck the world, it was not foreseeable that vaccines would be available in just about nine months. When they were available and hailed as the possible end of the pandemic, it may not have been clear that rolling out vaccines was so difficult. In countries around the world, there was a considerable amount of vaccine hesitancy. Dealing with this hesitancy has led policymakers and researchers to thinking about how to increase vaccination rates, by means of vaccination mandates and passports, nudges, cash and non-cash prizes and lotteries.

A very widely used tool, especially in Europe and the US, were vaccination passports. The access to social gatherings/places (e.g. restaurants, bars, clubs, stadiums), international travel and quarantine regulations were subject to vaccination against COVID-19. Besides ethical concerns, for example potential disqualification of minorities from social life because of a historically higher distrust in government (**gostin_digital_2021**), the evidence on the effectiveness of such regulations is mixed. A synthetic control analysis of six countries found that COVID passports were successful in increasing daily vaccinations in countries with lower than average vaccination rates. In more average countries (Germany and Denmark), such regulations were less successful (**mills_effect_2022**). These cross-country comparisons should however be treated with caution, since there are large variations across countries when it comes to the extent of the use of COVID passports. While a comparison of Poland (very restricted use of COVID passport) and Lithuania (wide use of COVID passport) suggests a positive effect of passports on vaccination rates (**walkowiak_covid-19_2021**), it has to be noted that COVID passport may also have negative effects on vaccine uptake, since frustration about reduced autonomy

might lower willingness to get vaccinated (**porat_vaccine_2021**).

Besides the carrot-and-stick approach, governments have also used smaller nudges and financial incentives, such as cash payments and non-cash rewards to increase COVID-19 vaccination rates. Probably the most influential study to date on cash payments and nudges was carried out in Sweden (**campos-mercade_monetary_2021**). Using a randomised control trial, the authors find that even “small” cash payments of around 24 US dollars can significantly increase vaccination rates, while small nudges could not increase vaccination rates. While some studies also suggest a measurable positive effect of cash payments on vaccination rates (**wong_guaranteed_2022**; **kluver_incentives_2021**; **kim_vaccination_2021-1**), there is also evidence against this effect. In another study, the results indicated that neither behavioural nudges (text messages) nor cash payments could increase vaccination rates among the hesitant citizens (**jacobson_can_2022**). **sprengholz_money_2021empty citation** also find that cash incentives do not increase the willingness to be vaccinated.

There is also a vast literature specifically on COVID-19 vaccine lotteries, also evaluating real-world lotteries. **dube_exploring_2022empty citation** analyse the effectiveness of a vaccine lottery in Québec (Canada) and find a relatively small impact on vaccination rates. A survey in Australia found that the vaccine lottery there was successful in increasing willingness to be vaccinated (**jun_association_2022**). The majority of studies on COVID-19 vaccine lotteries however dealt with lotteries in US states. Studies on vaccine lotteries in Louisiana and Massachusetts found different effects. Whereas the lottery in Louisiana increased vaccine uptake (**wang_moving_2023**), a vaccine lottery in Massachusetts did not significantly increase vaccination rates although prizes were higher (**kim_did_2023**). There are also several papers investigating multiple state COVID-19 lotteries at once. All of these papers find that most, but not all of the lottery programs were successful in increasing vaccine uptake (**robertson_are_2021**; **acharya_implementation_2021**; **fuller_assessing_2022**).

A specific focus can be observed with respect to Ohio. There is a quite large number of studies evaluating the “Ohio Vax-A-Million” lottery, which was the first COVID-19 vaccine lottery in the US. In total, a majority of the reviewed literature casts a positive light on the efficacy of the lottery. While **mallow_covid-19_2022empty citation** find a positive effect of the lottery on vaccination rates, another study cannot support this view (**walkey_lottery-based_2021**). There have also been four studies evaluating the lottery using the SCM. These studies construct a synthetic Ohio out of a donor pool of other US states. Three of these studies find small positive effects of

the lottery of vaccine uptake (**brehm_ohio_2022**; **barber_conditional_2022**; **sehgal_impact_2021**) and one does not find a robust effect (**lang_did_2022**).

So far, there has been one study dealing with the vaccine lottery analysed in this thesis. **kuznetsova_effectiveness_2022** shortly evaluate different vaccine incentives across Europe, including the Polish policy. By applying an interrupted time series analysis based on an ARIMA approach, the authors suggest a slight positive effect of this lottery. There has however not been a study dealing in detail with the Polish lottery yet.

2.1.3 Theoretical background

Possibly to add

2.2 Institutional background

The COVID-19 policies in Poland (especially with respect to vaccines) can be considered as relatively “relaxed”. Poland did not widely use the EU COVID passport with respect to social life (citation here). Instead, it was only used for travelling/entry into the country. Vaccination rates in Poland have been low compared to some western European countries, including neighbour Germany. In the context of eastern Europe, vaccination rates have however not been exceptionally low. Many eastern European countries also refrained from a large-scale use of COVID passport. Therefore, to increase vaccination rates, the only remaining options are campaigns/nudges and providing incentives.

Table 2.1: Prizes of Polish vaccine lottery

	Cash prizes	Non-cash prizes
Instant	13,000 * 500 PLN 39,000 * 200 PLN	-
Weekly	60 * 50,000 PLN	720 electric scooters
Monthly	6 * 100,000 PLN	6 small vehicles
Main	2 * 1,000,000 PLN	6 middle class vehicles

Source: Service of the Republic of Poland

The empirical analysis will be based on a vaccine lottery implemented in Poland

from July 1, 2021 to September 30, 2021. It was announced on May 25, 2021. The policy had two main elements: A lottery for all adult fully vaccinated people (two doses) in Poland (**service_of_the_republic_of_poland_national_2021**) and a lottery-like monetary incentive scheme for municipalities (**service_of_the_republic_of_poland_compe**). The main prize of the lottery was a cash prize of 2 * one million zloty¹, but it also included smaller monthly, weekly and daily cash prizes and non-cash prizes (cars and electric scooters) with a total volume of 140 million zloty, as depicted in table 2.1.

Poland's lottery can be seen as a mixture of different brands of lotteries. Especially in the US, state governments have focused on lotteries with high rewards and relatively low winning probabilities (e.g. Ohio, Massachusetts with prizes of one million USD). A completely different concept would be the use of relatively low prizes (e.g. below 1000 USD) with relatively high winning probabilities (citation/example here). The Polish policy included both relatively small prizes (instant prizes) but also quite large prizes (main/final draw), thereby combining the best of both worlds.

As part of the monetary incentive scheme for municipalities, the municipality with the highest percentage of the vaccinated in the country received two million zloty. Three other municipalities who had the highest percentage of the vaccinated in their comparison group² received one million zloty each. The 500 quickest other municipalities reaching a vaccination rate of 67% won 100.000 zloty each.

One obvious question with respect to the synthetic control is the time of intervention. Although the actual lottery started on July 1, we will choose the time of announcement as the point of intervention, since the time of being fully vaccinated does not matter for the entry into the lottery. If the lottery has an effect, we will expect it to be observable from the time of announcement. On the other hand, if we were to set the intervention time at July 1, we would have the problem of an anticipation effect, impacting the credibility of the synthetic control negatively. This will be further discussed in chapter 3.1. As a robustness check for the result we obtain, we will however also estimate a synthetic control using July 1 as the time of intervention.

¹At the time of announcement on 25/05/2021, this was equal to around 220,000€, with an exchange rate of around 0.22 PLN to EUR

²There were three groups: Municipalities with a population of up to 30,000, cities with a population of 30,000 - 100,000 and large cities with a population above 100,000.

3 Methods and data

3.1 Synthetic control method

The synthetic control method is a relatively new method in causal inference. It was first established by **abadie_economic_2003empty citation** in order to investigate the economic effects of terrorism in the basque country, further developed by **abadie_synthetic_2010empty citation** and summarized in **abadie_using_2021empty citation**. It has been applied widely in economics, but also in other (social) sciences such as political science. Its specific case of application are comparative case studies, where a specific case, e.g. a policy or intervention of any form are compared to another case, for example without a similar policy (?). One idea in the context of comparative case studies is difference-in-difference. It might be straightforward to use matching to find the closest/most similar unit to the treated unit and take this as a control, allowing to estimate the average treatment effect of the policy by simply taking the difference (citation for matching). Finding a single unit which matches well might however in many cases be difficult, especially when making cross-country comparisons. The synthetic control method comes into play here and extends the difference-in-difference method. The very basic idea is to create a synthetic control unit as a combination of multiple control countries, to then estimate the average treatment effect (ATE) of the policy/intervention. For instance, it has been used to evaluate the effects of European integration (**campos_institutional_2019**) or the effect of natural disasters on economic growth (**cavallo_catastrophic_2013**), by constructing synthetic control countries without European integration or natural disasters.

Requirements

There are some important requirements that need to be fulfilled, in order to obtain a valid and interpretable synthetic control. These have been outlined in detail by **abadie_using_2021empty citation** along with the formal definition and the inference. The first one is that the evaluated policy/intervention has a sufficiently large effect. When the effect of an intervention is too small, it may not be possible to distinguish this effect from other shocks to the outcome variable.

The second one is that there exists a suitable comparison/control group. Countries that are also subject so similar interventions or other shocks to the outcome variable

in the given time frame should be excluded from the donor pool. What this means for the analysis in this thesis is outlined in section 3.1. Furthermore, we should try to select countries that are not too different from the treated country for the donor pool, to prevent interpolation bias(cite or write about interpolation bias). In this analysis, the donor pool is therefore restricted to eastern European countries.

Another important requirement is that there is no anticipation effect, so that citizens do not anticipate the enactment of a policy. If there were an anticipation, we would expect our synthetic control to become biased and not useful for estimating the causal effect of the treatment.

Lastly, it is crucial that we do not have any spillover effects on untreated units. This requirement should however be fulfilled in the case of Poland's vaccine lottery. The fulfillment of these assumptions/requirements will be further discussed in section 5.

Formal definition

What we observe is some outcome variable Y_{jt} for $J + 1$ units from $t = 1$ to T . The first unit ($j = 1$) is the treated unit for $t > T_0$ while all other units are untreated units. The intervention (in this analysis the announcement of the lottery) occurs at $T_0 + 1$, meaning that there are T_0 pre-intervention time periods. We also observe k predictors, which include the pre-intervention outcome variable and additional covariates: X_{1j}, \dots, X_{kj} . These can be summarised by the vectors $\mathbf{X}_j = (X_{1j}, X_{2j}, \dots, X_{kj})'$ for units $j = 1, \dots, J + 1$. It therefore follows that the $(k \times J)$ matrix $\mathbf{X}_0 = (\mathbf{X}_2, \mathbf{X}_3, \dots, \mathbf{X}_{J+1})$ captures all the predictors of the untreated units¹.

The average treatment effect (causal effect) is defined as the difference between the potential outcome of the treated unit with intervention, which can be defined as Y_{1t}^I , and its potential outcome without the intervention, Y_{1t}^N :

$$\tau_{1t} = Y_{1t}^I - Y_{1t}^N \text{ for } t > T_0 \quad (3.1)$$

By definition, the outcome with intervention is known and the outcome without intervention is hypothetical for $t > T_0$ for the treated unit. Therefore, to estimate the causal effect, it is sufficient to estimate Y_{1t}^N . How can this problem be solved? By

$${}^1\mathbf{X}_0 = \begin{bmatrix} X_{12} & X_{13} & \dots & X_{1J+1} \\ X_{22} & X_{23} & \dots & X_{2J+1} \\ \vdots & \vdots & \ddots & \vdots \\ X_{k2} & X_{k3} & \dots & X_{kJ+1} \end{bmatrix}$$

abadie_economic_2003empty citation, the SCM proposes to use a weighted average of donor pool units as a synthetic control. The synthetic control is therefore defined as:

$$\hat{Y}_{1t}^N = \sum_{j=2}^{J+1} w_j Y_{jt} \quad (3.2)$$

The weights $\mathbf{W} = (w_2, w_3, \dots, w_{J+1})'$ are chosen, such that the synthetic control matches as closely as possible the pre-intervention path of the outcome variable for the treated unit. Therefore the weights have to be chosen so that they minimize this difference. The optimal weights $\mathbf{W}^* = (w_2^*, w_3^*, \dots, w_{J+1}^*)'$ solve:

$$\mathbf{W} = \arg \min_{\mathbf{w}: w_j \in [0,1], \sum_{j=2}^{J+1} w_j = 1} \|\mathbf{X}_0 \mathbf{W} - \mathbf{X}_1\| \quad (3.3)$$

(Potentially include factor model) This is subject to the weights being non-negative and summing up to one, an important assumption in the classic SCM. This assumption can be relaxed to allow for non-negative weights, in this thesis we will however keep it. We can therefore simply estimate the average treatment effect from (3.1) using these weights:

$$\hat{\tau}_{1t} = Y_{1t}^I - \sum_{j=2}^{J+1} w_j^* Y_{jt} \quad \text{for } t > T_0 \quad (3.4)$$

Inference

Based on Abadies works (possibly cite here), the most common way of inference in synthetic control is using permutation through the use of placebo effects. A synthetic control unit is constructed for all the untreated countries in the control group, as if there was a treatment for these countries. If the magnitude of the effect for the actually treated unit is extreme compared to the placebo effective, the effect can be regarded as significant. One possible problem of this concept might be that it could possibly be difficult to obtain a good pre-treatment fit for all units in the donor pool, especially with a relatively small donor pool. A possibility of quantification is a test statistic which measures the ratio of the post-intervention fit relative to the pre-intervention fit $R_j(t_1, t_2)$, which is defined as the root squared mean prediction error of the synthetic control. From there it is possible to compute r_j , which measures the quality of the fit in the post-intervention compared to pre-intervention. It is then also possible to find a p-value for the permuted test:

$$p = \frac{1}{J+1} \sum_{j=1}^{J+1} I_+(r_j - r_1) \quad (3.5)$$

where $I_+(\cdot)$ is an indicator function that returns one for non-negative arguments and zero otherwise.

Recently, Cattaneo et al. (cite one of their papers here) have advanced inference in synthetic control. Explain basic idea behind their inference procedure here. This analysis will employ this method to construct prediction intervals as an additional inference method together with the permutation based inference proposed by **abadie_synthetic_2010empty citation**.

3.2 Data

First, we will estimate an RDD model to estimate the effect of the lottery on COVID-19 cases in Poland, similar to the analysis by **kuznetsova_effectiveness_2022empty citation**. For this, time series data on COVID-19 cases by “Our world in data” will be utilized.

In the main SCM analysis, the impact of the policy on the vaccination rates will be investigated. Data for the outcome variable vaccination rate (both one vaccination and fully vaccinated) is taken from a data set created by “Our world in data” (**mathieu_global_2021**). This data set is a collection of vaccination rates and other information about vaccinations from all countries of the world, coming directly from the respective government/government agency. If the data is provided by the governments, it can give us a daily time-series of vaccination rates around the world.

One of the most important aspects in the application of SCM is the choice of the donor pool. As outlined in 3.1, the treated country should not be an outlier compared to the control countries. It is therefore sensible to select countries that are similar to Poland, both in general and with respect to vaccination rates. Therefore, twelve central/eastern European countries with sufficient data availability (AT, BG, CZ, EE, GR, LV, LT, HR, HU, RO, SI, SK) are initial candidates for the donor pool. From this list, several countries are dropped who experienced similar interventions or shocks to the vaccination rate in the given time frame. Greece (cash incentive of 150€ for young people), Czechia (holiday incentive), Austria (need to find a reason here), Lithuania (cash incentive + other incentives), Romania (cash and lottery incentive). Estonia, Czechia and Slovenia implemented some small incentive schemes for doctors and state employees, these are however not considered as a big enough shock to vaccination rates and Estonia, Czechia and Slovenia will not be dropped. Croatia and Hungary are removed because of too many missing values. The donor pool then consists of six countries: Bulgaria, Czechia, Estonia, Latvia, Slovakia and

Slovenia.

There are however missing values for several countries. Sometimes these missing values follow a specific pattern (e.g. Poland: values are missing on Sundays) while there is no specific pattern for some other countries. Linear interpolation is used to replace the missing values, by drawing a straight line between the two adjacent data points (citation here). Other imputation techniques such as kalman smoothing² were also considered, but ultimately the differences between the different techniques are marginal in this specific case.

Table 3.1: Predictors of selected countries

	Poland	Synthetic Poland	Mean donor
GDP per capita ^a	12,810	10,101.630	12,081.670
Influenza vaccination rate ^b	0.104	0.139	0.182
Population density ^c	123.600	73.798	58.100
Share with tertiary education ^d	0.289	0.277	0.297
Share of elderly ^d	0.182	0.207	0.205

^a in USD, 2020 (Eurostat)

^b 2019 (Eurostat)

^c in persons per km², 2019 (Eurostat)

^d 2020 (Eurostat)

In order to find the best fit for the weights, additional predictors are used. The choice of these variables can be very important for the synthetic control. GDP per capita, the share of elderly (over 65), the share of people (15-64) with tertiary education, population density and the year of entry into the EU all adjust for general country specific differences, but partly also for differences in vaccine uptake. Income, age, education and the proximity to the nearest vaccination center (it is assumed that countries with higher population density have - on average - a closer proximity to vaccination centers) are all relevant determinants of COVID-19 vaccine uptake (viswanath_individual_2021; need to check + possibly additional citation). The share of elderly vaccinated against Influenza and trust in science are possibly also important indicators of “vaccine openness”. We would expect countries with higher Influenza vaccination rates (before the spread of COVID-19) also to have higher COVID-19 vaccination rates, since the population might generally be more open to the basic idea of vaccinations and that there might be a more sophisticated culture of health prevention (too unspecific). A similar reasoning applies to trust in science.

²Here, kalman smoothing will shortly be explained

When citizens generally place more confidence in scientists, they would also be more likely to be open to the idea of vaccinations.

Ideally, the use of a “political variable” would have been a good idea, since large differences in vaccine uptake exist across party preferences. This problem might be the most well-known in the US, but it also applies to other countries (citation here). When using other countries as a donor pool, it is however very difficult because of the large differences of party ideologies between countries. One idea would be to use the vote share for parties along the European parties/groups as in the European Parliament, firstly there are however quite large differences between parties within certain groups and secondly, elections and surveys are very volatile in many European countries compared to e.g. some US states (if left, need citations).

Table 3.2: Composition of synthetic Poland

Country	Weight
Bulgaria	0.460
Estonia	0.001
Lithuania	0.210
Hungary	0.329

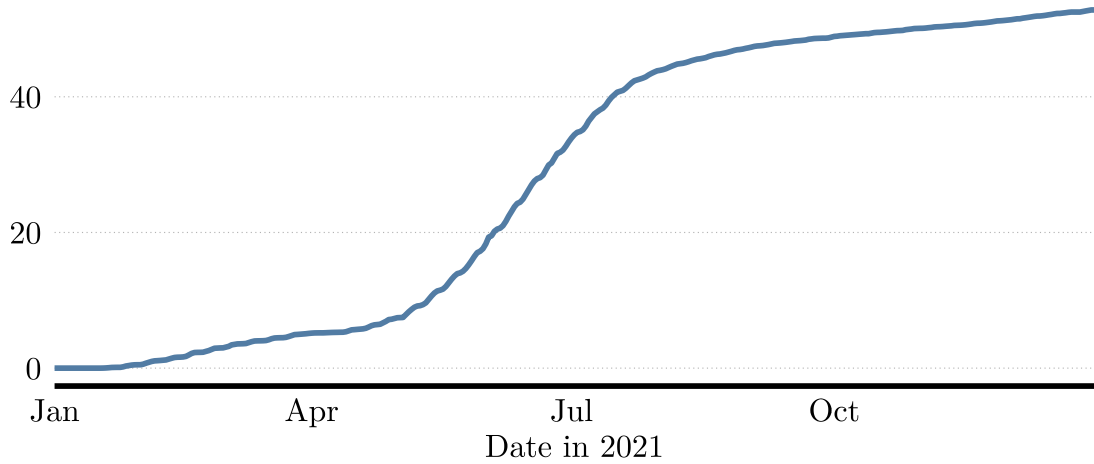
The data analysis has been carried out in R using the *tidysynth*, *scpi* and *SCtools* packages, generating synthetic Poland. Table 3.1 shows descriptive statistics of the predictors of Poland, synthetic Poland and the donor pool mean of the predictors. Table 3.2 presents the composition of synthetic Poland for the analysis of the share of fully vaccinated citizens with the respective unit weights. The data and R scripts can be found in the corresponding GitHub repository [↗](#)³.

³See appendix for further information

4 Results

First of all, let us look at vaccination rates in Poland from a descriptive point of view. Figure 4.1 plots the vaccination rate (fully vaccinated) in Poland in 2021.

Figure 4.1: Share of population fully vaccinated in Poland (in %)

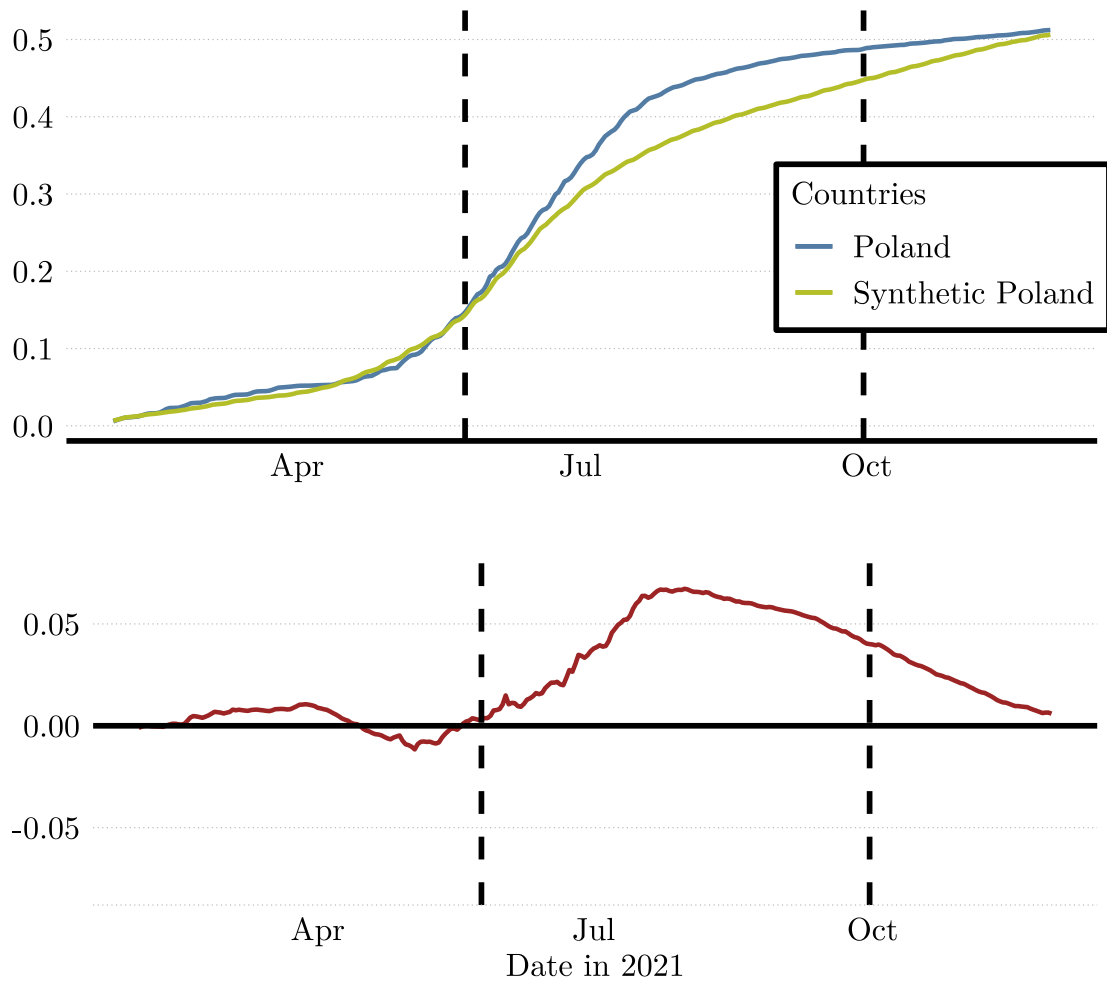


As other countries, Poland first dealt with a shortage of vaccines, leading to necessary rationing, having to favor older and chronically ill citizens first. Towards the summer, this shortage significantly loosened its grip. Although the growth rate in the vaccination rate increased significantly, for countries like Poland with a comparably high vaccine hesitancy, the problem turned from a vaccine shortage to a shortage of people willing to get vaccinated. Simply from looking at figure 4.1, we can not observe a sharp or outstanding change in the growth rate at the time of announcement or shortly after¹. This is however also not expected, since the magnitude of the effect of lotteries on vaccination rates is generally not very large, as outlined in section 2.1.

We therefore applied the synthetic control method, as described in section 3.2. Figure 4.2 plots the vaccination rate (fully vaccinated) for both Poland and synthetic Poland. We observe a solid, but not perfect pre-treatment fit (too unspecific). From the intervention, we can see a slow decoupling between Poland and its synthetic control. This difference continues increase to around 5 percentage points. As time progresses, the gap however tends to decrease again, and by the end of November (after the end of the lottery), the vaccination rates of Poland and synthetic Poland are

¹We would expect that it takes several weeks for any significant change to be visible, since getting fully vaccinated takes/took around six to eight weeks

Figure 4.2: Vaccination rates (fully vaccinated) and the gap between Poland and synthetic Poland



The two dashed lines refer to the announcement (25/05) and the end (30/09) of the lottery.

back to the same level. Simply based on the plot, one interpretation could be that the lottery successfully induces some people who would have gotten vaccinated anyway to do this earlier, to take advantage of the incentive provided by the government. It however also suggests that the vaccine lottery was not particularly effective in reaching new people. It has to be noted that the more time has passed since the intervention, the synthetic control becomes more unreliable, as the prediction intervals in figure ... show. Therefore, the development in October and November should be interpreted with caution, but at first glance, it seems like the lottery was not successful in getting more people vaccinated, but only in getting people vaccinated earlier.

Employing the permutation based inference techniques discussed in section 4.1, also shows no signs of a significant effect. Figure ... presents the placebo study. As can be seen, the magnitude of the effect of Poland is not comparably high and does not stand out. This finding also confirmed quantitatively. Using the discussed test procedure, a p-value of around 0.5 is obtained. Therefore, the hypothesis that the lottery had no effect in increasing vaccination rates cannot be rejected, at any known/relevant significance level. The findings of the permutation based inference are therefore in line with the prediction intervals and do not suggest a statistically significant effect of the lottery on vaccination rates (fully vaccinated).

5 Discussion

6 Conclusion

Appendix

Hier steht ein Anhang.

Affidavit

I affirm that this Bachelor thesis was written by myself without any unauthorised third-party support. All used references and resources are clearly indicated. All quotes and citations are properly referenced. This thesis was never presented in the past in the same or similar form to any examination board.

I agree that my thesis may be subject to electronic plagiarism check. For this purpose an anonymous copy may be distributed and uploaded to servers within and outside the University of Mannheim.

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Benedikt Stelter