Alcohol and Self-Control: A Field Experiment in India

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Abstract

High levels of alcohol consumption are more common among the poor. This fact could have economic consequences beyond mere income effects because alcohol impairs mental processes and decision-making. Since alcohol is thought to induce myopia, this paper tests for impacts on self-control and on savings behavior. In a three-week field experiment with low-income workers in India, I provided 229 individuals with a high-return savings opportunity and randomized incentives for sobriety. The incentives significantly reduced daytime drinking as measured by decreased breathalyzer scores. This in turn increased savings by approximately 60 percent. No more than half of this effect is explained by changes in income net of alcohol expenditures. In addition, consistent with enhanced self-control due to lower inebriation levels, incentivizing sobriety *reduced* the impact of a savings commitment device. Finally, alcohol consumption itself is prone to self-control problems: over half of the study participants were willing to sacrifice money to receive incentives to be sober, exhibiting demand for commitment to increase their sobriety. These findings suggest that heavy alcohol consumption is not just a result of self-control problems, but also creates self-control problems in other areas, potentially even exacerbating poverty by reducing savings.

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1 Introduction

Heavy alcohol consumption is correlated with poverty, yet the nature and consequences of this relationship are not well understood.[1] Poverty could cause demand for alcohol by enhancing its short-term benefits.[2] But alcohol may also be a cause of poverty. In particular, alcohol is thought to affect myopia and self-control. If these effects are large, then heavy alcohol consumption could interfere with a variety of forward-looking decisions. By affecting savings decisions, insurance take-up, human capital investments, and earnings, alcohol could reduce wealth accumulation and deepen poverty. However, though theoretically possible, we do not know whether such effects are present or economically meaningful in practice.

This paper empirically tests for one such effect: the impact of alcohol on savings behavior. To examine this relationship, I conducted a three-week field experiment with 229 cycle-rickshaw peddlers in Chennai, India, in which all subjects were provided with a high-return savings opportunity. To create exogenous variation in alcohol consumption, a randomly selected subset of study participants were offered financial incentives for sobriety. For a cross-randomized subset of study participants, the savings account was a commitment savings account, i.e. individuals could not withdraw their savings until the end of their participation in the study. This feature allowed me to consider the impact of increasing sobriety on self-control problems in savings behavior. In addition, I elicited willingness to pay for incentives for sobriety to assess the extent to which self-control problems themselves contribute to the demand for alcohol.

The incentives for sobriety significantly increased study participants' sobriety during their daily savings decisions, providing a "first stage" to estimate the impact of sobriety on savings behavior. Individuals who were given incentives for sobriety decreased their daytime drinking as measured by a 33 percent increase in the fraction of individuals who visited the study office sober. The intervention also reduced overall alcohol consumption and expenditures by 5 to 10 percent.

Offering incentives for sobriety increased individuals' daily savings at the study office by 60 percent compared to a control group that received similar average study payments independent of their alcohol consumption. This increase in savings is a combination of changes in income net of alcohol expenditures, and changes in savings behavior for given resources. Assessing the contribution of the former requires an estimate of the marginal

[1] In many countries, low-income individuals are in fact *more* likely to be abstinent from alcohol altogether. At the same time, in many countries including in India, heavy drinking is more common among the poor. This is described in more detail in the next section.

[2] Alcohol is known to be a powerful anesthetic (Woodrow and Eltherington 1988), it helps individuals fall asleep (Ebrahim et al. 2013) and it can make individuals feel better about themselves ("drunken self inflation," (Banaji and Steele 1989)), or relieve stress and anxiety ("drunken relief," (Steele and Josephs 1988)). At the same time, physical pain, poor sleep, low self-esteem, and stress are all correlated with poverty (Poleshuk and Green (2008), Patel et al. (2010), Haushofer and Fehr (2014), Patel (2007)).

propensity to save out of available income. Using an estimate of the marginal propensity to save obtained by separately randomizing study payments via a lottery and observing the impact on savings, I find that the combined effects of increased earnings outside of the study and decreased alcohol expenditures explain about half of the observed increase in savings. The remaining share of the increase in savings appears to be due to the effect of alcohol on time preferences. Consistent with this, the estimated marginal propensity to save is almost twice as large for individuals who were offered incentives for sobriety as for individuals in the control group, though this difference is not statistically significant.

The relationship between the effects of sobriety incentives and commitment savings provides further evidence that increasing sobriety directly affects time preferences. In particular, I find that sobriety incentives and the commitment savings feature were substitutes in terms of their effect on savings. While commitment savings and sobriety incentives each individually increased subjects' savings, there was no additional effect of the savings commitment feature on savings by individuals who were offered sobriety incentives, and vice versa. These patterns are consistent with alcohol increasing present bias. An alternative interpretation is that the incentives mitigated the need for commitment savings by reducing the consumption of alcohol, a key temptation good for this population. However, the intervention mainly reduced drinking or shifted it to later times of the day rather than causing abstinence from alcohol altogether. This makes a direct effect of alcohol on time preferences the more likely explanation.

Over 50 percent of subjects exhibited demand for commitment to increase their sobriety, indicating a greater awareness of and willingness to overcome self-control problems than found in other settings, for instance for smoking (Gine et al. 2010), or exercising (Royer et al. 2014). Specifically, in three sets of weekly decisions that each elicited preferences for sobriety incentives in the subsequent week, over half of the study participants chose options that implied weakly dominated study payments. In addition, more than a third preferred incentives for sobriety over unconditional payments, even when the latter were *strictly* higher than the maximum amount subjects could earn with the incentives. These individuals were willing to sacrifice study payments of about ten percent of daily income even in the best case scenario of visiting the study office sober every day. This finding provides clear evidence for a desire for sobriety by making future drinking more costly, in contrast to the predictions of the Becker and Murphy (1988) rational addiction model.[3]

[3]Becker and Murphy (1988) showed that many behaviors of addicted individuals are, at least in theory, consistent with optimization based on stable preferences. Gruber and Kőszegi (2001) subsequently challenged the implicit assumption of time-consistent preferences and replaced it with hyperbolic discounting as formalized by Laibson (1997). Given the similarity of predicted responses of consumption patterns to price changes by the two competing models, Gruber and Kőszegi (2001) were not able to reject Becker and Murphy's (1988) model in favor of their own. The ensuing literature produced suggestive but no conclusive evidence in the smoking domain (Gruber and Mullainathan 2005). Two recent examples in the context of alcohol consumption found mixed results (Bernheim et al. (2012) and Hinnosaar (2012)). Finally, other theories

The high demand for commitment does not appear to be the result of misunderstandings on the part of the subjects. Willingness to pay for sobriety incentives did *not* decrease over time among individuals who were asked to choose repeatedly. In fact, past exposure to the incentives *increased* individuals' demand for the incentives. Individuals who had been randomly selected to receive incentives for sobriety for 15 days were more likely to choose incentives for a subsequent week compared to individuals who had received payments independent of their sobriety. Further, individuals whose sobriety increased in response to the incentives were particularly likely to choose the incentives subsequently. Moreover, individuals with lower concurrent inebriation levels were more likely to choose the incentives. Finally, reassuringly, the demand for the incentives decreased in the cost of incentives.

The finding that alcohol *causes* self-control problems builds on psychology research on "alcohol myopia" (Steele and Josephs 1990). This line of research sought to reconcile the seemingly contradictory effects of alcohol found in a large body of previous research. Depending on circumstances, alcohol can relieve or increase anxiety and tension. It can inflate egos, yet lead to depression. However, according to the "alcohol myopia" theory, a defining feature of alcohol is that it *always* narrows attention, which in turn causes individuals to focus on simple, present, and salient cues. As a result, alcohol has particularly strong effects in situations of "inhibition conflict," i.e. with two competing motivations, one of which is simple, present, or salient, while the other is complicated, in the future, or remote.[4] The behavioral-economics interpretation of this theory is that alcohol causes present bias. The findings from my field experiment support this theory in the context of savings decisions. They demonstrate that alcohol-induced myopia can have economically meaningful consequences.

Moreover, this paper adds to the literature on poverty and self-control.[5] With the excep-

predict demand for commitment as well, including cue-based theories, dual-self models, or temptation and self-control models as in Thaler and Shefrin (1981), Laibson (2001), Gul and Pesendorfer (2001), Bernheim and Rangel (2004), or Fudenberg and Levine (2006). For detailed overviews on the empirical and theoretical literature on commitment devices, see DellaVigna (2009) and Bryan et al. (2010).

[4]In a series of studies, Steele and several coauthors aimed to explain a range of social behaviors caused by alcohol, emphasizing the effects of alcohol on aggression and altruism (Steele and Southwick (1985), Steele et al. (1985)). These studies and subsequent work on alcohol myopia did *not* study savings decisions or intertemporal choice (Giancola et al. 2010). However, many cross-sectional studies, including the ones on alcohol, found a correlation between impulsive "delayed reward discounting" (DRD) and addictive behavior, without establishing existence or direction of causality (MacKillopp et al. (2011), Vuchinich and Simpson (1999)). Experimental lab studies consistently found that acute alcohol intoxication reduced inhibitory control in computer tasks (Perry and Carroll 2008), but the two studies conducted so far did not find effects on impulsive DRD (Richards et al. 1999). In fact, to their own surprise, Ortner et al. (2003) found that alcohol intoxication *reduced* impulsivity. My study differs from previous experimental studies in a number of ways. In particular, (i) the duration of the experiment was significantly longer (over three weeks vs. one day), (ii) sample characteristics were markably different (low-income workers vs. college students; higher levels of regular drinking), (iii) stakes were higher (relative to income), and (iv) the main outcome was the amount saved after three weeks (as opposed to impulsive DRD).

[5]This literature goes back to at least Fisher (1930). It was recently revived by several theoretical and empirical contributions. On the theory side, Banerjee and Mullainathan (2010) and Bernheim et al. (2014)

tion of Banerjee and Mullainathan (2010), this line of research has largely sought to explain choices between overall levels of current and future consumption, rather than to understand how and whether specific goods may cause time-inconsistent preferences. In contrast, this paper argues that focusing on specific temptation goods may not only be an effective way to help individuals overcome their self-control problems regarding the consumption of these goods, but, in the case of alcohol, may also reduce self-control problems in other domains.

This paper also contributes to the growing literature on saving decisions among the poor (Karlan et al. 2014). The availability and design of savings accounts have recently been found to be important determinants of savings behavior among the poor (Ashraf et al. (2006), Dupas and Robinson (2013a), Dupas and Robinson (2013b), Prina (2014), Schaner (2014), Kast et al. (2014), Brune et al. (2014), Karlan et al. (2014)). Existing studies emphasize the importance of technologies for committing to savings. This paper argues that helping individuals to overcome underlying self-control problems regarding specific goods can be a substitute for commitment devices for overall consumption-saving decisions. More generally, it argues that time preferences are endogenous, in line with Becker and Mulligan (1997), and, more recently in the context of saving among the poor, Carvalho et al. (2014).

The results from this paper have the potential to inform alcohol policy, a much-debated topic in developing countries. In India, states have chosen a wide range of policy options ranging from prohibition (Gujarat) to government provision (Tamil Nadu), and private provision (Delhi) of alcohol.[6] When making such choices, policymakers lack sufficient information on the causes and the impact of alcohol consumption, and the feasibility and effectiveness of policy options. This paper contributes to this knowledge by investigating the relationship between alcohol and self-control, a key aspect in the consideration of policy options such as "sin taxes" or prohibition.

Finally, this paper contributes to our understanding of the effectiveness of incentives to encourage health-related behavior. Financial incentives are among the most successful policies to reduce drug consumption in general (Anderson et al. 2009), and alcohol consumption in particular (Wagenaar et al. 2009).[7] Providing short-run financial or other incentives can have substantial short-term and long-term effects on a number of health-related behaviors (Petry et al. (2000), Prendergast et al. (2006), Volpp et al. (2008), Charness and Gneezy (2009), Higgins et al. (2012), Dupas (2014)). In contrast to existing studies, I do not find

investigated the possibility of a poverty trap due to the association between poverty and self-control. Recent research on the empirical side includes Mani et al. (2013) and Mullainathan and Shafir (2013). For an excellent review, see Haushofer and Fehr (2014).

[6]See Rahman (2003) for a review of alcohol policy in India. In a major policy shift, Kerala has recently opted to move from government provision of alcohol to prohibition within the next ten years.

[7]This is the case for both incentives in the form of increased prices or taxes, even for heavy drinkers (Chetty et al. (2009), Cook and Tauchen (1982)), and in the form of contingency management, i.e. the use of monetary or non-monetary incentives for changing health-related behavior modification, and behavior therapy, especially in the addiction field (Higgins and Petry 1999). However, the vast majority of these studies were conducted in developed countries such that evidence from developing countries is limited.

evidence of effects of short-run incentives on alcohol consumption beyond the incentivized period.

The remainder of this paper is organized as follows. Section 2 provides an overview of the study background, including alcohol consumption patterns in Chennai and in developing countries more generally. Section 3 describes the experimental design, characterizes the study sample, and discusses randomization checks. Section 4 then considers the effect of increased sobriety on savings, and Section 5 investigates the interaction between sobriety and commitment savings. Section 6 considers the extent to which self-control problems contribute to the demand for alcohol. Section 7 concludes.

2 Alcohol in Chennai, India, and Developing Countries

There is scarce information regarding drinking patterns in developing countries, especially among the poor. In this section, I first describe alcohol consumption patterns among low-income individuals in Chennai, India. I then relate the observed patterns to existing data on alcohol consumption in India and in other developing countries.

2.1 Alcohol Consumption in Chennai

As a first step toward a systematic understanding of the prevalence of drinking among male manual laborers in developing countries, I conducted a short survey with 1,227 men from ten different low-income professions in Chennai.[8] Surveyors approached individuals from these groups during the day and asked whether they were willing to answer a short questionnaire about their alcohol consumption and take a breathalyzer test.[9] Figures A.1 through A.4 show summary statistics of drinking patterns for these professions, based on these surveys.

The overall prevalence of alcohol consumption among low-income men is high (Figure A.1). 76.1 percent of individuals reported drinking alcohol on the previous day, ranging across professions from 37 percent (porters) to as high as 98 percent (sewage workers).[10] In addition, on days when individuals consume alcohol, they drink considerable quantities of alcohol (Figure A.2). Conditional on drinking alcohol on the previous day, men of the

[8]The prevalence of alcohol consumption among women in Chennai and in India overall is substantially lower. It has been consistently estimated to be below five percent in India, with higher estimates for North-Eastern states and lower estimates for Tamil Nadu (where Chennai is located) and other South Indian states (Benegal 2005). In the most recent National Family Health Survey (Round 3, 2005/6), the prevalence of reported female alcohol consumption was 2.2 percent (IIPS and Macro International 2008). It is highest in the lowest wealth (6.2 percent) and education (4.3 percent) quintiles.

[9]To ensure a high participation rate, individuals were given Rs. 20 ($0.33) for their participation in this short survey. As result, only five out of 1,232 individuals approached declined to participate.

[10]Porters are individuals who help carry luggage or other items at train stations. Sewage workers spend their days working, and sometimes swimming, in waist-deep human sewage. These individuals report drinking heavily before and during work to numb themselves, in particular to the smell.

different professions reported drinking average amounts ranging from 3.8 to 6.5 standard drinks on this day.[11] Since alcohol is an expensive good, the resulting income shares spent on alcohol are enormous (Figure A.3). On average, individuals reported spending between 9.2 and 43.0 percent of their daily income of Rs. 300 ($5) to Rs. 500 ($8) on alcohol. These numbers are particularly remarkable because many low-income men in Chennai are the sole income earners of their families.[12] Finally, 25.2 percent of individuals were inebriated or drunk during these surveys, which all took place during the day (Figure A.4).[13]

2.2 Alcohol Consumption in India and in Developing Countries

The substantial level of alcohol consumption among low-income groups in Chennai shown in Figures A.1 through A.4 raises the question of how these numbers compare to other estimates for Chennai, for India, and for developing countries overall. Limited data availability and data inconsistencies make answering this question difficult. In particular, data on breathalyzer scores are rare. However, there is reason to believe that the estimates for Chennai are not unusual compared to other parts of India or other developing countries.

The daily average quantity of alcohol consumed by male drinkers in India, about a quarter of the male population, is only slightly higher than the average of the physical quantities shown in Figure A.2 (WHO 2014). The average male Indian drinker consumes about five standard drinks per day, exceeding the estimates for German, American, and even Russian drinkers in the same WHO (2014) report.[14] In comparison, individuals who drank alcohol on the previous day in Chennai report on average drinking about 5.3 standard drinks per day. Looking beyond India, male drinkers in Uganda (56 percent of the male population) consume about 4 standard drinks per day. The prevalence of male alcohol consumption is somewhat

[11] I follow the US definition of a standard drink as described in WHO (2001). According to this definition, a standard drink contains 14 grams of pure ethanol. A small bottle of beer (330 ml at 5% alcohol), a glass of wine (140 ml at 12% alcohol), or a shot of hard liquor (40 ml at 40% alcohol) each contain about one standard drink.

[12] The surveys reported here do not include questions about other family members and their incomes. However, female labor market participation is relatively low in Chennai. In my sample, less than a third of married men report that their wives earned income during the past month.

[13] Compared to other professions, the fraction of inebriated sewage workers is low given their reported expenditures and consumption. Anecdotally, this is explained by the fact that about a month before the surveys took place, one of the workers drowned in the sewage and his family was not given any severance payment because he was found to have been drunk at the time of the accident in an autopsy. After this incident, sewage workers stopped drinking at work, at least temporarily. Most individuals continued drinking alcohol regularly, but they did not drink during work hours.

[14] Some assumptions in this calculation can be questioned. In particular, the WHO (2014) calculates the number of drinks per drinker and day by dividing an estimate of the overall quantity consumed by the estimated fraction of drinkers in the population. Hence, underestimating the prevalence of alcohol consumption among males in India could lead to overestimates of the number of standard drinks per drinker. However, even adjusting for the somewhat higher prevalence according to IIPS and Macro International (2007), 31.9 percent rather than 24.8 percent in (WHO 2014), yields just over four standard drinks per drinker and day. In addition, other studies find significantly lower prevalence of drinking in India (e.g. Subramanian et al. (2005)).

lower in other Sub-Saharan countries, but the physical quantities consumed by drinkers are similarly high.[15] Alcohol consumption has also been steeply on the rise in China in recent years. According to the most recent WHO estimates, male Chinese drinkers (58.4 percent of the male population) consume 2.9 standard drinks per day.

There is also evidence that heavy alcohol consumption is more prevalent among the poor in developing countries. In India, both the prevalence of drinking and heavy alcohol consumption are more common among low-income and low-education individuals (Neufeld et al. (2005), Subramanian et al. (2005), IIPS and Macro International (2007)).

Moreover, surveys among low-income groups show a commonly held belief that the positive correlation between excessive alcohol consumption and poverty reflects a causal relationship. For instance, in village surveys in Uganda, 56 percent of individuals believed that excessive alcohol consumption was a cause of poverty (USAID 2003). Strikingly, this percentage was higher than the percentages of individuals that believed "lack of education and skills," "lack of access to financial assistance and credit," or "idleness and laziness," caused poverty. At the same time, a quarter of individuals viewed excessive alcohol consumption as an outcome of poverty.

3 Experimental Design and Balance Checks

The first part of this section consists of a broad overview of the experimental design of my study. Next, I describe the recruitment and screening procedures and, hence, the selection mechanism of potential study participants into the study. I then provide detailed information about the timeline and the treatment conditions, followed by a description of the mechanism used to elicit willingness to pay for sobriety incentives and the outcomes of interest of the experiment. Finally, I discuss summary statistics for the study sample and balance checks.

3.1 Overview of Experimental Design

Between April and September 2014, I asked 229 cycle-rickshaw peddlers working in central Chennai to visit a nearby study office every day for three weeks each. During these daily visits, study participants completed a breathalyzer test and a short survey on labor supply, earnings, and expenditure patterns on the previous day, and alcohol consumption both on the previous day and on the same day before coming to the study office. To study the impact of increased sobriety due to financial incentives on savings behavior, all subjects were given the opportunity to save money at the study office. Additionally, participants were

[15] For instance, an average drinker in Rwanda is estimated to consume 4.2 standard drinks per day. These numbers are similar for Burundi (4.1 standard drinks), Kenya (3.5 standard drinks), and Tanzania (3.4 standard drinks).

randomly assigned to varying conditions with the following considerations. First, to create exogenous variation in sobriety, a randomly selected subsample of study participants was offered financial incentives to visit the study office sober while the remaining individuals were paid for coming to the study office regardless of their alcohol consumption. Second, to examine the interaction between sobriety incentives and commitment savings, a cross-randomized subset of individuals was provided with a commitment savings account, i.e. their savings account did not allow them to withdraw their savings until the end of their participation in the study. Finally, to identify self-control problems regarding alcohol, a randomly selected subset of individuals was given the choice between incentives for sobriety and unconditional payments.

3.2 Recruitment and Screening

The study population consisted of male cycle-rickshaw peddlers aged 25 to 60 in Chennai, India.[16] Individuals enrolled in the study went through a three-stage recruitment and screening process. Due to capacity constraints, enrollment was conducted on a rolling basis such that there were typically between 30 and 60 participants enrolled in the study at any given point in time.

Field recruitment and screening. Field surveyors approached potential participants during work hours near the study office, and asked interested individuals to answer a few questions to determine their eligibility to participate in "a paid study in Chennai." Individuals were eligible to proceed to the next stage if they met the following screening criteria: (i) between 25 and 60 years old, inclusive, (ii) fluent in Tamil, the local language, (iii) worked at least five days per week on average as a rickshaw puller during the previous month, (iv) having lived in Chennai for at least six months, (v) without plans to leave Chennai during the ensuing six weeks, and (vi) reporting an average daily consumption of 0.7 to 2.0 "quarters" of hard liquor (equivalent to 3.0 to 8.7 standard drinks) per day.[17] If an individual satisfied all field screening criteria, he was invited to visit the study office to learn more about the study and to complete a more thorough screening survey to determine his eligibility.

[16] The study population included both passenger cycle-rickshaw peddlers as in Schofield (2014) and cargo cycle-rickshaw peddlers. Schofield (2014) exclusively enrolled passenger-rickshaw peddlers with a body-mass index (BMI) below 20. To avoid overlap between the two samples, my study only enrolled passenger cycle-rickshaw peddler with a BMI above 20. There was no BMI-related restriction for cargo cycle-rickshaw peddlers.

[17] "Quarters" refer to small bottles of 180 ml each. Nearly 100% of drinkers among cycle-rickshaw peddlers (and most other low-income populations in Chennai) consume exclusively hard liquor, specifically rum or brandy. The drinks individuals consume contain over 40 percent alcohol by volume (80 proof) and they maximize the quantity of alcohol per rupee. One quarter of hard liquor is equivalent to approximately 4.35 standard drinks.

Office screening. The primary goal of the more detailed office screening procedure was to reduce the risks associated with the study, in particular risks related to alcohol withdrawal symptoms. The criteria used in this procedure included screening for previous and current medical conditions such as seizures, liver diseases, previous withdrawal experiences, and intake of several sedative medications and medications for diabetes and hypertension. This thorough medical screening procedure was strictly necessary since reducing one's alcohol consumption (particularly subsequent to extended periods of heavy drinking) can lead to serious withdrawal symptoms. If not adequately treated, individuals can develop delirium tremens, a severe and potentially even lethal medical condition (Wetterling et al. (1994), Schuckit et al. (1995)).

Lead-in period. Overall attrition and, in particular, differential attrition are first-order threats to the validity of any randomized-controlled trial. In my study, attrition was of particular concern since the study requested participants to visit the study office for three weeks every day with varying payment structures across treatment groups. In early-stage piloting, a non-negligible fraction of individuals visited the study office on the first day, which provided high renumeration to compensate for the time-consuming enrollment procedures, but then dropped out of the study relatively quickly. To avoid this outcome in the actual study, participants were required to attend on three consecutive study days (the "lead-in period") before being fully enrolled in the study and informed about their treatment status. Individuals were informed about this feature of the study during their first visit to the study office. They were allowed to repeat the lead-in period if they missed one or more of the three consecutive days. However, individuals were only allowed to repeat the lead-in period once.

Selection. At each stage, between 64 and 83 percent of individuals were able and willing to proceed to the subsequent stage (Table 3). Among individuals who were approached on the street to conduct the field screening survey, 64 percent were eligible and decided to visit the study office to complete the office screening survey. 21 percent were either not willing to participate in the survey when first approached (14 percent), or were not interested in learning more about the study after participating in the survey and being found to be eligible (7 percent). The majority among the remaining individuals (12 percent) participated in the survey, but did not meet the drinking criteria outlined above, primarily because they were abstinent from alcohol or reported drinking less than 3 standard drinks per day on average (11 percent). During the next stage, the office screening survey, 83 percent of individuals were found eligible. The majority of the remaining, ineligible individuals (13 percent) were not able to participate due to medical reasons. Finally, 66 percent of individuals passed the lead-in period. Importantly, leaving the study at this stage does *not* appear to be related to alcohol consumption as measured by individuals' sobriety during their first visit to the study

office.

3.3 Timeline and Treatment Groups

Figure 1 provides an overview of the study timeline, the different activities, and the treatment conditions. All participants completed five phases of the study as described in more detail below. During the first four phases, consisting of 20 study days in total, individuals were asked to visit the study office every day, excluding Sundays, at a time of their choosing between 6 pm and 10 pm. The office was located in the vicinity of their usual area of work to limit the time required for the visit. During Phase 1, the first four days of the study, all individuals were paid Rs. 90 ($1.50) for visiting the study office, regardless of their blood alcohol content (BAC). This period served to gather baseline data in the absence of incentives and to screen individuals for willingness to visit the study office regularly. On day 4, individuals were randomly allocated to one of the following three experimental conditions for the subsequent 15 days.

(I) **Control Group.** The Control Group was paid Rs. 90 ($1.50) per visit regardless of BAC on days 5 through 19. These participants simply continued with the payment schedule from Phase 1.

(II) **Incentive Group.** The Incentive Group was given incentives for sobriety on days 5 through 19. These payments consisted of Rs. 60 ($1) for visiting the study office, and an additional Rs. 60 if the individual was sober as measured by a score of zero on the breathalyzer test. Hence, the payment was Rs. 60 if they arrived at the office with a positive BAC and Rs. 120 if they arrived sober. Given the reported daily labor income of about Rs. 300 ($5) in the sample, Rs. 60 ($1) was a relatively strong incentive for sobriety.

(III) **Choice Group.** To familiarize individuals with the incentives, the Choice Group was given the same incentives as the Incentive Group in Phase 2 (days 5 to 7). Then, right before the start of Phase 3 (day 7) and Phase 4 (day 13), they were asked to choose for the subsequent week (six study days) whether they preferred to continue receiving the same incentives, or to receive unconditional payments ranging from Rs. 90 ($1.50) to Rs. 150 ($2.50), as described below.

Eliciting willingness to pay for incentives. On days 7 and 13 of the study, surveyors elicited individuals' preferences in each of the three choices shown in Table 1. Each of these choices consisted of a tradeoff between two options. The first option, Option A, was the same for all choices. The payment structure in this option was the same as in the Incentive Group, i.e. a payment of Rs. 60 ($1) for arriving with a positive BAC, and Rs. 120 ($2) for arriving

sober. In contrast, Option B varied across the three choices, with unconditional amounts of Rs. 90, Rs. 120, and Rs. 150. To gather as much information as possible while ensuring incentive compatibility, preferences for all three choices were elicited, before one of these choices was randomly selected to be implemented.[18] However, to maintain similar average study payments across treatment groups, Choice 1 was implemented in 90 percent of choice instances (independent over time) so that particularly high payments were only actually paid out to a small number of individuals in the Choice Group.[19]

Table 1: Choices between Incentives for Sobriety and Unconditional Payments

	Option A		**Option B**
Choice	BAC > 0	BAC $= 0$	regardless of BAC
(1)	Rs. 60	Rs. 120	Rs. 90
(2)	Rs. 60	Rs. 120	Rs. 120
(3)	Rs. 60	Rs. 120	Rs. 150

I designed these choices with two main objectives in mind: first, to elicit demand for commitment to sobriety and, hence, potential self-control problems regarding alcohol consumption; second, to allow the Choice Group to be part of the evaluation of the impact of incentives for sobriety. In addition, given low literacy and numeracy levels in the study sample, the design seeks to minimize the complexity of decisions while achieving the other two objectives. In particular, Option A was the same across choices and individuals were given three days to familiarize themselves with these incentives during Phase 2. Accordingly, in all three choices, subjects knew Option A from previous office visits, and Option B was simply a fixed payment regardless of BAC as already experienced in Phase 1. To address

[18]This is an application of the "random-lottery incentive system" (RLIS), in which a subject is asked to choose in several choice situations, one of which is randomly selected to be implemented once all choices are made. This method is extensively used in the experimental economics literature, for instance, recently by Augenblick et al. (2014) or Andreoni and Sprenger (2012). Holt (1986) put forward a theoretical criticism suggesting that subjects may not perceive every choice situation as isolated, but instead treat all choices as a grand meta-lottery. However, in subsequent experimental work, Starmer and Sugden (1991) and Hey and Lee (2005) did not find evidence in support of this concern. For a brief summary of the debate, see Wakker (2007).

[19]Before making their choices, study participants were told to take all choices seriously since each choice had a positive probability of being implemented. Individuals were *not* informed regarding the specific probabilities of implementing each of the choices. One potential concern regarding the procedure to elicit demand for commitment in this study is that subjects' choices may have been affected by the fact that none of the choices were implemented with certainty. Such effects would be a particular concern for this study if they increased the demand for commitment. However, the existing evidence suggests that introducing uncertainty into intertemporal choices *reduces* present bias (as measured by the immediacy effect) rather than increasing it (Keren and Roelofsma (1995); Weber and Chapman (2005)).

potential concerns regarding anchoring effects, the order of choices was randomized. Half of participants made their choices in the order as outlined above, and the remaining individuals completed the choices in the opposite order.

Demand for commitment. The choice of the conditional payment (Option A) in Choice 1 is *not* evidence of demand for commitment. An individual who did not prefer to change his drinking patterns may have chosen Option A if he expected to visit the study office sober at least 50 percent of the time and, therefore, to receive higher average study payments than from choosing Option B. In contrast, study payments for Option A were weakly dominated by the ones in Option B for Choice 2. Therefore, choosing Option A in Choice 2 is evidence of demand for commitment to increase sobriety, which reveals underlying self-control problems. Furthermore, study payments in Option A were *strictly* dominated by the ones in Option B for Choice 3. Choosing Option A in Choice 3 implied sacrificing Rs. 30 ($0.50) in study payments per day even during sober visits to the study office, a non-trivial amount given reported labor income of about Rs. 300 ($5) per day.

Endline. On day 20 of the study, all participants were asked to come to the study office once again for an endline visit at any time of the day of their choosing. No incentives for sobriety were provided on this day. During this visit, surveyors conducted the endline survey with individuals, and participants were we given the money they had saved. Moreover, *all* study participants were given the same set of three choices, described above. This allows me to understand whether exposure to incentives for sobriety affected subsequent demand for incentives. Again, preferences for all three choices were elicited, and then one of them was randomly selected to be implemented. However, the choices from day 20 were only implemented for a randomly selected five percent of individuals for budgetary and logistical reasons. These individuals were invited to visit the study office for six additional days. The endline visit was the last scheduled visit to the study office for the remaining study participants.

Follow-up visits. To measure the effects of the intervention beyond the incentivized period, surveyors attempted to visit each study participant about one week after their last scheduled office visit. This visit was announced during the informed consent procedures, and participants were reminded of this visit on day 20 of the study, but they were not informed regarding the exact day of this visit. During the follow-up visit, individuals were breathalyzed and surveyed once again on the main outcomes of interest. The compensation for this visit did *not* depend on the individuals' breathalyzer scores.

3.4 Lottery

In addition to the payments described above, study participants were given the opportunity to earn additional study payments in a lottery on days 10 through 18 of the study. The lottery was conducted as follows: If the participant arrived at the study office on a day on which he was assigned to play the lottery, he was given the opportunity to spin a 'wheel of fortune'. This gave him the chance to win a voucher for Rs. 30 or Rs. 60, at a probability of approximately 5 percent each. This voucher was valid only on the participant's subsequent study day, i.e. if the participant came back on the following study day and showed the voucher, he received the equivalent cash amount at the beginning of his visit. The lottery allows me 1) to estimate the impact of increased study payments on labor supply and earnings, 2) to estimate the impact of study payments on attendance and savings at the study office, and 3) to test whether sobriety incentives raised the marginal propensity to save.

3.5 Outcomes of Interest and Savings Treatments

The main outcomes of interest in this study are: (i) alcohol consumption and expenditures, (ii) savings behavior, and (iii) labor market participation and earnings. Each of these outcomes is described below.

Alcohol consumption data was collected daily during each study office visit by measuring individuals' blood alcohol content (BAC), and via self-reports regarding drinking times, quantities consumed and amounts spent on alcohol. BAC was measured via breathalyzer tests using devices with US Department of Transportation level of precision.[20] During each visit, after the breathalyzer test, individuals were asked about their alcohol consumption on the same day prior to visiting the study office, and about their overall alcohol consumption on the previous day. To cross-check self-reported drinking patterns, a randomly selected subset of subjects was visited unannounced between 7:30 pm and 10 pm for random breathalyzer tests.[21]

Saving. To study individuals' savings behavior, all individuals were given the opportunity to save money in an individual savings box at the study office. During each office visit,

[20] As in Burghart, Glimcher, and Lazzaro (2013), this study uses the breathalyzer model AlcoHawk PT500 (Q3 Innovations LLC). For more information on the measurement of BAC via breathalyzers, see O'Daire (2009).

[21] Ideally these tests would have been conducted at later times in the night to fully capture individuals' drinking patterns at night. However, staff constraints, safety considerations, and the intrusive nature of visiting individuals late at night at their homes made it infeasible to conduct these tests after 10 pm. The random breathalyzer tests were only conducted for the subset of individuals who consented to be visited unannounced. However, since the renumeration for these visits was deliberately chosen to be high (Rs. 100 for a successful visit regardless of the outcome of the breathalyzer test), the fraction of individuals that agreed to be randomly breathalyzed was nearly 100 percent.

study participants could save up to Rs. 200, using either payments received from the study or money from other sources. Two features of the savings opportunity were cross-randomized to the sobriety incentive treatment groups.

(i) **Matching contribution rate.** Individuals were given a matching contribution ("savings bonus") as an incentive to save. During their endline visit, subjects were paid out their savings plus a matching contribution, randomized with equal probability to be either 10% or 20% of the amount saved. Hence, even in a setting with high daily interest rates, saving money at the study office was a high-return activity for many study participants.[22]

(ii) **Commitment savings.** Half of study participants were randomly selected to have their savings account include a commitment feature. Instead of being able to withdraw money during any of their daily visits between 6 pm and 10 pm, they were only allowed to withdraw money at the end of their participation in the study.[23] Notably, the savings option for the remaining individuals also entailed a weak commitment feature. While individuals could withdraw as much as they desired on any given office visit, they were only able to withdraw money in the evenings, i.e. between 6 pm and 10 pm.

The savings option served three purposes. First, it allows me to study the impact of increased sobriety on savings behavior and, more generally, the impact of alcohol on intertemporal choices and investments in high return opportunities. Second, the cross-randomized commitment savings feature allows to consider the relationship between sobriety and self-control in savings decisions. Third, the savings feature was meant to help study participants avoid using the money received from the study to drink alcohol on the same evening or on subsequent days.

Labor market outcomes included reported earnings, labor supply, and productivity. These outcomes are measured by individuals' self-reports during the baseline survey, daily surveys, and the endline survey. Reported earnings are a combination of income from rickshaw work and other sources such as load work. Labor supply is a combination of the number of days worked per week and the number of hours worked per day. Finally, productivity is measured as income per hour worked.

[22]Individuals found the matching contribution easier to understand rather than a daily interest rate on savings during early-stage piloting work. The implied daily interest rate from saving an additional rupee increased for each participant over the course of his participation in the study. However, anecdotal evidence suggests that few individuals were aware of this feature.

[23]For ethical reasons, all individual had the option to leave the study and withdraw all of their money at any day in the study.

3.6 Sample Characteristics and Randomization Checks

Appendix Tables A.1 through A.3 summarize study participants' key background characteristics, and demonstrate balance on these characteristics across treatment groups. Tables A.1 and A.2 give an overview of basic demographics, and work- and savings-related variables. As to be expected with a large number of comparisons, there are imbalances across treatment groups for some characteristics. However, overall only 5 out of 72 coefficients are statistically significantly different at the 10 percent level, and 3 coefficients are significantly different at the 5 percent level.[24] Most notably among these, individuals in the Control Group reported lower savings at baseline than in the Incentive and Choice Groups. Baseline savings are calculated as the sum of amounts saved in a number of different options including savings at home in cash or in gold or silver, with relatives and friends, with self-help groups, or with shopkeepers, as reported in the baseline survey. There is no statistically significant difference in the comparisons between the Incentive and Choice Group with the Control Group individually. However, the difference in reported baseline savings is statistically significant when comparing the Control Group to the Incentive and Choice Groups combined. As illustrated in the Appendix Figure A.5, this difference is driven entirely by six individuals who reported very high savings, among them one individual in the Choice Group who reported in the baseline survey having Rs. 1 million in cash savings at his home.[25]

Differences in reported baseline savings are *not* driving the savings result shown below. First, there were only small and statistically insignificant differences in savings at the study office across treatment groups in the unincentivized Phase 1 (last row of Table A.2). Second, controlling for Phase 1 savings and baseline survey variables, including total savings, does not substantially alter the regression results. If anything, the estimated effect of sobriety incentives on savings becomes larger. Third, there is no apparent relationship between reported savings in the baseline survey and savings at the study office. Among the six individuals with total savings above Rs. 200,000 in the baseline survey, four are in the Choice Group, and two are in the Incentive Group.[26] Only two of them, both in the Choice Group, saved more than the average study participant in the course of the study.[27] However, their influence on the below results is negligible, in particular because these individuals already saved high amounts in the unincentivized Phase 1, and the below regressions control for savings in Phase. Hence,

[24] Among the demographics in Table A.1, the Control Group reports having lived for a few years longer in Chennai, and they are more likely to have electricity and a TV. In addition, they are somewhat less likely to own a rickshaw. In contrast, the overall fraction of individuals who reports 'lack of money' as a reason for not owning a rickshaw is balanced across treatment groups. Other reasons for not owning a rickshaw include not having a safe place to store it, or getting it provided by an employer.

[25] This amount was confirmed not only in the endline survey, but also during a subsequent follow-up visit.

[26] This outcome is more likely than it may seem. The probability of that none of the six high savers were allocated into the Control Group is $(2/3)^6 \approx 9\%$.

[27] Three of the remaining four individuals saved a total of Rs. 50 or less, and the fourth individual saved Rs. 500 in the course of the study, i.e. about the average amount in the Control Group.

excluding these two individuals from the analysis does not change the conclusions of this paper.

Table A.3 shows balance of alcohol consumption at baseline. Only one of the 36 comparisons shows a statistically significant difference at the 10 percent level. Compared to the Control Group, individuals in the Choice Group report somewhat lower alcohol expenditures per day.

4 Does Alcohol Affect Saving?

Time preferences are a fundamental aspect of decision-making and are critical for consumption-saving decisions. Savings can increase future consumption and serve as a buffer against adverse shocks, such as health emergencies. Accordingly, a growing body of recent research has focused on savings behavior among the poor and the impact of offering different savings accounts to low-income individuals in developing countries (Karlan et al. 2014). This literature largely focuses on the availability of different savings technologies and their potential impact on savings behavior (Ashraf et al. 2006) and other outcomes such as investment in health (Dupas and Robinson 2013b). There is less emphasis on determinants of savings behavior for given technologies and on heterogeneity in take-up or impact. In this section, I present evidence that alcohol distorts intertemporal choice by causing present bias, and hence self-control problems in savings decisions. I show that increasing sobriety can impact individuals' savings behavior beyond effects on income net of alcohol expenditures. I complement this evidence with Section 5, which shows that sobriety incentives lower the impact of a commitment savings feature on savings.

Figure 3 shows a strong correlation between daily amounts saved at the study office and blood alcohol content (BAC) measured during the same office visits, both across Control Group participants and within the same individuals over time. Individuals who, on average, exhibited higher sobriety also saved more. Moreover, individuals in the Control Group saved more during study office visits with lower levels of inebriation than the same individuals during high-inebriation visits. The remaining part of this section considers whether this correlation reflects a causal impact of alcohol consumption on individuals' savings behavior. Understanding the causal impact of alcohol on savings behavior requires exogenous variation in sobriety. Therefore, I first consider the impact of financial incentives on alcohol consumption. While the outcomes in this section are of interest in and of themselves, they can also be viewed as a first stage for the subsequent analysis of the impact of increased sobriety on savings decisions.

4.1 The Impact of Incentives on Alcohol Consumption (First Stage)

Financial incentives significantly reduced daytime drinking, but they had only a moderate effect on overall drinking. Table 4 give a summary of the results from this section. Since estimated treatment effects of the Incentive and Choice Conditions on alcohol consumption are remarkably similar, the table shows results from regressions that pool these two groups. Both sobriety incentive treatments lowered daytime drinking (left panel of Table 4), as measured by the fraction of individuals showing up sober, measured BAC, and the reported number of standard drinks before coming to the study office. The estimated treatment effects for all three measures correspond to a 33% change relative to the mean in the Control Group. However, this effect translates into only a moderate reduction of overall drinking (right panel of Table 4). Reductions in self-reported consumption and expenditures are relatively small (5.0 to 9.5 percent decrease), and, while larger in relative terms, the effect on reported abstinence is only moderate (2 percentage points) and not statistically significant.

4.1.1 The Impact of Sobriety Incentives on Daytime Drinking

The main outcome measure used to assess the impact of incentives on daytime drinking is the fraction of individuals who arrived sober at the study office among *all* participants who were enrolled (as opposed to only among individuals who visited the study office). That is, anyone who did not visit the study office on a particular day is counted as "not sober at the study office," along with individuals for whom a positive BAC was measured when they visited the office. Since attendance in the Incentive Group is lower than in the Control Group, this measure is preferable to other measures of sobriety as it less vulnerable to attrition concerns.

Financial incentives significantly increased sobriety during the day, as measured by the fraction of individuals who visited the study office *and* had a zero breathalyzer test result among all individuals in the respective treatment groups (upper panel of Figure 2). In the pre-incentive period, there are only small differences in sobriety across treatment groups. In each group, about half of the individuals visited the study office sober on days 1 through 4. This fraction gradually decreased in the Control Group over the course of the study to about 35 percent by the end of the study.[28] In contrast, with the start of the incentivized period (day 5), sobriety in the Incentive and Choice Groups increased by about 15 percentage points. Sobriety at the study office declined as well in the course of the study, but individuals in these two groups remained about ten to fifteen percentage points more likely to visit the study office sober than the Control Group through the end of the study.

Remarkably, the two treatments had a nearly identical effect on the fraction of individuals

[28]The decline in sobriety in the Control Group over the course of the study is in part explained by lower overall attendance in all treatment groups. In addition, individuals may have felt more comfortable visiting the study office inebriated or drunk at later stages of the study.

who visited the study office sober. This is not a surprise in Phases 1 and 2 since the payment structure was the same in the Incentive and Choice Groups at the beginning of the study. However, overall sobriety levels in these two groups tracked each other even once individuals were given the choice of whether they wanted to continue receiving incentives at the beginning of Phase 3. The Incentive Group was only slightly more likely to visit the study office sober compared to the Choice Group in Phase 4. The similarity of drinking patterns in the Choice and Incentive Groups suggests sophistication regarding the effect of the incentives on individuals' sobriety. The subset of study participants who would have increased their sobriety during study office visits if they had been provided with incentives also chose to receive the incentives when given the choice.[29]

The corresponding regressions in Table 5 confirm the visual results. Individuals in the Incentive and Choice Group were approximately ten percentage points more likely to visit the study office sober, respectively (column 1). The estimates increase to 13 percentage points when regressions include baseline survey and Phase 1 control variables, in particular sobriety in Phase 1 (columns 2 to 4). This estimate corresponds to a 33 percent increase compared to the Control Group. Conditional on visiting the study office, individuals' measured BAC in the Incentive Group was four percentage points lower than in the Control Group (columns 5 through 7). The estimate is smaller for the Choice Group, which translates into a lower pooled estimate (column 8). Nonetheless, the three percentage-point decrease in BAC shown represents a 33 percent reduction compared to the Control Group. Moreover, both treatments reduced the reported number of drinks before visiting the study office by about one standard drink from a base of just under three standard drinks (columns 9 through 12). The point estimate for the pooled treatment effect, 0.98 standard drinks (column 12), corresponds to a reduction of 33 percent as well.

4.1.2 The Impact of Sobriety Incentives on Overall Drinking

The estimated treatment effect on overall alcohol consumption is substantially lower than the estimated effect on daytime drinking (Table 6). First, both treatments reduced reported overall alcohol consumption by about 0.3 standard drinks per day (columns 1 to 4), about a third of the effect on the reported number of drinks before coming to the study office described above. None of these estimates are statistically significant. Second, the reduction at the extensive margin of drinking was small at best (columns 5 to 8). The point estimate for the pooled treatment effect suggests a 2 percentage point increase in reported abstinence from drinking altogether (column 8), but none of the estimates are statistically significant either. Third, the treatment effect on reported overall alcohol expenditures is about Rs. 10 per day

[29]This assumes that self-imposed and external incentives were equally effective, which may not have been the case. For instance, external incentives may have decreased intrinsic motivation to stay sober (Bénabou and Tirole 2003).

(columns 9 to 12), with a point estimate of Rs. 8.7 for the pooled treatment effect, statistically significant at the ten percent level. Taken together, these estimates provide evidence that subjects who responded to the incentives mostly shifted their alcohol consumption to later times of the day rather than reducing their overall consumption, or not drinking at all.

4.1.3 The Role of Differential Attendance

The estimated effect of incentives on sobriety was not caused by differences in attendance across treatment groups. Across all treatment groups and days of the study, attendance was high (lower panel of Figure 2).[30] However, compared to the Choice and Control Groups, individuals in the Incentive Group were 7 percentage points less likely to visit the study office post Phase 1. This attendance gap emerged with the start of sobriety incentives, and remained relatively constant thereafter. Anecdotal evidence suggests that this difference in attendance was caused by individuals in the Incentive Group who were not able or willing to remain sober until their study office visit on some days, and, hence, faced reduced incentives to visit the study office on these days. This explanation is consistent with the fact that there was no attendance gap between the Choice and Control Groups because individuals for whom sobriety incentives were not effective or preferable could select out of them.[31]

On average, the Incentive Group was seven to eight percentage points less likely to visit the study office compared to the Control Group (column 1 of Table 7). Moreover, though not statistically significant, surprisingly, higher sobriety during the unincentivized Phase 1 *negatively* predicts subsequent attendance (column 2). This appears to be the case in the Incentive and Control Groups, but not in the Choice Group (column 3). Finally, on average, participants with higher savings in Phase 1 exhibited significantly higher subsequent attendance (column 4). However, there is no evidence that the two treatments caused high savers to visit the study office more frequently. If anything, the opposite was the case (column 5). This suggests that differential attendance of high savers does *not* explain the savings results shown below.

4.2 Did Increased Sobriety Change Savings Behavior?

Both sobriety incentive treatments increased savings at the study office (upper panel of Figure 4). Until day 4, when individuals learnt about their incentive treatment status, average amounts saved were nearly identical across treatment groups. After the start of the incentivized period, individuals in the Incentive and Choice Groups saved 46 percent and 65 percent more until the end of the study (Rs. 446 and Rs. 505 in the Incentive and Choice

[30] Attendance was 88.4 percent overall and 85.4 percent post treatment assignment. By construction, attendance in the lead-in period (Phase 1) was 100 percent.

[31] However, it remains unclear why there is an attendance gap for the Choice Group on days 5 through 7 of the study.

Groups, respectively, compared to Rs. 306 in the Control Group). The difference in savings across treatment groups did not emerge immediately after the beginning of the incentivized period, but accumulated mainly between days 8 and 15.

The corresponding regression results in Table 8 confirm the visual evidence. Individuals in both the Incentive and Choice Groups saved more at the study office, though only the coefficient for the Choice Group is statistically significant at the 10 percent level in the specification without controls (column 1). The pooled estimate shows a treatment effect of Rs. 12.45, corresponding to an increase of 61 percent compared to Control Group savings of Rs. 20.42 (column 6). This estimate–as well as both individual estimates in column 1–is larger than the coefficients for both the high matching contribution and the commitment savings option. Incentives for sobriety had a larger effect than increasing the matching contribution on savings from 10 to 20 percent, or introducing a commitment feature on the savings option.[32] Importantly, these estimates are ITT estimates, i.e. they measure the impact of *offering* incentives for sobriety. While only effective for a relatively small fraction of individuals as shown above, sobriety incentives increased savings by 61% overall.[33]

4.3 Robustness and Potential Confounds

Before examining the potential channels of the described effect of sobriety incentives on savings, this subsection investigates three potential confounds.

Pre-existing differences across treatment groups do not explain the observed differences in savings after day 4. The amounts saved by day 4 are nearly identical across treatment groups (upper panel of Figure 4). Moreover, controlling for baseline savings and baseline survey characteristics both decreases standard errors and increases point estimates (columns 2 of Table 8). The resulting point estimate for the pooled regression in column 4 is Rs. 13.44 and statistically significant at the 1 percent level (column 7 of Table 8).

Differential study payments across treatment groups could have been responsible for the increase in savings in the two treatment groups. Indeed, the Choice Group received slightly higher study payments (Rs. 7 per day) compared to the Control Group. However, the Incentive Group received in fact slightly lower study payments (lower panel of Figure 4), which implies that differences in average study payments cannot explain higher savings in both treatment groups. Consistent with this, controlling for study payments does not substan-

[32] As discussed above, even individuals in the "no commitment savings" group were given a weak commitment feature since they were only able to withdraw money during their study visits between 6 pm and 10 pm. Hence, the estimate for "commitment savings" is likely an underestimate of the impact of commitment on savings.

[33] Since BAC levels differed across treatment groups conditional on visiting the study office with a positive blood alcohol content, using the difference in the fraction sober to calculate a ToT is not accurate.

tially alter the estimated treatment effects (columns 3 and 8 in Table 8). The estimate for the pooled treatment effect decreases slightly to Rs. 11.57 per day.

Differential attendance could have caused the increase in savings. However, as discussed in Section 4.1.3, while attendance was nearly identical in the Choice and Control Groups, it was in fact significantly *lower* in the Incentive Group (lower panel of Figure 2). In addition, if anything, the two treatments caused high savers to visit the study office *less* (column 5 of Table 7). Accordingly, restricting the sample to days when individuals showed up at the study office increases the estimated treatment effects (columns 4, 5, 9, and 10 of Table 8).

4.4 The Effect of Changes in Income Net of Alcohol Expenditures

This paper argues increased sobriety caused changes in time preferences, which in turn increased savings. An alternative or complementary channel could be increased income net of alcohol expenditures, either due to reduced overall alcohol expenditures or increased earnings. This section considers the contribution of these channels to the increase in savings. I estimate this contribution to be about one half of the treatment effect on savings, and attribute the remaining share to a change in preferences.

4.4.1 Estimating the Marginal Propensity to Save

Assessing the contribution of increased resources requires knowledge of the marginal propensity to save out of additional resources, which the lottery allows me to estimate. Table 9 shows regressions of the daily amounts saved on a dummy for the pooled alcohol treatment as well as the amount won in the lottery on the previous day, and interactions of the treatment dummies with the lottery amount.[34] These regressions show a marginal propensity to save of 0.15 to 0.21 in the Control Group, and 0.36 to 0.37 in the pooled alcohol treatment groups. The below calculations use the marginal propensity to save from the Control Group in the preferred specification in column 4 of Table 9.

The estimates in Table 9 provide additional suggestive evidence that increasing sobriety affected time preferences. While the difference is not statistically significant, the estimated marginal propensity to save is higher (0.37, statistically significant at the 5 percent level) for the two groups that received sobriety incentives compared to the Control Group (0.21, not significant). Importantly, this difference is unlikely to be explained by the aforementioned confounds or increases in overall resources, since they are conditional on participating in the lottery.

[34]The regressions also control for whether the lottery was conducted on the previous day.

4.4.2 The Effect of Reduced Alcohol Expenditures on Savings

Cycle-rickshaw peddlers spend a large fraction of their income on alcohol, on average, about Rs. 100 per day. Hence, even relatively small reductions in alcohol consumption can significantly increase the overall resources available. The above estimates find that the two treatments decreased alcohol expenditures by between Rs. 4.7 (using the implied expenditure reduction based on the reported physical quantities consumed) to Rs. 8.7 per day (using the estimate from reported expenditures). Combining these estimates with the estimated marginal propensity to save from available resources of 0.21 in the Control Group (column 4 of Table 9) implies that reduced alcohol expenditures account for Rs. 1.0 to Rs. 1.8 of the increase in savings.[35]

4.4.3 The Effect of Increased Earnings on Savings

Alcohol consumption may interfere with individuals' ability to earn income.[36] In addition to reduced alcohol expenditures, the treatments may have affected available resources via increased earnings. However, while positive, I estimate the effect of sobriety incentives on earnings to be relatively small and statistically insignificant, with a point estimate for the pooled treatment effect of Rs. 17.8 per day (columns 1 through 3 of Table 10.) Combined with the marginal propensity to save from above, this estimate implies that increased earnings account for Rs. 3.7 in increased savings. Similarly, the estimates on labor supply are relatively small and not statically significant (columns 4 through 9 of Table 10). In fact, the estimates of the treatment effect on labor supply at the extensive margin (i.e. whether an individual worked at all on any given day) is negative (columns 4 through 6). In contrast, the estimates on hours worked overall are positive in most specifications (columns 7 and 9).

Importantly, the estimates from this paper do *not* imply that alcohol does not have important effects on labor market outcomes for at least three reasons. First, the estimates in Table 10 are relatively imprecise. Since, while large in relative terms, the effect of incentives

[35] I use the estimated marginal propensity from the Control Group since the purpose of this exercise is to understand the effect of increased resources for *given* preferences, i.e. under the null hypothesis of unchanged preferences.

[36] Irving Fisher (1926) was among the first to investigate the relationship between alcohol and productivity. Based on small-sample experiments by Miles (1924) that showed negative effects of alcohol on typewriting efficiency, he argued that drinking alcohol slowed down the "human machine". He also argued that industrial efficiency was one of the main reasons behind the introduction of alcohol prohibition in the US. While many studies since Fisher (1926) have considered the relationship between alcohol consumption, income, and productivity (for an overview, see Science Group of the European Alcohol and Health Forum (2011)), there is a dearth of well-identified studies of the causal effect of alcohol on earnings and productivity, especially in developing countries. Cook and Moore (2000) summarized the literature as follows: "Modern scholars studying productivity effects have enjoyed larger sample sizes but unlike Fisher have utilized non-experimental data. The typical econometric study estimates the productivity effects of drinking, utilizing survey data in which respondents are asked about their drinking, work, income, and other items. The dependent variable is a measure of earnings or hours worked, while the key independent variable is a measure of the quantity or pattern of contemporaneous drinking, or alcohol-related psychiatric disorder (alcohol dependence or abuse)."

on daytime drinking is only moderate in absolute terms (13 percentage points), I cannot rule out large effects of daytime drinking on labor market behavior. Thus a more powerful intervention to reduce daytime drinking would have caused larger effects. Second, the impact of reduced drinking in the medium or long run might be much larger than the short-run effects considered in this paper. Third, the potentially negative impact of alcohol on productivity and labor supply via reduced physical or cognitive function may have been mitigated by analgesic effects of alcohol, which may not be the case in other settings.

4.5 Accounting for Mechanical Effects

Table 2 shows a decomposition of the effect of incentives on savings. This composition considers what share of the increase in savings is explained by mechanical effects, i.e. by individuals having increased resources for given preferences. The starting point in this decomposition is the estimate of Rs. 11.57 for the overall pooled treatment effect in column 8 of Table 8 (which controls for study payments). From this effect, I subtract the contribution of the two effects described above: (i) the contribution of reduced alcohol expenditures, and (ii) the contribution of increased earnings. This leaves an unexplained treatment effect of Rs. 6.00, i.e. about half of the overall treatment effect, and about 29% of control group savings. I attribute this share of the increase in savings to the effect of increased sobriety on time preferences. This argument is further supported by the next section, which shows evidence that sobriety incentives and commitment savings are substitutes.

Table 2: Decomposing the Impact of Incentives on Savings

Estimated overall treatment effect	**Rs. 11.57**
Resource effect 1: reduced expenditures	Rs. 1.83
Resource effect 2: increased earning	Rs. 3.74
Remaining treatment effect	**Rs. 6.00**

4.6 Household Resources and Complementary Consumption

This subsection addresses two additional concerns regarding the above findings. First, the increase in savings at the study office due to increased sobriety may have come at the cost of reduced household resources. Second, reduced alcohol consumption during the day or overall may have lowered complementary consumption such as smoking.

4.6.1 Household Resources

The increase in savings due to the incentives treatments does not appear to have crowded out money spent on family resources (Table A.4). While not statistically significant, I find that sobriety incentives *increased* money given to wives by about Rs. 17.4 (columns 1 through 3). In contrast, resources spent on other family expenses decreased by about Rs. 8.9 (columns 4 through 6) such that reported resources spent on family expenses overall increased by about Rs. 8.6 (columns 7 through 9).

4.6.2 Food Expenditures and Complementary Consumption

I find no evidence of the treatment affecting expenditures on other goods (Table A.5). Expenses on food outside of the household increased slightly by about Rs. 4 (columns 1 through 3), and reported expenditures on coffee and tea remained constant (columns 4 through 6; these may be underreported altogether). Of particular interest are expenses on tobacco products as they are often thought of as complements to alcohol (Room 2004). However, there is no evidence of such effects (columns 7 through 9). This is not particular surprising in the light of the facts that reported expenditures on tobacco and paan[37] products are low to start with, and the incentives reduced overall alcohol expenditures only moderately, hence limiting the scope of effects through complementarities in consumption.

5 Are Sobriety and Commitment Savings Substitutes?

The structure of the experiment allows for an additional test of the hypothesis that increasing sobriety lowers self-control problems. The intuition for this test is straightforward. If self-control problems prevent individuals from saving as much as they would like to, and if commitment savings products help sophisticated individuals overcome these problems, then commitment savings should have a larger effect for individuals with more severe self-control problems. Hence, if alcohol reduces self-control, then increasing sobriety should lower the effect of commitment savings. However, this intuition overlooks an additional, opposing effect. While commitment savings products may help individuals overcome self-control problems in future savings decisions by preventing them from withdrawing their savings prematurely, the immediate decision to save always requires incurring instantaneous costs. A sophisticated individual with severe self-control problems may not save (much) even if a commitment savings product is offered, simply because he does not put much weight on future consumption. In the extreme case, for β close to zero, the individual will not save regardless of the availability of a commitment option.

[37] Paan is a mixture of ingredients including betel leaf, areca nut, and often tobacco. Chewing paan is popular in many parts of India.

This section shows a simple model that formalizes this intuition. I then consider a specific case (isoelastic utility) to demonstrate two features of this model. First, the impact of commitment savings is an inverse-U shaped function in present bias for sophisticated individuals. The impact of commitment savings devices on savings is lowest for individuals without present bias ($\beta \approx 1$) and for the most present-biased individuals ($\beta \approx 0$). At least in theory, for individuals with the greatest need to overcome self-control problems, commitment savings devices in the form in which they are often offered may only be moderately helpful (if at all).[38] Second, for the empirically relevant parameter range of $\beta > 0.5$, an increase in β lowers the impact of commitment savings on savings. Accordingly, a decrease in the impact of commitment savings due to increased sobriety, as demonstrated in Section 5.2, can be viewed as evidence for increased self-control due to increased sobriety.

5.1 A Simple Model

Consider a simple consumption-saving problem. A consumer lives for three periods. In Period 1 he receives an endowment Y_1. There are no other income sources in Periods 2 and 3, but the consumer is paid a matching contribution of M times the amount saved by the start of Period 3. In Periods $t = 1, 2$, he has to decide how to allocate his available resources into instantaneous consumption c_t or savings. The instantaneous utility function $u(c_t)$ is increasing and concave: $u'(\cdot) > 0$ and $u''(\cdot) < 0$. The consumer has β-δ time preferences as in Laibson (1997), with $\delta = 1$ for simplicity and $\beta \in (0, 1]$. The individual is sophisticated in the O'Donoghue and Rabin (1999) sense. He understands the extent of future self-control problems, i.e. he knows his future β. There is no uncertainty. In Period 1, he maximizes $U_1(c_1, c_2, c_3) \equiv u(c_1)+\beta[u(c_2)+u(c_3)]$ and in Period 2 he maximizes $U_2(c_2, c_3) \equiv u(c_2)+\beta u(c_3)$.

No commitment savings. Consider first a situation without commitment savings. We solve the problem recursively. In Period 3, the individual will consume the entire amount saved plus the matching contribution: $c_3 = (Y_1 - c_1 - c_2)(1 + M)$. In Period 2, the individual takes c_1 as given and maximizes

$$\max_{c_2} \; u(c_2) + \beta u((Y_1 - c_1 - c_2)(1 + M)) \tag{1}$$

The associated FOC is $u'(c_2) = \beta(1 + M)u'((Y_1 - c_1 - c_2)(1 + M))$. This choice is anticipated

[38] Note that interventions designed along the lines of the Save More Tomorrow program (Thaler and Benartzi 2004) overcome this problem, since it allows individuals to commit to saving more without reducing today's consumption.

in Period 1 such that the individual chooses c_1 to solve the following problem:

$$\max_{c_1} u(c_1) + \beta[u(c_2) + u(c_3)] \tag{2}$$

$$\text{s.t.} \quad c_3 = (Y_1 - c_1 - c_2)(1 + M) \tag{3}$$

$$u'(c_2) = \beta(1 + M)u'(c_3) \tag{4}$$

$$c_1, c_2, c_3 \geq 0 \tag{5}$$

Defining $Y_2 \equiv Y_1 - c_1$, the solution is described by the following three equations.

$$u'(c_1) = \beta \left[u'(c_2)\frac{dc_2}{dY_2} + u'(c_3)\frac{dc_3}{dY_2} \right] \tag{6}$$

$$u'(c_2) = \beta(1 + M)u'(c_3) \tag{7}$$

$$c_3 = (Y_2 - c_2)(1 + M) \tag{8}$$

Combining these equations yields a version of the familiar modified Euler equation (Harris and Laibson 2001):[39]

$$u'(c_1) = \left[\beta\frac{dc_2}{dY_2} + \left(1 - \frac{dc_2}{dY_2}\right) \right] u'(c_2) \tag{9}$$

Commitment savings. Consider now the situation in which a commitment savings account is available. That is, any money that is saved in Period 1 cannot be withdrawn until Period 3. Period 1 self would like to set $u'(c_2) = (1+M)u'(c_3)$. However, in the absence of commitment savings, Period 2 self deviates from this, i.e. chooses c_2 such that $u'(c_2) = \beta(1+M)u'(c_3)$ and, hence, consumes more than the Period 1 self would like him to. This creates a demand for commitment for Period 1 self. Since the Period 1 self is always (weakly) more patient than the Period 2 self, this implies that the solution to this problem is simply the case in which the Period 1 self determines consumption in all three periods. The individual will consume c_1 and deposit c_3 into the commitment savings account such that $u'(c_1) = \beta u'(c_2) = \beta(1+M)u'(c_3)$, subject to the above budget constraint. Hence, the solution is described by the following equations:

$$u'(c_1) = \beta u'(c_2) \tag{10}$$

$$u'(c_2) = (1 + M)u'(c_3) \tag{11}$$

$$c_3 = (Y_2 - c_2)(1 + M) \tag{12}$$

Comparing the two above solutions clarifies the relationship between present bias and

[39] In contrast to Harris and Laibson (2001), there is no interest rate in this equation since M is a matching contribution rather than an interest rate.

commitment savings. Introducing a commitment savings option increases savings iff $0 < \beta < 1$, since the commitment savings device makes both the Period 1 and 2 selves consume a smaller share of their available resources Y_1 and Y_2, respectively. If $\beta = 1$, commitment savings has no effect as there is no discrepancy between the Period 1 and Period 2 preferences. At the other extreme, if $\beta \to 0$, there are no savings even if commitment is available such that there is no impact of the commitment device on savings choices either.[40] Taken together, this implies that the impact of commitment savings is non-monotonic in present bias.

For $\beta \in (0, 1)$, changing β has two opposing effects on the impact of commitment on savings. The first effect is that, in the absence of commitment, the Period 2 self will deviate more from the allocation that maximizes Period 1 self's utility (by increasing c_2 relative to c_3). This not only reduces Period 2 self's savings for given resources, but it also reduces Period 1 self's saving as he anticipates this effect. In contrast, in the presence of the commitment device, the Period 1 self can prevent this from happening by saving the desired amount using the commitment device. Hence, the impact of the commitment device on savings is larger for increased present bias due to this effect. However, there is a second, opposing effect. Since Period 1 self's β also decreases, the desire to allocate resources to Periods 2 and 3 falls even if a commitment savings option is available. This lowers the impact of offering the commitment savings option. In the extreme case for $\beta \to 0$, there is no effect.

Solving for the isoelastic case. Consider the case of the commonly used isoelastic utility function.

$$u(c_t) = \begin{cases} \frac{c_t^{1-\gamma}}{1-\gamma} & \text{if } \gamma \neq 1, \\ \log(c_t) & \text{if } \gamma = 1. \end{cases} \tag{13}$$

The impact of commitment savings on savings is given by the difference in consumption levels in period 3 with and without commitment (see Appendix Section A.1 for details).

$$\Delta \equiv c_3^{\mathrm{C}} - c_3^{\mathrm{NC}} = \frac{Y(1+M)}{1+\theta+\theta\left[\frac{1+\beta\theta}{1+\theta}\right]^{\frac{-1}{\gamma}}} - \frac{Y(1+M)}{1+\theta+(1+M)^{1-\frac{1}{\gamma}}}. \tag{14}$$

Figure 5 depicts Δ as a function of β for different values of γ. For the empirically relevant ranges of $\beta \in [0.5, 1]$ and $\gamma > 0.5$, a decrease in present bias, i.e. an increase in β, lowers the impact of commitment savings devices on savings.[41] This implies that an increase in sobriety (which lowers the use of commitment savings in my experiment) is effectively equivalent to an increase in β.

[40] Subsistence levels in consumption could change this in the absence of income sources in Periods 2 and 3.

[41] See, for instance, Frederick et al. (2002) for a review of estimates of present bias, and Chetty (2006) for estimates of γ.

5.2 Empirical Evidence

In my study, increasing sobriety and commitment savings are substitutes in terms of their impact on savings. Figure 6 shows cumulative savings by the (pooled) sobriety treatment and the cross-randomized savings conditions.[42] In the upper panel of the figure, individuals are divided into four groups according to whether they were offered sobriety incentives—pooling the Incentive and Choice Groups—and whether their savings option included the cross-randomized Commitment Savings feature.[43] Cumulative savings for the four groups are nearly identical through the pre-incentive period until day 4, and throughout the study, three of the four lines in the graph remain nearly indistinguishable. However, the group that received neither commitment savings nor the alcohol treatment (as represented by the green line with solid circles) saved much less than each of the remaining groups subsequently. While both incentives for sobriety and the commitment savings option have a large impact on savings, being assigned to both does not further increase savings.

These differences across treatment groups are due to differences in both deposits and withdrawals (Figure 7). Compared to the group without either incentives for sobriety or commitment savings, sobriety incentives and commitment savings each on their own increased deposits (upper panel), and reduced withdrawals (lower panel). The magnitudes of these effects vary slightly. The effect of sobriety incentives on deposits is somewhat larger than the effect of commitment savings, but this difference is offset by an equivalent difference in withdrawals resulting in nearly identical overall savings.

These results suggest that increasing sobriety reduced self-control problems. An alternative interpretation could be that alcohol is a key temptation good for this population such that reducing alcohol consumption mitigates the need for commitment savings. However, given that the intervention only moderately reduced overall alcohol consumption and expenditures, this channel is unlikely.

A second competing explanation could be that there was an upper bound of how much individuals were able to or wanted to save. However, average daily savings are well below the savings limit of Rs. 200 per day. Moreover, in the course of the study, all individuals received relatively large study payments in addition to their earnings outside of the study, which appear to have been largely unaffected by the study. This suggests that the majority of individuals would have been able to increase their savings if they had preferred to do so. Consistent with this, increasing the matching contribution rate did *not* serve as a complement to increased sobriety, i.e. the effects of incentives for sobriety and a high matching contribution

[42]The two sobriety treatments are pooled solely for expositional purposes. The equivalent graphs without pooling the sobriety treatment groups show only very minor differences in savings behavior between the Incentive and Choice Groups (Figure A.6).

[43]For instance, the blue line with squares shows cumulative savings for individuals who were not offered incentives for sobriety, but who were given the commitment savings options.

appear to have been additive (lower panel of Figure 6).

6 Do Individuals Want to Reduce Their Drinking?

Given the above short-term costs and other longer-run costs of alcohol consumption, a natural question to ask is whether individuals are aware of the costs of alcohol consumption. In particular, if these costs exceed the benefits of drinking, why are individuals not reducing their consumption? This section considers the extent to which self-control problems contribute to individuals' demand for receiving incentives for sobriety. After receiving incentives for three days, individuals in the Choice Group were asked to choose between incentives to arrive sober and different amounts of unconditional payments. Individuals in the Choice Group first made these choices at the beginning of Phase 3 (day 7), and then again at the beginning of Phase 4 (day 13). Finally, regardless of experimental condition, all study participants were given the same choices at the end of Phase 4 (day 20). This structure allows me to investigate whether individuals in the Choice Group changed their choices over time, and whether receiving incentives in earlier phases of the study affected individuals' demand for commitment. During each choice session, individuals chose their incentive structure for the subsequent six study days.[44]

The demand for incentives was high, even when choosing incentives entailed a potential (Choice 2) or certain (Choice 3) reduction in overall study payments (upper panel of Figure 8 and Table A.7). More than one third of individuals in the Choice Group preferred sobriety incentives over receiving Rs. 150 regardless of their breathalyzer scores, and in each week, over 50 percent of individuals chose incentives over receiving Rs. 120 unconditionally. Holding attendance constant, this choice implied losses of Rs. 30 ($0.50) in study payments at the minimum (on days when the individual visits the study office sober) and Rs. 90 ($1.50) at the maximum (on days when the individual visits the study with a positive breathalyzer score). These amounts are economically meaningful, representing between 10 and 30 percent of reported daily labor earnings. Moreover, the fraction of individuals choosing sobriety incentives over Rs. 150 unconditionally did not decline over time. Instead, though not statistically significant, it in fact increased slightly over the course of the study.

[44] Attrition and inconsistencies of preferences during the choice session cause relatively minor concerns for the below analysis (Table A.6). In the Choice Group, less than 7 percent of individuals missed their choices in any given week, and, in each week, less than 7 percent of individuals stated inconsistent preferences. Furthermore, over 88 percent of all study participants completed the endline choices with consistent choices. This fraction varies only slightly across treatment groups (90.1 in the Incentive Group and 88.0 in the Choice Group vs. 86.7 in the Control Group). In an attempt to be conservative regarding the demand for commitment in Figure 8 and Table A.7, an individual is counted as not choosing incentives in any given choice when he did not attend the respective choice session or when he attended, but made inconsistent choices. The below regressions in Tables 12 and 13 are conditional on attendance. The analysis is robust to alternative specifications.

Subjects' choices provide clear evidence of self-control problems. In particular, the fraction of individuals who exhibited costly demand for commitment was larger than found previously for smoking (Gine et al. 2010) or exercising (Royer et al. 2014). A growing literature has demonstrated demand for commitment in a number of domains.[45] However, with the exceptions of Beshears et al. (2011) and Milkman et al. (2014), there is little existing evidence that individuals are willing to pay for commitment beyond the potential costs of failing to achieve the behavior they are committing to.[46] In my study, about a third of subjects made choices that implied significant losses in study payments even in the best case of visiting the study office sober every day.

Moreover, Table 12 shows the relationship between the number of sober days in each phase of the study and the demand for sobriety incentives. Individuals who visited the study office sober more often in the incentivized Phase 2 were subsequently more likely to choose incentives for all three unconditional amounts. This is not surprising since expected study payments from choosing incentives were higher if a study participant was more likely to visit the study office sober. In contrast, the difference in sobriety between Phase 2 (when some individuals were receiving incentives) and Phase 1 (the pre-incentive period) positively predicts demand *only* for costly incentives (i.e. when the unconditional payment is Rs. 150). This is reassuring since individuals should have chosen costly incentives only when they expected them to help increase their sobriety, which in turn should have been informed by their own experience in the study.

Exposure to incentives for sobriety increased the demand for the incentives (lower panel of Figure 8). For all three choices, the Incentive Groups were more likely to choose incentives than the Control Group. The fraction of individuals choosing incentives in the Choice Groups (on day 20) was in between the corresponding fractions in the Incentive and Control Groups. The corresponding regressions show significant differences between the fraction choosing incentives in the Incentive and Control Groups for all three choices (Table 13). These differences are not explained by differences in sobriety while making these choices, or by differences in expectations of future sobriety under incentives. Before preferences were elicited, individuals were asked how often they expected to visit the study office sober if they

[45] For instance, Ashraf et al. (2006) and Beshears et al. (2011) on commitment savings; Gine et al. (2010) on smoking cessation; Kaur et al. (2014) on self-control at the workplace; Ariely and Wertenbroch (2002), Augenblick et al. (2014), and Houser et al. (2010) on effort tasks; and Royer et al. (2014) and Milkman et al. (2014) for gym attendance. See Bryan et al. (2010) and Augenblick et al. (2014) for overviews.

[46] A large number of studies in the psychology literature have associated excessive alcohol consumption with survey measures of (lack of) self-control, behavioral undercontrol, and susceptibility to temptation (Hull and Slone 2004). In addition, the existence of and demand for disulfiram (Antabuse) can be viewed as evidence of self-control problems causing alcohol consumption (Glazer and Weiss (2007), Bryan et al. (2010)). However, evaluations of disulfiram treatment for alcohol dependence have shown inconsistent findings, in a large part because of low treatment adherence as in Fuller et al. (1986). Studies evaluating incentives to increase compliance (O'Farrell et al. 1995) and a combination of disulfiram with other medication to reduce cravings or withdrawal symptoms such as naltrexone or acamprosate have found more promising results (Suh et al. 2006), but do not necessarily show evidence of demand for commitment and, hence, self-control problems.

were to be given incentives for sobriety. Reassuringly, subjects' beliefs about their expected sobriety under incentives strongly predicts demand for incentives. Finally, higher sobriety during the time of choosing predicts a higher probability of choosing incentives.

The above findings raise the question why so many study participants exhibited the demand for commitment despite the fact that overall drinking only fell moderately. Several, not mutually exclusive explanations are possible. First, the above estimates suggest that incentives for sobriety caused several small benefits, which taken together may well exceed Rs. 30. On average, though not statistically significant, sobriety incentives increased reported earnings by about Rs. 17.6), and reduced reported alcohol expenditures by about Rs. 8.7. Moreover, as shown above, savings increased significantly. Increasing sobriety may have also improved other decisions, and individuals may have valued daytime sobriety on its own despite potentially increased disutility of work due to increased physical pain.

Second, partial naïveté may have contributed to the demand for commitment. On the one hand, underestimating the extent of their self-control problems due to partial or full naïveté as in O'Donoghue and Rabin (1999) may lower the demand for (costly) commitment by decreasing the perceived benefits of commitment (Laibson 2015). On the other hand, partial naïveté can also increase the demand for commitment by causing individuals to overestimate the effectiveness of commitment devices in overcoming their self-control problems.[47] In the context of my study, while being aware of their own self-control problems, some individuals may have overestimated the usefulness of the incentives for sobriety in reducing their daytime or overall drinking.

7 Conclusion

This paper provides evidence that self-control problems may not only cause undesired alcohol consumption, but that alcohol itself exacerbates present bias, and hence creates further self-control problems in other domains. Increasing sobriety during the day causes a stark increase in individuals' savings at the study office. I provide evidence that this increase was not just the result of mechanical effects from increased resources, but due to lowered self-control problems in savings decisions as a consequence of decreased myopia. Taken together, these results imply that effective commitment devices for sobriety not only help individuals reduce undesired alcohol consumption, but also lessen self-control problems caused by alcohol. More generally, the results suggest that alcohol changes decision processes in a way that may reinforce poverty.

A significant fraction of cycle-rickshaw peddlers in a large Indian city were willing to sacrifice money for commitment to increase sobriety during the day, indicating a greater

[47]For a more detailed treatment of this argument and an application in the savings domain, see John (2014).

awareness of and willingness to overcome self-control problems than found in most other settings. This high prevalence of self-control problems suggests that "sin taxes" could be an attractive policy option (Gruber and Kőszegi (2001), O'Donoghue and Rabin (2006)). Given the negative correlation of alcohol consumption and income, such taxes may be regressive. However, the regressiveness of taxation may be mitigated if consumers have self-control problems. Gruber and Kőszegi (2004) show that "sin taxes" can even be progressive (in particular in the utility domain) if poor individuals are more price-elastic and/or are more present-biased compared to rich individuals. The results from this study suggest that the regressiveness of taxing alcohol may be further lessened due to effects of reduced drinking on earnings and savings. However, given that the price elasticity of the demand for alcohol in this setting is below unity, increasing taxes would further reduce individuals' – and therefore many families' – already low income net of alcohol expenditures, unless the effects of reduced drinking on earnings turn out to be particularly large.[48]

A second, more extreme policy option could be prohibition, as already implemented in several Indian states such as Gujarat. Prohibition may be a particularly attractive policy option for India and other developing countries compared to developed countries since the distribution of alcohol consumption is heavily skewed, with the majority of the population abstaining from alcohol and a relatively large share among the drinkers consuming alcohol excessively. However, enforcement of prohibition is known to be difficult and may result in other unintended consequences such as crime and corruption (Thornton 1991). Moreover, many Indian state governments heavily depend on excise taxes, which makes the implementation of prohibition difficult. Given these concerns, second-best policies aimed at reducing the costs of inebriation by shifting critical decision away from drinking times could be welfare-improving even if they do not change overall drinking levels.

[48]In most other studies, the price elasticity of alcohol consumption has been found to be below unity, and heavy drinkers' price response tends to be particularly small (Manning et al. 1995). For an overview, see Wagenaar et al. (2009).

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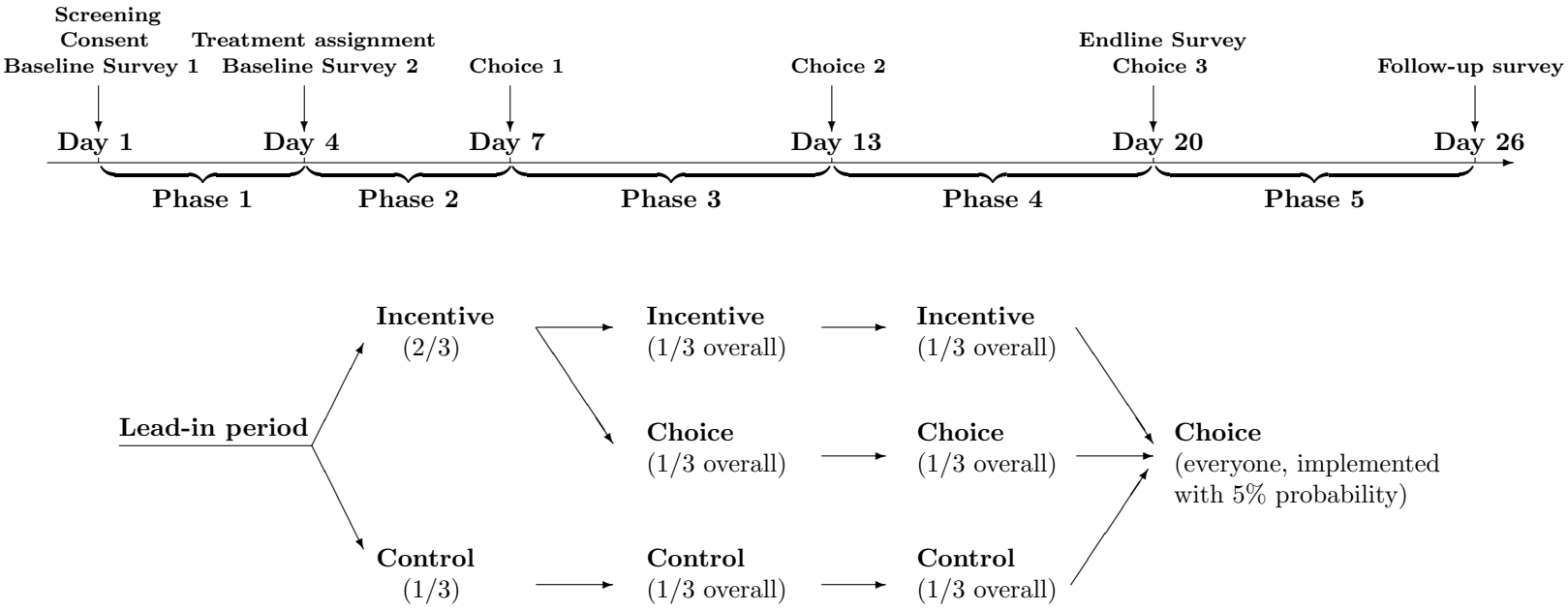
Figure 1: Experimental Design



Notes: This figure gives an overview of the experimental design and the timeline of the study.

1. On day 1, individuals responded to a screening survey. Interested individuals then gave informed consent upon learning more about the study. Regardless of the consent decision regarding participation decision in the full study, all individuals were asked to complete a baseline survey, for which a separate consent was elicited.

2. On day 4, individuals who passed the lead-in period (Phase 1) completed a second baseline survey, and were then informed of their treatment status. On this day, individuals were fully informed about their payment structure and the decisions to be made over the course of the study.

3. The payments for the three treatment groups were as follows.

   (i) The Control Group was given the same unconditional payments as in Phase 1 (Rs. 90 regardless of breathalyzer score).

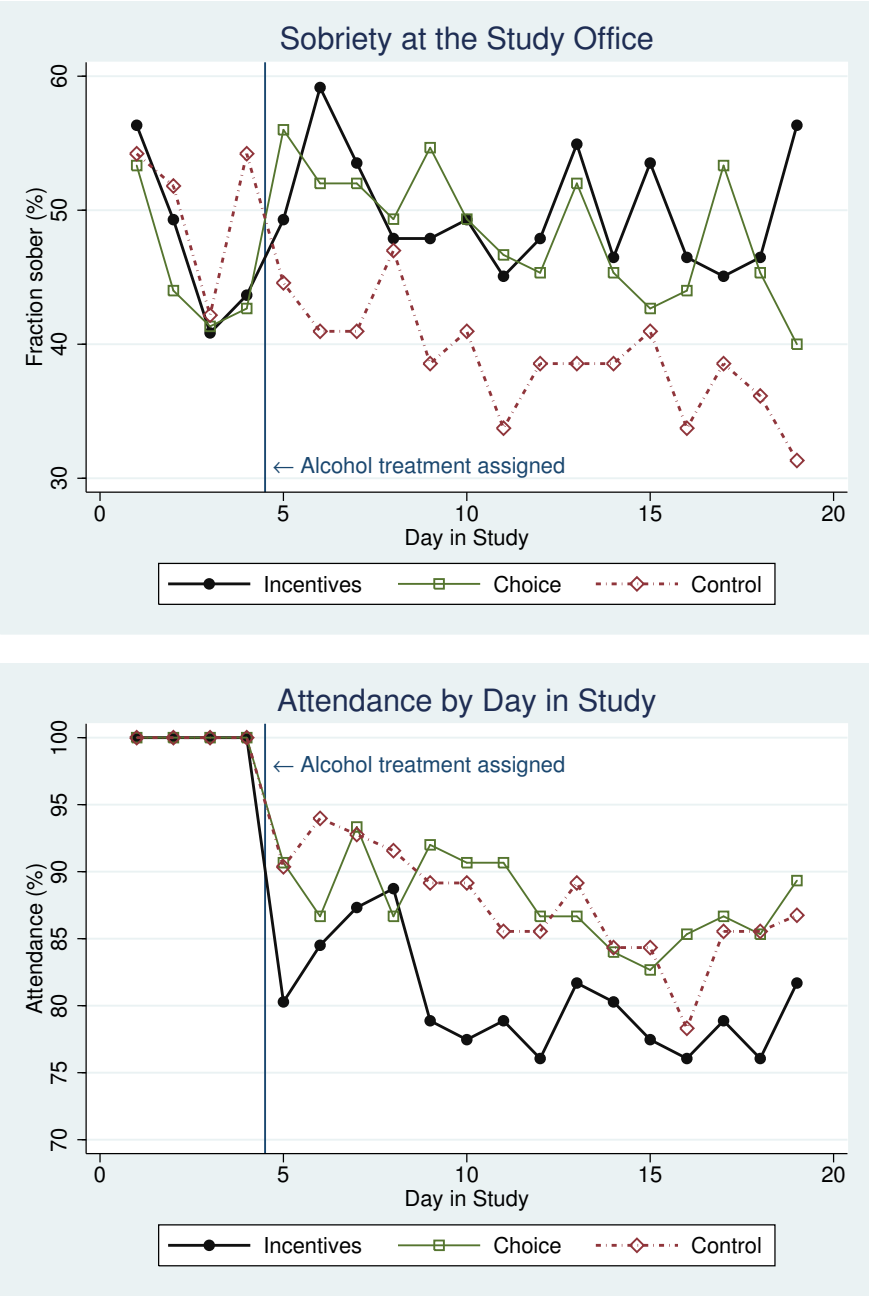
   (ii) Study payments for the Incentive Group depended on the breathalyzer score starting with day 5 of the study (Rs. 60 if BAC $>$ 0, Rs. 120 if BAC $=$ 0).

   (iii) After facing the same payment schedule as the Incentive Group in Phase 2, the Choice Group was asked to choose whether they wanted to continue receiving these incentives, or whether they preferred payments that did not depend on their breathalyzer scores. These choices were made on days 7 and 13, each for the subsequent week.

4. On day 20, all individuals were asked to participate in an endline survey. No incentives for sobriety were given on this day. *All* individuals were then given the same choices between conditional and unconditional payments as individuals in the Choice Group on days 7 and 13. To ensure incentive compatibility, these choices were then implemented for a small subset (5 percent) of study participants.

5. One week after their last day in the study, individuals were visited for a follow-up survey including a breathalyzer test.

Figure 2: Sobriety and Attendance by Alcohol Incentive Treatment Group



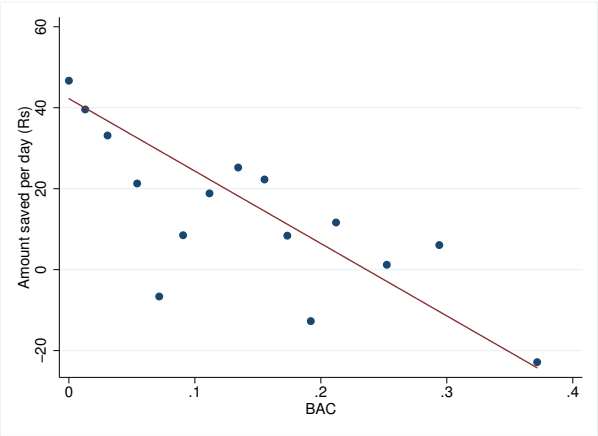
Notes: This figure shows sobriety and attendance over the course of the study for each of the three sobriety incentive treatment groups.

1. The upper panel of this figure shows the fraction of individuals who visited the study office sober. The indicator variable 'sober at the study office' takes on the value '1' for a study participant on any given day of the study if he (i) visited the study office on this day, *and* (ii) his breathalyzer test was (exactly) zero. The variable is, hence, '0' for individuals with a positive breathalyzer or those who did not visit the study office on this day.

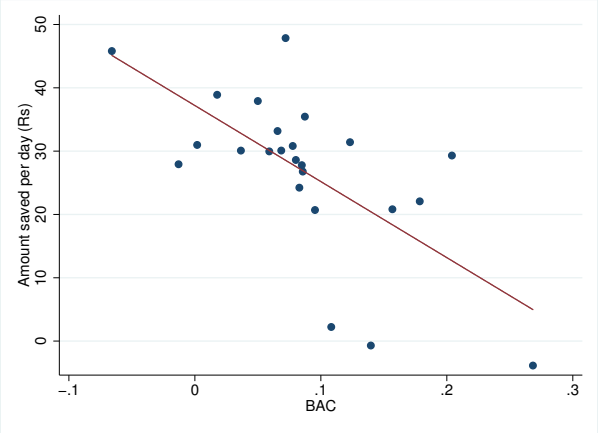
2. The lower panel of the figure shows the fraction of individuals who visited the study office. Since only individuals who came to the study office on days 2 through 4 were fully enrolled in the study, by construction, attendance is 100 percent on days 1 through 4.

Figure 3: Cross-sectional Relationship between Daily Amounts Saved and BAC

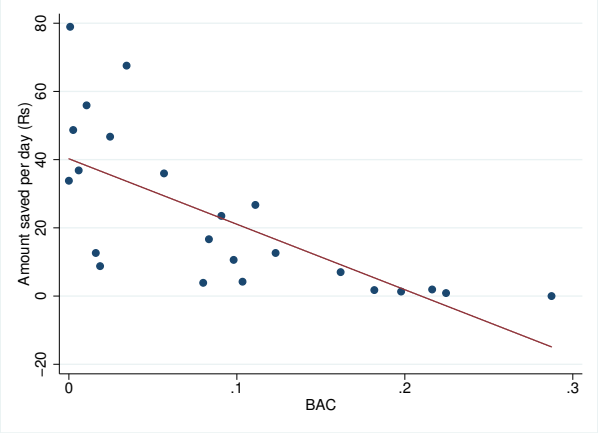
(a) Daily amount saved and BAC (no individual FE)



(b) Daily amount saved and BAC (individual FE)

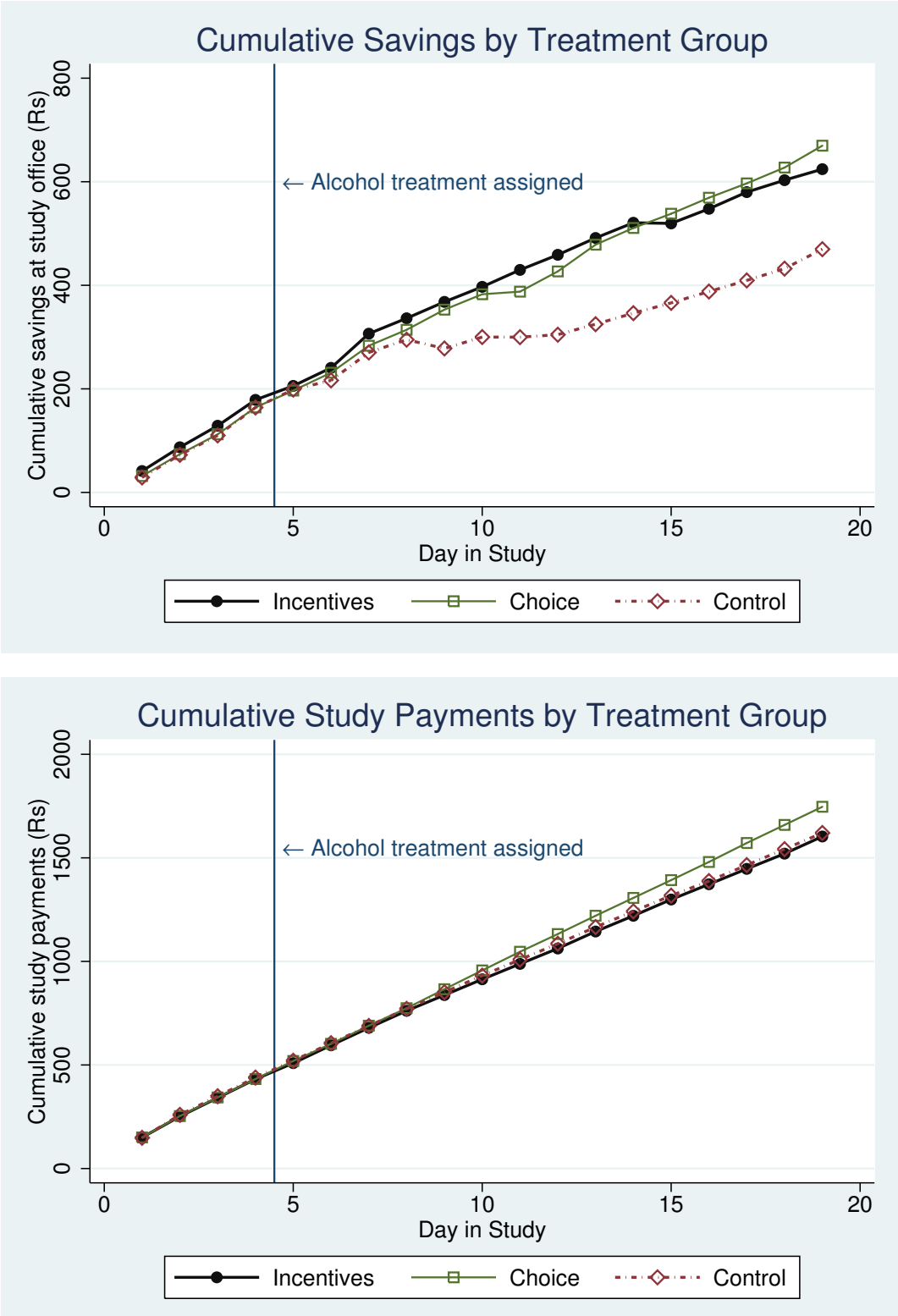


(c) Mean amount saved and mean BAC



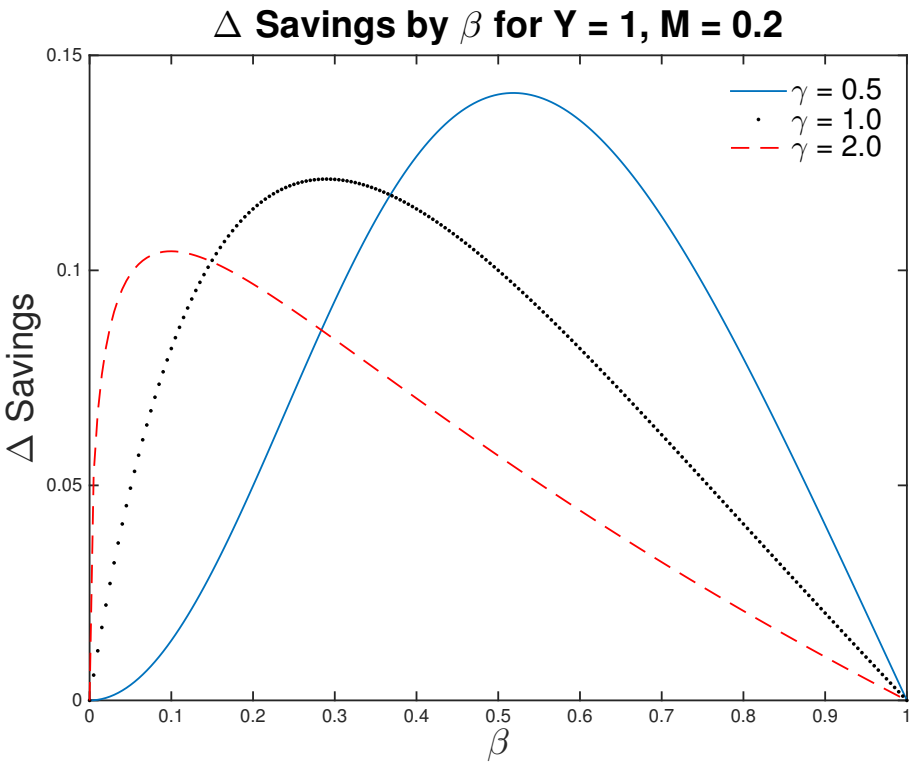
Notes: This figure shows the correlation between breathalyzer scores during study office visits and amounts saved at the study during the same visits for individuals in the Control Group. The top panel depicts a binned scatter plot (including regression line) for all observations in the Control Group. The center panel shows the same graph, controlling for individual fixed effects. The bottom panel depicts the correlation across study participants by collapsing observations by individual.

Figure 4: Cumulative Savings by Day in Study



Notes: This figure depicts subjects' cumulative savings at the study office (upper panel) and cumulative study payments (lower panel) by alcohol incentive treatment group.

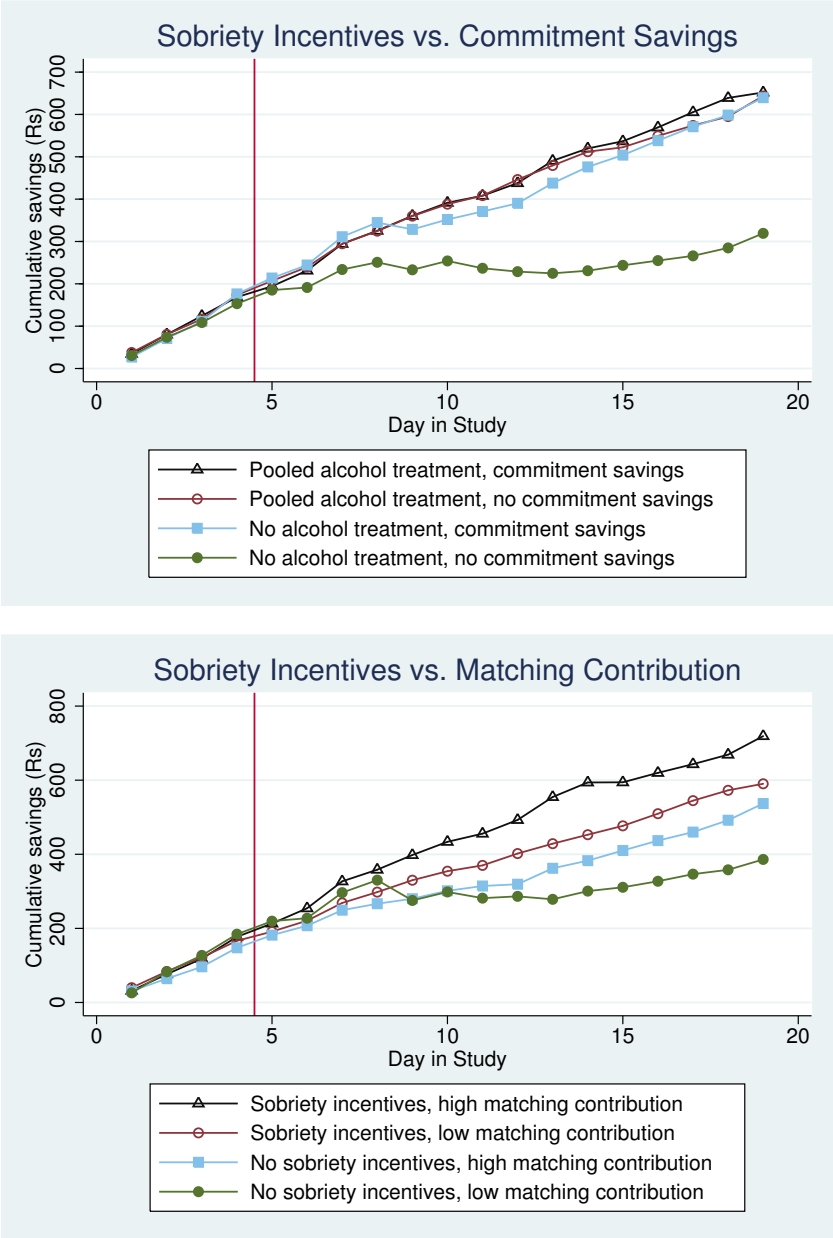
Figure 5: Effect of Commitment Savings as Function of β



Notes: This figure shows the relationship between present bias and the effect of commitment savings in the model described in Sections 5.1 and A.1.

1. The figure shows the present bias (as measured by $\beta \in [0, 1]$) on the horizontal axis and the increase in savings due to offering a commitment savings option on the vertical axis for the isoelastic utility case.
2. This increase in savings is given by the difference in consumption in period 3 between the two cases described in my model, i.e. $\Delta = c_3^{\text{C}} - c_3^{\text{NC}}$ as shown in equation (14).
3. The figure depicts the relationship between Δ and β for $\gamma = 0.5$ (the solid line), $\gamma = 1$ (the dotted line), and $\gamma = 2$ (dashed line).
4. In the specific figure shown here, $Y = 1$ and $M = 0.2$. The relationship is very similar, if not identical, for different parameter values. An explicit solution for Δ in the log case ($\gamma = 1$) is given in the Supplementary Appendix below.

Figure 6: Interaction between Sobriety Incentives and Savings Treatments



Notes: This figure shows the interaction between the cross-randomized sobriety incentives and savings treatments. The upper panel shows cumulative savings for four different groups: individuals who were offered

(i) neither sobriety incentives nor commitment savings (green line with solid circles),

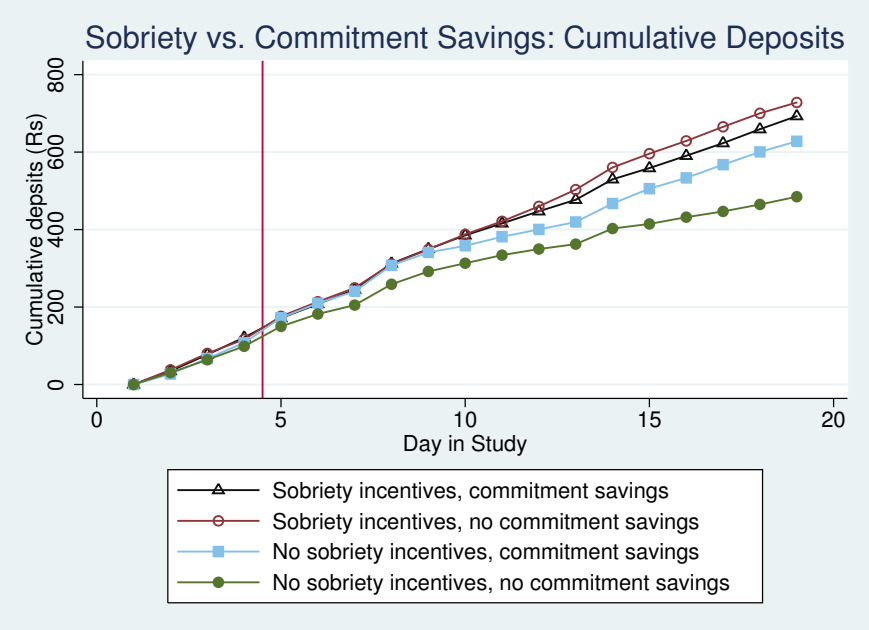
(ii) no sobriety incentives, but commitment savings (blue line with squares),

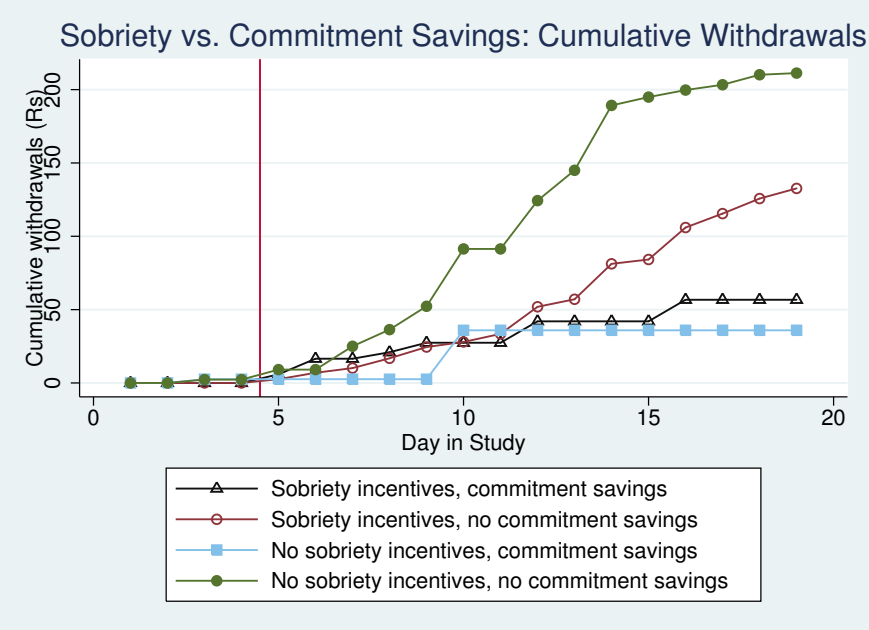
(iii) sobriety incentives, but not commitment savings (red line with hollow circles), and

(iv) both sobriety incentives and commitment savings (black line with triangles).

The lower panel of the figure shows the equivalent graph for the interaction between receiving sobriety incentives and a matching contribution (20 percent instead of 10 percent on the amount saved by day 20).

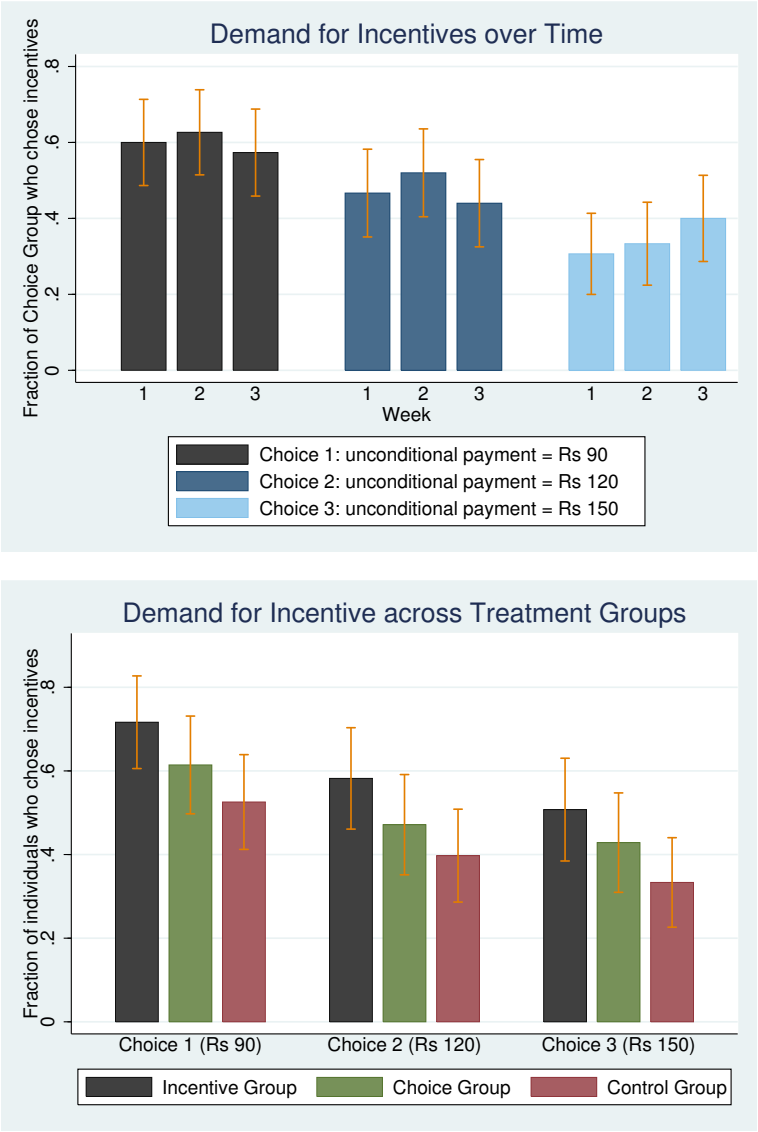
Figure 7: Sobriety Incentives vs. Commitment Savings: Deposits and Withdrawals





Notes: This figure splits up the results shown in the upper panel of Figure 6 into cumulative deposits (upper panel) and cumulative withdrawals (lower panel).

Figure 8: Choices Across Treatment Groups and Over Time



Notes: This figure depicts the fraction of individuals who preferred incentives for sobriety over unconditional payments.

1. All choices were made for the subsequent week, i.e. for the next six days in the study. Under incentives for sobriety, if an individual visited the study office, he received Rs. 60 ($1) if his breathalyzer score was positive, and Rs. 120 ($2) if his breathalyzer score was zero.

2. Unconditional payments are Rs. 90 (Choice 1), Rs. 120 (Choice 2), and Rs. 150 (Choice 3). Hence, an individual exhibited demand for commitment to sobriety if he chose incentives in Choices 2 and/or 3. At any point in time, individuals made all rickshaw peddlers three choices before one of these choices was randomly selected to be implemented.

3. If an individual did not complete the set of choices, or if he chose inconsistently, the observation is counted as *not* preferring incentives. During a given choice session, an individual chose inconsistently if he chose Option B for the unconditional amount Y_1, but Option A for the unconditional amount Y_2 with $Y_2 > Y_1$.

4. The upper panel of the figure shows how the fraction of individuals in the Choice Group who chose incentives evolved over time (i.e. on days 7, 13, and 20 of the study). The lower panel of the figure depicts the fraction of individuals who chose incentives on day 20 in the three treatment groups, i.e. it shows how previous exposure to incentives affected the demand for incentives. Error bars show 95 percent confidence intervals.

Table 3: Eligibility Status at Different Recruitment Stages

STAGE	FRACTION
(1) Field Screening Survey	
Eligible and willing to participate	**64%**
Not willing to conduct survey	14%
Drinks too little to be eligible	11%
Drinks too much to be eligible	1%
Ineligible for other reasons	3%
Eligible, but not interested	7%
(2) Office Screening Survey	
Eligible in Office Screening	**83%**
Ineligible for medical reasons	13%
Ineligible for other reasons	4%
(3) Lead-in Period	
Proceeded to enrollment	**66%**
Didn't proceed and BAC = 0 on day 1	19%
Didn't proceed and BAC > 0 on day 1	15%

Notes: This table gives an overview of the three-stage screening process of the study.

1. For each stage, it shows the fraction of individuals who were eligible and willing to proceed to the next stage of the study, the reasons for individuals not to proceed, and the relative frequencies of these reasons (each conditional on reaching the respective stage).

2. The tiers of the selection process are (1) the field screening survey (top panel), (2) the office screening survey (center panel), and (3) the lead-in period (bottom panel).

Table 4: Summary of Estimated Effect of Incentives on Alcohol Consumption

	Before/during visits			Overall drinking		
	Control	Change	%	Control	Change	%
Breathalyzer scores						
Fraction sober/abstinent	0.39	+0.13***	+33.3	0.10	+0.02	+19.0
BAC (%)	0.09	−0.03***	–33.3	–	–	–
Self reports						
# standard drinks	2.96	−0.98***	–33.1	5.65	−0.28	–5.0
Expenditures (Rs/day)	–	–	–	91.2	−8.7*	–9.5

Notes: This table gives an overview of the estimated treatment effects on sobriety before/during the study office visit (left panel) and overall alcohol consumption (right panel).

1. The table includes control means and estimated coefficients, both in absolute terms and as a share of the respective control mean.
2. The coefficients shown are from pooled estimates (i.e. pooling the Incentive and Choice Groups) from Table 5 (left panel) and Table 6 (right panel), including Phase 1 and baseline survey controls.
3. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively.

Table 5: The Effect of Incentives on Sobriety Before and During Study Office Visits

VARIABLES	(1) Sober	(2) Sober	(3) Sober	(4) Sober	(5) BAC	(6) BAC	(7) BAC	(8) BAC	(9) # Drinks	(10) # Drinks	(11) # Drinks	(12) # Drinks
Incentives	0.11*	0.13***	0.13***		-0.04***	-0.04***	-0.04***		-1.09***	-1.22***	-1.14***	
	(0.058)	(0.047)	(0.044)		(0.013)	(0.010)	(0.010)		(0.372)	(0.279)	(0.262)	
Choice	0.10*	0.13***	0.13***		-0.01	-0.02*	-0.02*		-0.76**	-0.86***	-0.84***	
	(0.058)	(0.041)	(0.043)		(0.015)	(0.010)	(0.010)		(0.375)	(0.246)	(0.255)	
Pooled alcohol treatment				0.13***				-0.03***				-0.98***
				(0.038)				(0.009)				(0.221)
Observations	3,435	3,435	3,435	3,435	2,932	2,932	2,932	2,932	2,932	2,932	2,932	2,932
R-squared	0.010	0.248	0.294	0.294	0.019	0.299	0.355	0.352	0.022	0.280	0.306	0.305
Baseline survey controls	NO	NO	YES	YES	NO	NO	YES	YES	NO	NO	YES	YES
Phase 1 controls	NO	YES	YES	YES	NO	YES	YES	YES	NO	YES	YES	YES
Control group mean	0.389	0.389	0.389	0.389	0.0910	0.0910	0.0910	0.0910	2.957	2.957	2.957	2.957

Notes: This table considers the effect of the two sobriety incentives treatments on sobriety before and during study office visits.

1. All regressions use data from day 5 (the first day of sobriety incentives) through day 19 (the last day of sobriety incentives) of the study.
2. The outcome variable in columns 1 through 4, sobriety at the study office, is an indicator variable that is "1" for an individual on a given day if he visited the study office on this day *and* had a zero breathalyzer score on this day, and "0" otherwise. That is, individuals who did not visit the study office on any given day are included in these estimates as "not sober at the study office".
3. Columns 5 through 12 are conditional on visiting the study office. The outcome variable in columns 5 through 8 is individuals' measured blood alcohol content from a breathalyzer test. The outcome variable in columns 9 through 12 is the reported number of drinks *before* visiting the study office on any given day.
4. Standard errors are in parentheses, clustered by individual. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively.
5. Phase 1 controls are the fraction of sober days, mean BAC during study office visits, the mean reported number of standard drinks consumed before coming to the study office and overall, and reported overall alcohol expenditures (all in Phase 1). Baseline survey control variables are all baseline survey variables shown in Tables A.1 through A.3.

Table 6: The Effect of Incentives on Overall Alcohol Consumption

VARIABLES	(1) # Drinks	(2) # Drinks	(3) # Drinks	(4) # Drinks	(5) No drink	(6) No drink	(7) No drink	(8) No drink	(9) Rs Exp	(10) Rs Exp	(11) Rs Exp	(12) Rs Exp
Incentives	-0.34	-0.20	-0.32		0.01	0.01	0.02		-10.27**	-8.12*	-8.01	
	(0.288)	(0.252)	(0.246)		(0.028)	(0.028)	(0.031)		(4.883)	(4.752)	(5.237)	
Choice	-0.35	-0.16	-0.25		0.02	0.01	0.02		-10.10**	-6.70	-9.31*	
	(0.344)	(0.261)	(0.269)		(0.029)	(0.028)	(0.030)		(4.986)	(4.274)	(4.747)	
Pooled alcohol treatment				-0.28				0.02				-8.71*
				(0.217)				(0.025)				(4.485)
Observations	2,932	2,932	2,932	2,932	2,932	2,932	2,932	2,932	2,932	2,932	2,932	2,932
R-squared	0.003	0.147	0.181	0.181	0.001	0.025	0.064	0.064	0.012	0.132	0.172	0.172
Baseline survey controls	NO	NO	YES	YES	NO	NO	YES	YES	NO	NO	YES	YES
Phase 1 controls	NO	YES	YES	YES	NO	YES	YES	YES	NO	YES	YES	YES
Control group mean	5.650	5.650	5.650	5.650	0.105	0.105	0.105	0.105	91.22	91.22	91.22	91.22

Notes: This table shows regressions of measures of *overall* alcohol consumption on indicator variables for the two sobriety incentive treatments.

1. All regressions use data from day 5 (the first day of sobriety incentives) through day 19 (the last day of sobriety incentives) of the study, conditional on visiting the study office.
2. The outcome variables are the reported overall number of standard drinks consumed per day (columns 1 through 4), abstinence from drinking altogether on a given day (columns 5 through 8), and reported alcohol expenditures (Rs. per day, columns 9 through 12).
3. Standard errors are in parentheses, clustered by individual. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively.
4. Phase 1 controls are the fraction of sober days, mean BAC during study office visits, the mean reported number of standard drinks consumed before coming to the study office and overall, and reported overall alcohol expenditures (all in Phase 1). Baseline survey control variables are all baseline survey variables shown in Tables A.1 through A.3.

Table 7: The Effect of Incentives on Attendance

VARIABLES	(1) Present	(2) Present	(3) Present	(4) Present	(5) Present
Incentives	-0.07*	-0.07*	-0.08	-0.08*	-0.06
	(0.043)	(0.043)	(0.053)	(0.042)	(0.069)
Choice	0.00	0.00	-0.05	0.00	0.04
	(0.036)	(0.035)	(0.049)	(0.035)	(0.055)
Fraction of sober days in phase 1		-0.04	-0.08		
		(0.040)	(0.064)		
Incentives X Fraction sober in Phase 1			0.02		
			(0.105)		
Choice X Fraction sober in Phase 1			0.12		
			(0.084)		
Amount saved in Phase 1 (divided by 100)				0.02***	0.04***
				(0.009)	(0.012)
Incentives X Amount saved in Phase 1					-0.01
					(0.025)
Choice X Amount saved in Phase 1					-0.02
					(0.014)
Observations	3,435	3,435	3,435	3,435	3,435
R-squared	0.009	0.011	0.015	0.025	0.027
Baseline survey controls	NO	NO	NO	NO	NO
Phase 1 controls	NO	NO	NO	NO	NO
Control group mean	0.875	0.875	0.875	0.875	0.875

Notes: This table shows regressions of daily attendance at the study office on indicators for the two sobriety incentive treatments.

1. All regressions use data from day 5 (the first day of sobriety incentives) through day 19 (the last day of sobriety incentives) of the study.
2. The outcome variable is an indicator variable for whether an individual visited the study office on any given study day when he was supposed to.
3. Standard errors are in parentheses, clustered by individual. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively.

Table 8: The Effect of Sobriety Incentives on Savings at the Study Office

VARIABLES	(1) Rs/day	(2) Rs/day	(3) Rs/day	(4) Rs/day	(5) Rs/day	(6) Rs/day	(7) Rs/day	(8) Rs/day	(9) Rs/day	(10) Rs/day
Incentives	10.10	9.98	10.28*	14.81**	10.34					
	(7.555)	(6.455)	(6.194)	(7.031)	(6.700)					
Choice	14.71*	16.56***	12.77**	19.21***	13.07**					
	(7.772)	(5.679)	(5.382)	(6.288)	(6.208)					
Pooled alcohol treatment						12.45**	13.44***	11.57**	17.18***	11.77**
						(6.262)	(5.030)	(4.801)	(5.529)	(5.293)
High matching contribution	9.40	9.82**	11.41**	12.67**	11.77**	9.29	9.87**	11.45**	12.68**	11.77**
	(6.534)	(4.849)	(4.613)	(5.051)	(4.958)	(6.532)	(4.855)	(4.608)	(5.045)	(4.955)
Commitment savings	7.74	3.15	3.01	4.84	4.64	7.59	2.92	2.92	4.69	4.55
	(6.516)	(5.004)	(4.788)	(5.353)	(5.283)	(6.539)	(5.063)	(4.816)	(5.369)	(5.300)
Daily study payment (Rs)			0.34***		0.49***			0.34***		0.50***
			(0.050)		(0.125)			(0.050)		(0.123)
Observations	3,435	3,435	3,435	2,932	2,932	3,435	3,435	3,435	2,932	2,932
R-squared	0.007	0.114	0.129	0.123	0.131	0.006	0.113	0.129	0.123	0.131
Baseline survey controls	NO	YES	YES	YES	YES	NO	YES	YES	YES	YES
Phase 1 controls	NO	YES	YES	YES	YES	NO	YES	YES	YES	YES
Control mean	20.42	20.42	20.42	20.42	20.42	20.42	20.42	20.42	20.42	20.42

Notes: This table shows the impact of the two sobriety incentive treatments on participants' daily amount saved at the study office (Rs/day).

1. All regressions use data from day 5 (the first day of sobriety incentives) through day 19 (the last day of sobriety incentives) of the study. The outcome variable is the amount saved at the study office. If an individual did not visit the study office on any given day of the study, the amount saved is set to zero on this day. Similarly, the daily study payment is zero for those observations.

2. Regressions include the dummies "high matching contribution" for individuals who were offered a 20 percent matching contribution on their savings as opposed to 10 percent, and "commitment savings" for individuals who were not allowed to withdraw their saving until the last day of the study.

3. Columns (1) through (5) show regressions for the two sobriety incentive treatments separately. Columns (6) through (10) show pooled regressions for the Incentive and Choice Groups. Columns (1) and (6) are without controls, columns (2) and (7) include baseline survey and Phase 1 controls as in the previous tables. Columns (3) and (8) show the same regressions, but additionally control for study payments. The columns (4), (5), (9), and (10) show regressions conditional on attendance.

4. Standard errors are in parentheses, clustered by individual. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively. Phase 1 and baseline survey controls are the same as in the above tables.

Table 9: The Marginal Propensity to Save out of Lottery Earnings

VARIABLES	(1) Rs saved	(2) Rs saved	(3) Rs saved	(4) Rs saved
Pooled alcohol treatment	12.32*	11.71*	15.03***	14.44***
	(6.256)	(6.110)	(5.174)	(5.202)
Amount won in lottery on previous study day	0.29*		0.29**	
	(0.166)		(0.143)	
Pooled alcohol treatment X Lottery amount		0.36*		0.36**
		(0.192)		(0.162)
Control Group X Lottery amount		0.15		0.16
		(0.295)		(0.261)
Observations	3,435	3,435	3,435	3,435
R-squared	0.008	0.008	0.117	0.118
Baseline survey controls	NO	NO	YES	YES
Phase 1 controls	NO	NO	YES	YES
Control mean	20.42	20.42	20.42	20.42

Notes: This table shows estimates of the impact of lottery winnings on the amounts saved at the study office.

1. All regressions use data from day 5 (the first day of sobriety incentives) through day 19 (the last day of sobriety incentives) of the study. The outcome variable is the amount saved at the study office. If an individual did not visit the study office on any given day of the study, the amount saved is set to zero on this day. Similarly, the daily study payment is zero for those observations.

2. The lottery was conducted on days 10 through 18 of the study. All regressions control for whether individuals participated in the lottery on any given day. Lottery winnings were Rs. 0 (no win), Rs. 30, or Rs. 60. If an individual won in the lottery, he was given a personalized voucher for the respective amount (Rs. 30 or Rs. 60) that was redeemable *only* by this individual *only* on the subsequent study day.

3. Standard errors are in parentheses, clustered by individual. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively. Phase 1 and baseline survey controls are the same as in the above tables.

Table 10: The Effect of Sobriety Incentives on Labor Market Outcomes

VARIABLES	(1) Rs earned	(2) Rs earned	(3) Rs earned	(4) Worked	(5) Worked	(6) Worked	(7) Hours	(8) Hours	(9) Hours
Incentives	20.03	17.46		-0.04	-0.04		0.23	0.27	
	(23.365)	(16.130)		(0.029)	(0.028)		(0.395)	(0.347)	
Choice	-2.83	17.67		-0.05	-0.02		-0.32	0.21	
	(25.363)	(19.991)		(0.032)	(0.030)		(0.401)	(0.330)	
Pooled alcohol treat			17.57			-0.03			0.24
			(15.552)			(0.025)			(0.293)
Observations	3,084	3,084	3,084	3,084	3,084	3,084	3,082	3,082	3,082
R-squared	0.002	0.315	0.315	0.004	0.070	0.069	0.003	0.163	0.163
Baseline survey controls	NO	YES	YES	NO	YES	YES	NO	YES	YES
Phase 1 controls	NO	YES	YES	NO	YES	YES	NO	YES	YES
Control group mean	287.4	287.4	287.4	0.894	0.894	0.894	6.829	6.829	6.829

Notes: This table shows the impact of the two sobriety incentive treatments on labor market outcomes.

1. All regressions use data from day 5 (the first day of sobriety incentives) through day 19 (the last day of sobriety incentives) of the study.
2. The outcome variables are (i) reported earnings (Rs. per day; columns 1 through 3) (ii) whether an individual worked on a particular day (columns 4 through 6), and (iii) the number of hours worked on this day (columns 7 through 9). If an individual did not work on any given day, this is counted as zero hours worked.
3. The data used in the regressions is from retrospective surveys on the consecutive study days, during which individuals are asked about earnings and hours worked on the previous day. In addition, if individuals missed a day or two (and on Mondays), they were asked about the same outcomes two or three days ago, respectively.
4. Standard errors are in parentheses, clustered by individual. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively. Phase 1 and baseline survey controls are the same as in the above tables.

Table 11: Interaction between Sobriety Incentives and Savings Treatments

VARIABLES	(1) Rs/day	(2) Rs/day	(3) Rs/day	(4) Rs/day
Either Incentives or Commitment Savings	19.77**	15.48*		
	(9.037)	(8.679)		
Sobriety Incentives only	0.49	0.06		
	(9.745)	(9.048)		
Both Incentives and Commitment Savings	1.43	2.36		
	(9.562)	(9.997)		
Either Incentives or High Matching Contribution			12.43	12.23
			(8.841)	(9.489)
Sobriety Incentives only			2.42	0.15
			(8.957)	(9.851)
Both Incentives and High Matching Contribution			10.16	8.30
			(9.468)	(9.731)
Observations	3,435	3,435	3,435	3,435
R-squared	0.006	0.037	0.005	0.037
Baseline survey controls	NO	YES	NO	YES
Phase 1 controls	NO	NO	NO	NO
Control mean	20.42	20.42	20.42	20.42

Notes: This table shows estimates of the impact of lottery winnings on the amounts saved at the study office.

1. All regressions use data from day 5 (the first day of sobriety incentives) through day 19 (the last day of sobriety incentives) of the study. The outcome variable is the amount saved at the study office. If an individual did not visit the study office on any given day of the study, the amount saved is set to zero on this day. Similarly, the daily study payment is zero for those observations.

2. Columns (1) and (2) show the relationship between the effects of offering sobriety incentives and commitment savings. Columns (3) and (4) show the relationship between the effects of offering sobriety incentives and a high matching contribution.

3. Standard errors are in parentheses, clustered by individual. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively. Baseline survey controls are the same as in the above tables.

Table 12: Demand for Incentives over Time

VARIABLES	(1) Rs 90	(2) Rs 90	(3) Rs 90	(4) Rs 120	(5) Rs 120	(6) Rs 120	(7) Rs 150	(8) Rs 150	(9) Rs 150
Week 2	0.01	0.04	0.01	0.05	0.07	0.04	0.02	0.03	0.01
	(0.060)	(0.060)	(0.063)	(0.070)	(0.070)	(0.070)	(0.067)	(0.068)	(0.068)
Week 3	0.01	-0.01	-0.04	0.00	-0.02	-0.03	0.12	0.11	0.10
	(0.082)	(0.081)	(0.075)	(0.081)	(0.079)	(0.076)	(0.081)	(0.081)	(0.079)
BAC during choice	-1.63***			-1.12***			-0.67**		
	(0.318)			(0.322)			(0.279)		
Days sober in Phase 1		0.06			0.02			-0.05	
		(0.043)			(0.045)			(0.049)	
Days sober in Phase 2		0.09**			0.07			0.07	
		(0.042)			(0.043)			(0.045)	
Incentives increased sobriety			0.04			0.08			0.15**
			(0.065)			(0.077)			(0.071)
Exp frac sober under incentives			0.56***			0.40***			0.21**
			(0.083)			(0.085)			(0.086)
Constant	0.76***	0.40***	0.22**	0.58***	0.36***	0.18**	0.37***	0.27***	0.12
	(0.057)	(0.080)	(0.085)	(0.065)	(0.082)	(0.080)	(0.062)	(0.079)	(0.077)
Observations	211	211	211	211	211	211	211	211	211
R-squared	0.122	0.147	0.205	0.057	0.046	0.109	0.028	0.024	0.062

Notes: This table considers the relationship between the demand for incentives and sobriety for the Choice Group at different points in the study.

1. In all columns, the outcome variable is whether the individual chose incentives over unconditional payments. The unconditional amounts are Rs. 90 in columns (1) through (3), Rs. 120 in columns (4) through (6), and Rs. 150 in columns (7) through (9).

2. "BAC during choice" refers to the subjects' blood alcohol content measured before making choices between incentives and unconditional amounts. "Exp sober days under incentives" are subjects' answers to asking how many days they expected to show up sober if they were to receive incentives for sobriety during the subsequent six days (always asked before choices were made). "Days sober in Phase 1" and "Days sober in Phase 2" refer to the number of days the individual visited the study office sober during Phase 1 and 2, respectively. "Incentives increased sobriety" indicates whether the difference in the fraction of sober days in the phase before choosing and the fraction of sober days in Phase 1 is positive.

3. Standard errors are in parentheses, clustered by individual. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively.

Table 13: Demand for Incentives Across Treatment Groups

VARIABLES	(1) Rs 90	(2) Rs 90	(3) Rs 90	(4) Rs 120	(5) Rs 120	(6) Rs 120	(7) Rs 150	(8) Rs 150	(9) Rs 150
Incentives	0.13*	0.15**	0.13*	0.15*	0.16**	0.15**	0.14*	0.16**	0.14*
	(0.075)	(0.070)	(0.070)	(0.082)	(0.075)	(0.076)	(0.081)	(0.077)	(0.078)
Choice	0.10	0.07	0.08	0.09	0.06	0.07	0.11	0.09	0.10
	(0.079)	(0.074)	(0.074)	(0.081)	(0.078)	(0.078)	(0.079)	(0.078)	(0.078)
BAC during choice	-1.70***		-0.85**	-1.10***		-0.32	-1.10***		-0.52
	(0.315)		(0.358)	(0.323)		(0.355)	(0.304)		(0.349)
Exp sober days under incentives		0.10***	0.08***		0.08***	0.07***		0.06***	0.06***
		(0.011)	(0.014)		(0.011)	(0.013)		(0.011)	(0.012)
Observations	215	215	215	215	215	215	215	215	215
R-squared	0.144	0.251	0.275	0.070	0.170	0.173	0.071	0.122	0.130
Control mean	0.494	0.494	0.494	0.373	0.373	0.373	0.313	0.313	0.313

Notes: This table considers how the two sobriety incentives treatments affected the demand for incentives.

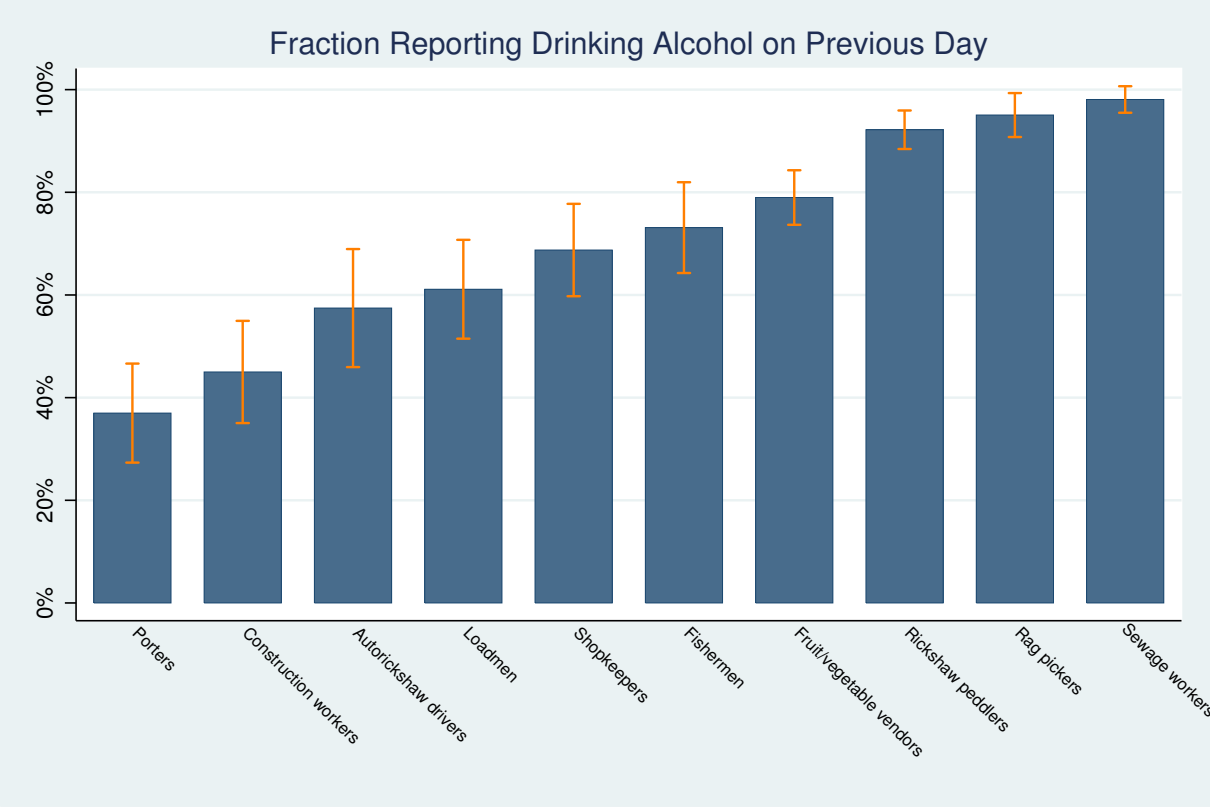
1. In all columns, the outcome variable is whether the individual chose incentives over unconditional payments. The unconditional amounts are Rs. 90 in columns (1) through (4), Rs. 120 in columns (5) through (8), and Rs. 150 in columns (9) through (12).

2. "BAC during choice" refers to the subjects' blood alcohol content measured during the visit to the study office when he was choosing between incentives and unconditional amounts. Before making these choices, individuals were asked on how many days they expected to show up sober if they were to receive incentives for sobriety during the subsequent six days. The variable "Expected sober days under incentives" refers to subjects' answer to this question.

3. Standard errors are in parentheses, clustered by individual. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively.

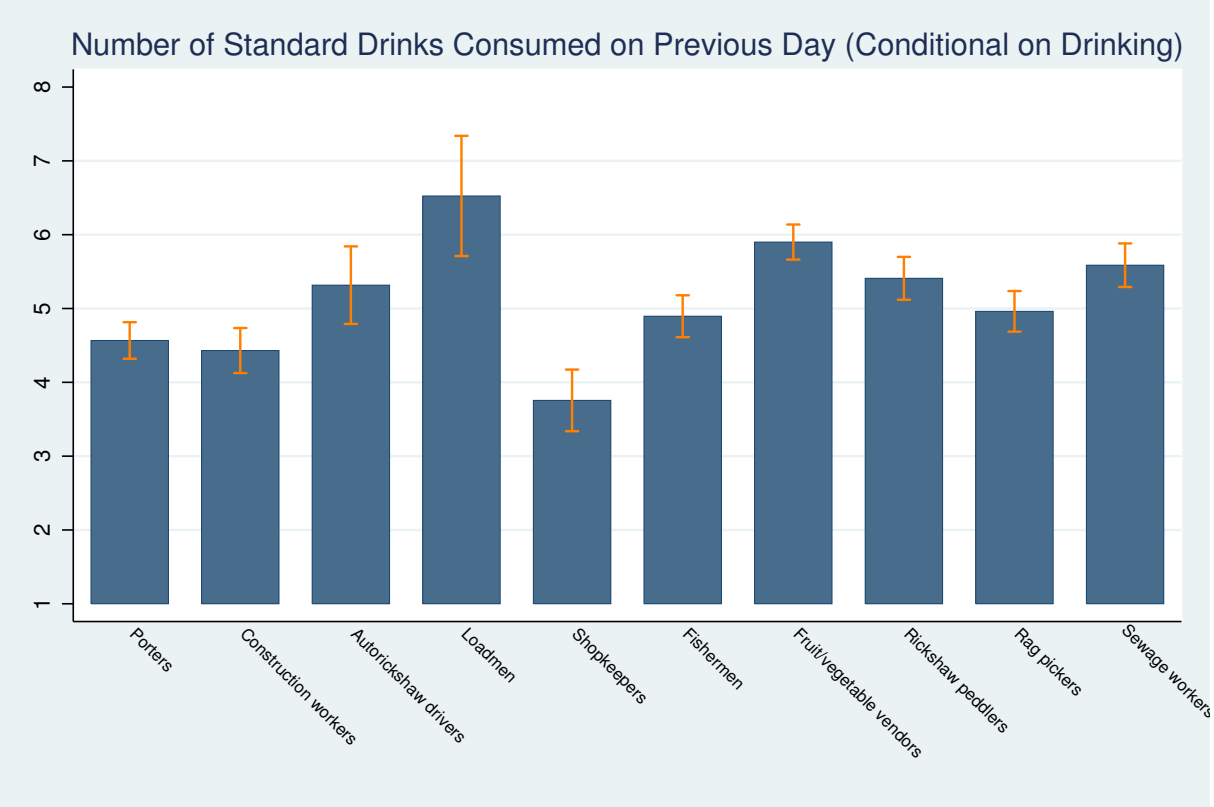
A Supplementary Appendix

Figure A.1: Prevalence of Alcohol Consumption among Low-Income Males in Chennai



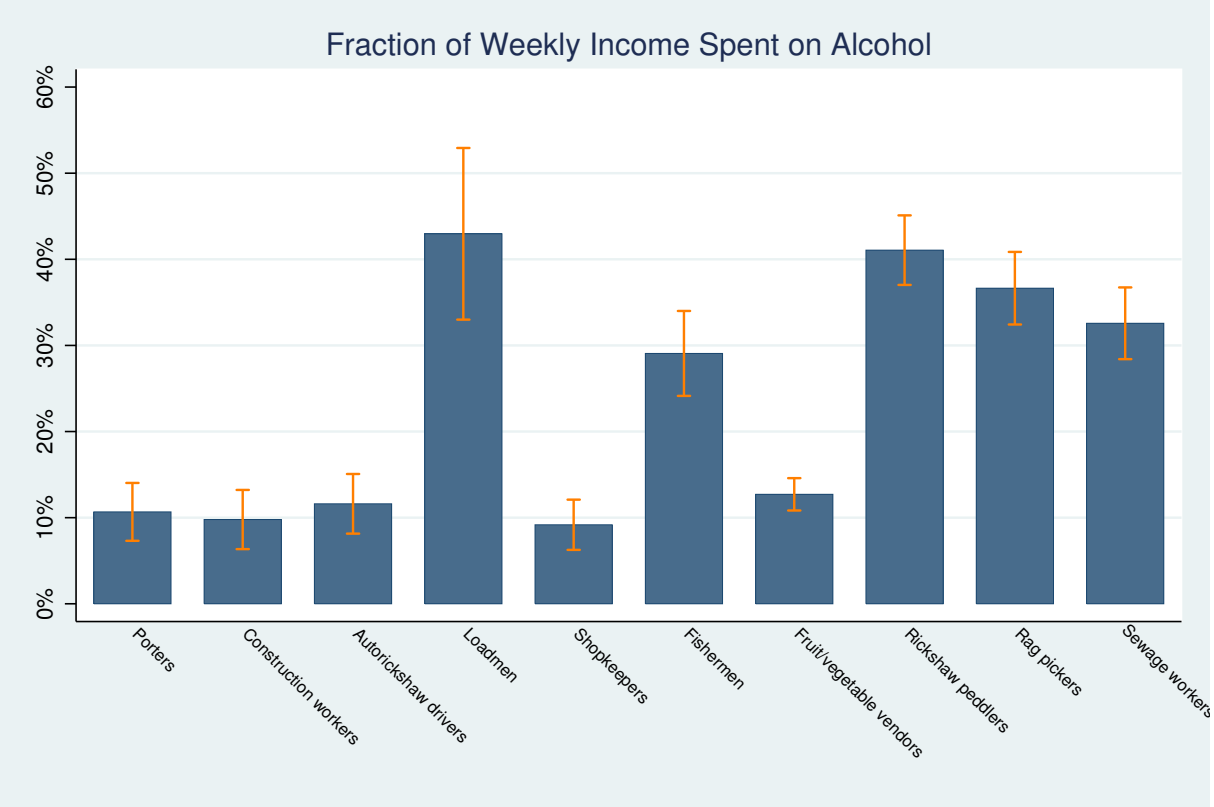
Notes: This figure depicts the prevalence of alcohol consumption among males in ten different low-income professions in Chennai, India, as measured by the fraction of individuals who reported consuming alcohol on the previous day. The underlying data from these figures are from a short survey conducted with a total sample size of 1,227 individuals. The number of individuals surveyed in each profession varies from 75 (auto rickshaw drivers) to 230 (fruit and vegetable vendors). Error bars show 95 percent confidence intervals.

Figure A.2: Prevalence of Alcohol Consumption among Low-Income Males in Chennai



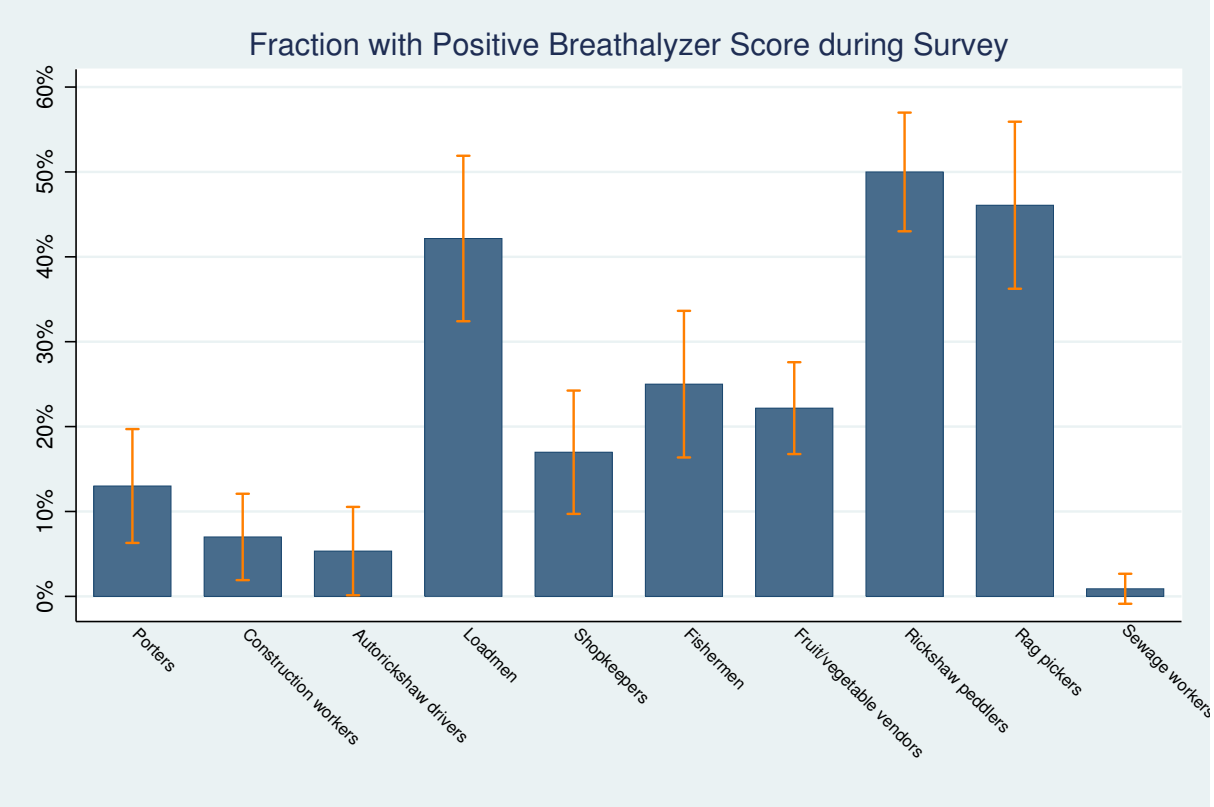
Notes: This figure shows the number of standard drinks consumed on the previous day, conditional on reporting any alcohol consumption on the previous day as described in Figure A.1. Reported consumption levels are converted into standard drinks according to WHO (2001). A small bottle of beer (330 ml at 5% alcohol), a glass of wine (140 ml at 12% alcohol), or a shot of hard liquor (40 ml at 40% alcohol) each contain about one standard drink. Error bars measure 95 percent confidence intervals.

Figure A.3: Fraction of Weekly Income Spent on Alcohol



Notes: This figure shows the fraction of weekly income spent on alcohol for the sample described in Figure A.1. For each individual, the fraction spent on alcohol is calculated by dividing reported weekly alcohol expenditures by reported weekly earnings. Weekly alcohol expenditures are calculated by multiplying the number of days the individual reported consuming alcohol in the previous week times the amount spent on alcohol per drinking day. Weekly earnings are calculated by the number of days worked during the previous week times the amount earned per working day. Error bars measure 95 percent confidence intervals.

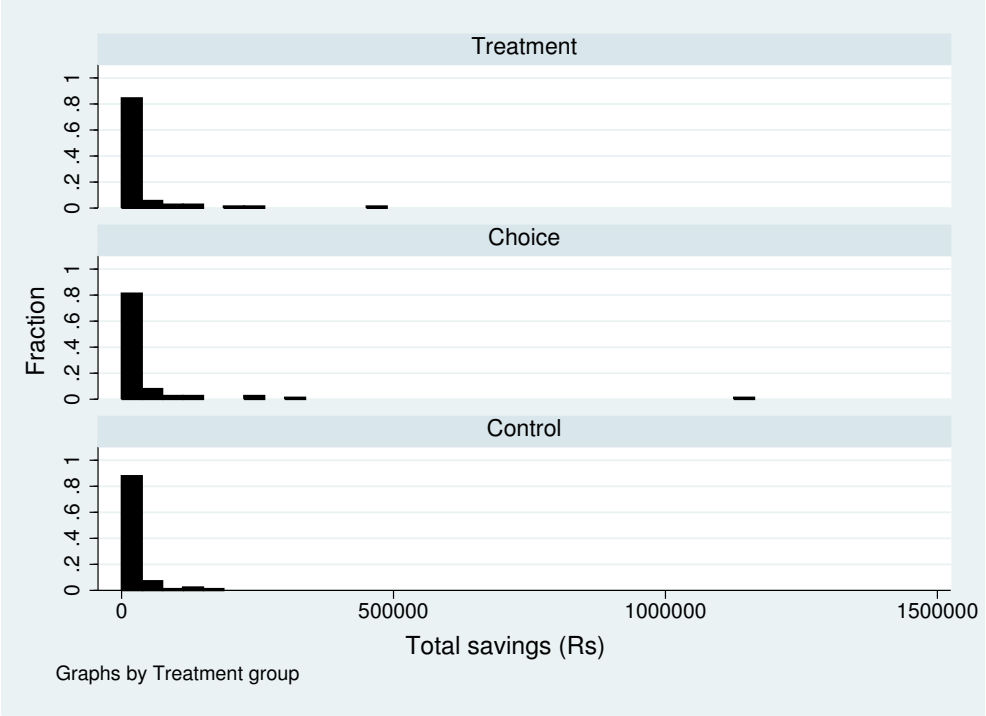
Figure A.4: Fraction with Positive Breathalyzer Score



Notes: This figure shows the fraction of individuals who were inebriated at the time of the survey, as measured by having a positive blood alcohol content in a breathalyzer test (BAC > 0). The sample is the same as described in Figure A.1. All surveys were conducted during the day, i.e. between 8 am and 6 pm. Error bars measure 95 percent confidence intervals.

Figure A.5: Reported Sum of Total Savings by Incentive Treatment Group at Baseline

(a) All individuals



(b) Only individuals with savings below Rs. 200,000

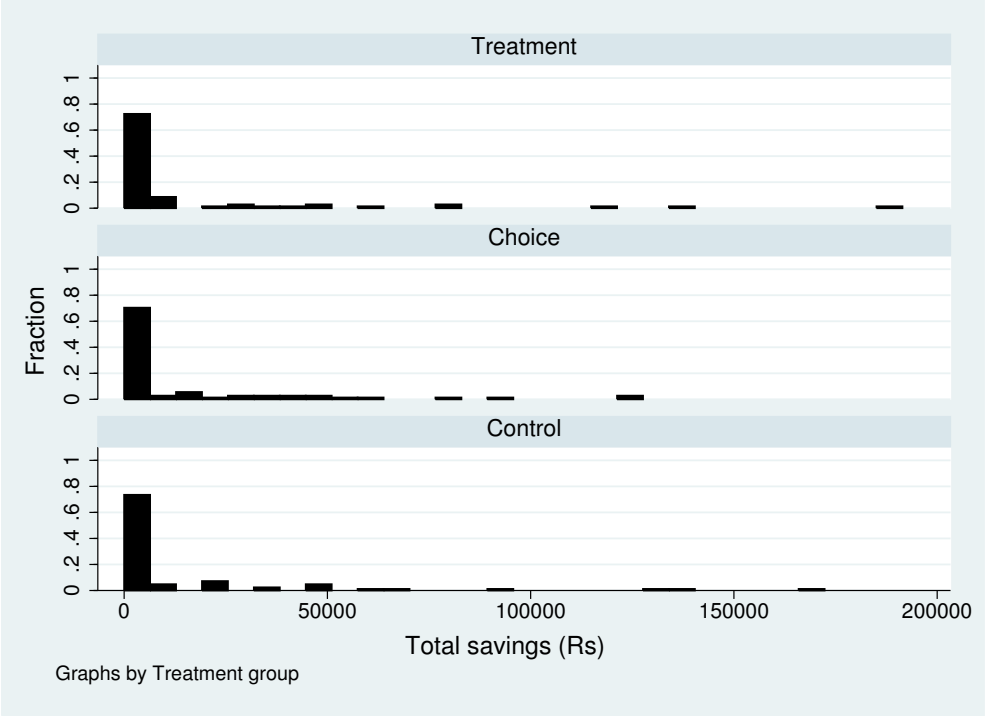
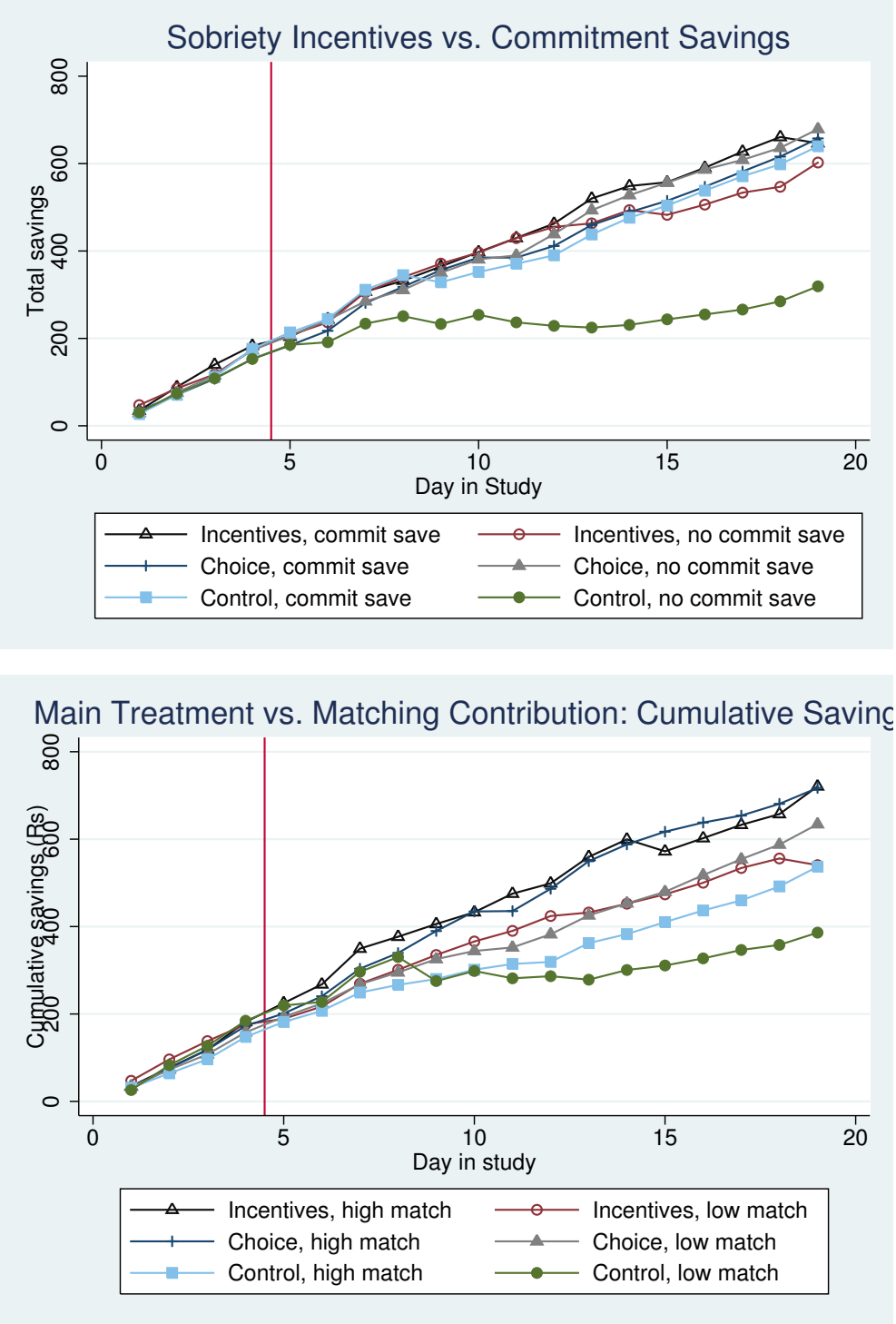


Figure A.6: Interaction between Sobriety Incentives (not pooled) and Savings Treatments



Notes: This figure shows the interaction between the cross-randomized sobriety incentives and savings treatments. The figure is the same as Figure 6, except for the fact that the two sobriety incentive treatment groups are shown separately rather than pooled (as in Figure 6).

Table A.1: Balance Table for Main Demographs

	Treatment groups			**p value for test of:**		
	Control	Incentives	Choice	1=2	1=3	$1 = (2 \cup 3)$
	(1)	(2)	(3)	(4)	(5)	(6)
Age	36.54	35.27	35.08	0.43	0.29	0.30
	(9.96)	(9.92)	(7.40)			
Married	0.82	0.80	0.81	0.80	0.92	0.84
	(0.39)	(0.40)	(0.39)			
Number of children	1.80	1.77	1.80	0.93	0.98	0.97
	(1.19)	(1.55)	(1.19)			
Lives with wife in Chennai	0.73	0.72	0.73	0.82	0.98	0.88
	(0.44)	(0.45)	(0.45)			
Wife earned income during past month	0.24	0.17	0.28	0.27	0.58	0.80
	(0.43)	(0.38)	(0.45)			
Years of education	4.89	5.45	5.49	0.38	0.34	0.28
	(3.93)	(3.95)	(3.92)			
Able to read the newspaper	0.63	0.62	0.63	0.93	1.00	0.96
	(0.49)	(0.49)	(0.49)			
Added 7 plus 9 correctly	0.86	0.77	0.77	0.20	0.19	0.12
	(0.35)	(0.42)	(0.42)			
Multiplied 5 times 7 correctly	0.48	0.41	0.47	0.36	0.85	0.53
	(0.50)	(0.50)	(0.50)			
Distance of home from office (km)	2.64	2.30	2.65	0.20	0.99	0.54
	(2.15)	(1.06)	(1.72)			
Years lived in Chennai	31.57	27.77	29.16	0.04**	0.17	0.05*
	(12.19)	(11.10)	(9.81)			
Reports having ration card	0.65	0.52	0.61	0.11	0.63	0.22
	(0.48)	(0.50)	(0.49)			
Has electricity	0.81	0.68	0.75	0.07*	0.37	0.10
	(0.40)	(0.47)	(0.44)			
Owns TV	0.76	0.59	0.68	0.03**	0.27	0.05**
	(0.43)	(0.50)	(0.47)			
Happiness ladder score (0 to 10)	5.73	5.46	5.76	0.43	0.94	0.68
	(2.14)	(2.08)	(2.11)			

Notes: This table shows balance checks for main demographics across the incentive treatment groups. Columns 1 through 3 show sample means for individuals in the Control Group (1), Incentive Group (2), and the Choice Group (3), respectively. Standard deviations are in parentheses. Columns 4 through 6 show p-values of OLS regressions of each variable on dummies for each treatment group. Columns 4 and 5 shows p-values of tests for equality of means between the Incentive and Choice Groups compared to the Control Group, respectively. Column 6 shows the corresponding p-values for comparisons between the Control Group and the Incentive and Choice Groups combined.

Table A.2: Balance Table for Work and Savings

	Treatment groups			**p value for test of:**		
	Control	Incentives	Choice	1=2	1=3	$1 = (2 \cup 3)$
	(1)	(2)	(3)	(4)	(5)	(6)
Years worked as a rickshaw puller	14.06	12.49	12.81	0.29	0.34	0.25
	(9.53)	(8.78)	(6.73)			
# of days worked last week	5.41	5.18	5.43	0.36	0.94	0.60
	(1.35)	(1.65)	(1.39)			
Has regular employment arrangement	0.47	0.52	0.47	0.53	0.97	0.74
	(0.50)	(0.50)	(0.50)			
Owns rickshaw	0.17	0.25	0.28	0.20	0.10*	0.08*
	(0.38)	(0.44)	(0.45)			
Says 'no money' reason for not owning rickshaw	0.61	0.65	0.59	0.67	0.72	0.98
	(0.49)	(0.48)	(0.50)			
Reported labor income in Phase 1 (Rs/day)	291.86	301.08	273.94	0.69	0.39	0.79
	(119.97)	(160.54)	(138.33)			
Total savings (Rs)	13261	23903	38184	0.22	0.13	0.07*
	(31197)	(67739)	(139224)			
Total borrowings (Rs)	11711	5648	7913	0.11	0.36	0.18
	(29606)	(15762)	(22253)			
Savings at study office in Phase 1 (Rs/day)	40.98	44.67	41.04	0.62	0.99	0.77
	(41.93)	(49.28)	(48.25)			

Notes: This table shows balance checks for work- and savings-related variables across the incentive treatment groups. Columns 1 through 3 show sample means for individuals in the Control Group (1), Incentive Group (2), and the Choice Group (3), respectively. Standard deviations are in parentheses. Columns 4 through 6 show p-values of OLS regressions of each variable on dummies for each treatment group. Columns 4 and 5 shows p-values of tests for equality of means between the Incentive and Choice Groups compared to the Control Group, respectively. Column 6 shows the corresponding p-values for comparisons between the Control Group and the Incentive and Choice Groups combined.

Table A.3: Balance Table for Alcohol Consumption

	Treatment groups			**p value for test of:**		
	Control	Incentives	Choice	1=2	1=3	$1 = (2 \cup 3)$
	(1)	(2)	(3)	(4)	(5)	(6)
Years drinking alcohol	12.89	11.68	12.86	0.42	0.99	0.65
	(10.02)	(8.42)	(9.03)			
Number of drinking days per week	6.72	6.83	6.68	0.39	0.70	0.77
	(0.80)	(0.76)	(0.60)			
Drinks usually hard liquor ($\geq$ 40 % alcohol)	0.99	1.00	0.99	0.32	0.94	0.71
	(0.11)	(0.00)	(0.12)			
Alcohol expenditures in Phase 1 (Rs/day)	91.95	87.09	81.92	0.39	0.07*	0.12
	(37.03)	(32.48)	(32.98)			
# of standard drinks per day in Phase 1	6.17	5.71	5.80	0.21	0.31	0.19
	(2.29)	(2.17)	(2.18)			
# of std drinks during day in Phase 1	2.13	2.45	2.40	0.38	0.42	0.31
	(2.01)	(2.48)	(2.10)			
Baseline fraction sober	0.49	0.45	0.43	0.48	0.30	0.30
	(0.40)	(0.43)	(0.41)			
Alcohol Use Disorders Identification Test score	14.61	13.94	14.69	0.44	0.92	0.67
	(4.32)	(6.16)	(4.98)			
Drinks usually alone	0.87	0.82	0.85	0.40	0.80	0.51
	(0.34)	(0.39)	(0.36)			
Reports life would be better if liquor stores closed	0.84	0.80	0.77	0.52	0.27	0.29
	(0.37)	(0.40)	(0.42)			
In favor of prohibition	0.81	0.77	0.84	0.62	0.59	0.99
	(0.40)	(0.42)	(0.37)			
Would increase liquor prices	0.07	0.14	0.12	0.18	0.32	0.15
	(0.26)	(0.35)	(0.33)			

Notes: This table shows balance checks for alcohol-related variables across the incentive treatment groups. Columns 1 through 3 show sample means for individuals in the Control Group (1), Incentive Group (2), and the Choice Group (3), respectively. Standard deviations are in parentheses. Columns 4 through 6 show p-values of OLS regressions of each variable on dummies for each treatment group. Columns 4 and 5 shows p-values of tests for equality of means between the Incentive and Choice Groups compared to the Control Group, respectively. Column 6 shows the corresponding p-values for comparisons between the Control Group and the Incentive and Choice Groups combined.

Table A.4: Effect of Sobriety Incentives on Family Resources

VARIABLES	(1) Wife	(2) Wife	(3) Wife	(4) Other	(5) Other	(6) Other	(7) Total	(8) Total	(9) Total
Incentives	19.89	10.93		-10.21	-9.90		9.68	1.03	
	(19.068)	(16.914)		(7.482)	(7.591)		(17.914)	(14.942)	
Choice	16.03	21.94		-9.85	-7.65		6.18	14.30	
	(20.117)	(16.590)		(8.441)	(8.379)		(19.924)	(15.585)	
Pooled alcohol treat			16.94			-8.67			8.28
			(13.969)			(7.115)			(12.699)
Observations	2,991	2,991	2,991	2,991	2,991	2,991	2,991	2,991	2,991
R-squared	0.002	0.127	0.126	0.006	0.082	0.082	0.000	0.144	0.143
Baseline survey controls	NO	YES	YES	NO	YES	YES	NO	YES	YES
Phase 1 controls	NO	YES	YES	NO	YES	YES	NO	YES	YES
Control group mean	148.7	148.7	148.7	25.13	25.13	25.13	173.9	173.9	173.9

Notes: This table shows the impact of the two sobriety incentive treatments on family resources.

1. All regressions use data from day 5 (the first day of sobriety incentives) through day 19 (the last day of sobriety incentives) of the study.

2. The outcome variables are (i) money given to the wife (Rs./day; always zero for unmarried individuals) (ii) other family expenses (the sum of money given to other family members and direct household expenses), and (iii) total family resources (i.e. the sum of (i) and (ii)).

3. The data used in the regressions is from retrospective surveys on the consecutive study days, during which individuals are asked about each of the above variables on the previous day. In addition, if individuals missed a day or two (and on Mondays), they were asked about the same outcomes two or three days ago, respectively.

4. Standard errors are in parentheses, clustered by individual. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively. Phase 1 and baseline survey controls are the same as in the above tables.

Table A.5: Expenses on Food, Coffee & Tea, and Tobacco & Paan

VARIABLES	(1) Food	(2) Food	(3) Food	(4) Cof/Tea	(5) Cof/Tea	(6) Cof/Tea	(7) Tob/Paan	(8) Tob/Paan	(9) Tob/Paan
Incentives	3.03	5.83		0.02	0.38		2.13	2.58	
	(6.609)	(6.126)		(1.013)	(1.015)		(1.818)	(1.732)	
Choice	-3.45	3.05		-0.14	0.02		-2.95*	-2.35	
	(5.907)	(5.771)		(1.011)	(0.938)		(1.557)	(1.545)	
Pooled alcohol treat			4.34			0.18			-0.06
			(5.085)			(0.840)			(1.409)
Observations	1,034	1,034	1,034	1,047	1,047	1,047	1,047	1,047	1,047
R-squared	0.003	0.154	0.153	0.000	0.117	0.117	0.026	0.086	0.065
Baseline survey controls	NO	YES	YES	NO	YES	YES	NO	YES	YES
Phase 1 controls	NO	YES	YES	NO	YES	YES	NO	YES	YES
Control group mean	50.93	50.93	50.93	4.522	4.522	4.522	10.52	10.52	10.52

Notes: This table shows the impact of the two sobriety incentive treatments on other expenditures.

1. All regressions use data from day 5 (the first day of sobriety incentives) through day 19 (the last day of sobriety incentives) of the study. Individuals were only asked about the below variables every third day (the timing was unannounced).

2. The outcome variables are (i) money given to the wife (Rs./day; always zero for unmarried individuals) (ii) other family expenses (the sum of money given to other family members and direct household expenses), and (iii) total family resources (i.e. the sum of (i) and (ii)).

3. Standard errors are in parentheses, clustered by individual. ***, **, and * indicate significance at the 1, 5, and 10 percent level, respectively. Phase 1 and baseline survey controls are the same as in the above tables.

Table A.6: Attrition and Inconsistencies of Choices

	Choice Group			**Incentive Group**	**Control Group**
	Week 1	Week 2	Week 3	Week 3	Week 3
Present & consistent (%)	88.0	89.3	88.0	90.1	86.7
Absent (%)	5.3	6.7	6.7	5.6	6.0
Inconsistent (%)	6.7	4.0	5.3	4.2	7.2

Notes: This table shows the fraction of individuals who were present and made consistent choices by treatment group and week of study. During a given choice session, an individual chose inconsistently if he chose Option B for the unconditional amount Y_1, but Option A for the unconditional amount Y_2 with $Y_2 > Y_1$. For instance, his choices are inconsistent if he preferred Option B in Choice 1, but not in Choice 3.

Table A.7: Summary of Choices in Choice Group Over Time

	Option A		**Option B**	**Percent choosing A**		
Choice	BAC > 0	BAC $= 0$	regardless of BAC	Week 1	Week 2	Week 3
(1)	Rs. 60	Rs. 120	Rs. 90	60.0	62.7	57.3
(2)	Rs. 60	Rs. 120	Rs. 120	46.7	52.0	44.0
(3)	Rs. 60	Rs. 120	Rs. 150	30.7	33.3	40.0

Notes: This table shows the fraction of individuals among the Choice Group who preferred incentives over unconditional amounts for each of the choices by week of study. Individuals who were either absent or did not choose consistently are counted as *not* preferring incentives.

A.1 Solution for the Case of Isoelastic Utility

This section provides the solution of the model described in section 5.1 for the commonly used case of isolelastic utility.

No commitment savings. Equations (7) and (9) become

$$c_2^{-\gamma} = \beta(1+M)c_3^{-\gamma} \tag{15}$$

$$c_1^{-\gamma} = \left[\beta\frac{dc_2}{dY_2} + \left(1 - \frac{dc_2}{dY_2}\right)\right] c_2^{-\gamma} \tag{16}$$

Using (8) and (15), we can solve for c_3 and c_2 as functions of Y_2:

$$c_3 = \left(\frac{1+M}{1+\theta}\right) Y_2 \quad \text{and} \quad c_2 = \left(\frac{\theta}{1+\theta}\right) Y_2. \tag{17}$$

where $\theta \equiv (\beta(1+M))^{\frac{-1}{\gamma}}(1+M)$. This implies $\frac{dc_2}{Y_2} = \frac{\theta}{1+\theta}$ and, using (16), we get

$$c_1 = \left(\frac{1+\beta\theta}{1+\theta}\right)^{\frac{-1}{\gamma}} c_2. \tag{18}$$

Using the budget constraint and rewriting (15) to $c_2 = \frac{\theta}{1+M}c_3$, this yields

$$c_3^{\text{NC}} = \frac{Y(1+M)}{1+\theta+\theta\left[\frac{1+\beta\theta}{1+\theta}\right]^{\frac{-1}{\gamma}}}. \tag{19}$$

Commitment savings. Equations (10) and (11) become

$$c_2 = (1+M)^{\frac{-1}{\gamma}} c_3, \tag{20}$$

$$c_1 = \beta^{\frac{-1}{\gamma}} c_2 = \left(\frac{\theta}{1+M}\right) c_3. \tag{21}$$

Using the budget constraint (12), this implies

$$c_3^{\text{C}} = \frac{Y(1+M)}{1+\theta+(1+M)^{1-\frac{1}{\gamma}}}. \tag{22}$$

A.2 A Special Case: Log Utility

This section considers a special case of log utility ($\gamma = 1$), i.e. $u(c_t) = \log(c_t)$.

No commitment savings. Equations (7) and (9) become

$$c_3 = \beta(1+M)c_2 \tag{23}$$

$$c_2 = \left[\beta\frac{dc_2}{dY_2} + \left(1 - \frac{dc_2}{dY_2}\right)\right] c_1 \tag{24}$$

Using $c_3 = (Y_2 - c_2)(1+M)$, we use (23) to solve for c_3 and c_2 as functions of Y_2:

$$c_2 = \frac{1}{1+\beta}Y_2 \quad \text{and} \quad c_3 = \frac{\beta(1+M)}{1+\beta}Y_2 \tag{25}$$

This implies $\frac{dc_2}{dY_2} = \frac{1}{1+\beta}$ and, hence $c_2 = \frac{2\beta}{1+\beta}c_1$ and $c_3 = (1+M)\frac{2\beta^2}{1+\beta}c_1$. Hence, we get

$$c_1 = Y - c_2 - \frac{c_3}{1+M} = Y - \frac{2\beta}{1+\beta}c_1 - \frac{2\beta^2}{1+\beta}c_1 = \frac{Y}{1 + \frac{2\beta}{1+\beta} + \frac{2\beta^2}{1+\beta}} \tag{26}$$

This implies $c_3^{\text{NC}} = \frac{2\beta^2}{1+3\beta+2\beta^2}Y(1+M)$.

Commitment savings. Consider now the solution for the commitment savings case. Equations (10) and (11) become

$$c_2 = \beta c_1 \qquad c_3 = (1+M)c_2 \tag{27}$$

Using the budget constraint (12), this yields

$$c_3^C = (Y - c_1 - c_2)(1+M) \tag{28}$$

$$= Y(1+M) - \frac{c_3}{\beta} - c_3 \tag{29}$$

$$= \frac{\beta}{1+2\beta}Y(1+M) \tag{30}$$

Comparing the two solutions yields

$$\Delta \equiv c_3^{\text{C}} - c_3^{\text{NC}} = \left[\frac{\beta(1-\beta)}{(1+2\beta)(1+\beta)}\right] Y(1+M) \tag{31}$$

Taking the derivative of the expression in brackets with respect to β yields

$$\frac{\partial[\cdot]}{\partial\beta} = \frac{1 - 2\beta - 5\beta^2}{(1+3\beta+2\beta^2)^2} \tag{32}$$

This expression is positive for $0 \leq \beta \approx 0.29$ and negative for $0.29 \approx \beta \leq 1$.