

Appendix

A.1 The Cause of the “Strategic Effect”

The main difference between our equilibrium and that of ? is the presence of a “strategic effect”, wherein doctor j takes into account the behavior of other doctors in the selection of her own $\bar{\kappa}_j$. Of the different modifications we made to her framework, we’ll argue it’s the absence of *additive separability* across patients in physician utility $U_j(\cdot)$ which accounts for this.

In our context of unbounded maximization by doctor j , the absence of additive separability implies she can’t consider each patient individually when it comes to whether she’s willing to allow (or induce) their visit, as such a decision is no longer independent of other patients’ visits; the marginal utility of an additional patient is dependent on the aggregate of clients up to that point, both in terms of the visit itself as well as in the number of sick leave certificates granted up to that point.

Let’s illustrate this point. Consider for a moment a finite number of patients $1, \dots, k$, where each patient is inputted directly as an argument in our doctor j ’s $U_j(\cdot)$, like so: $U_j(1, \dots, k)$. If $U_j(\cdot)$ has the property of additive separability, this means it may be reformulated like so:

$$U_j(1, \dots, k) = v_{j1}(1) + \dots + v_{jk}(k) = \sum_{i=1}^k v_{ji}(i)$$

Unconstrained optimization in this context implies she’s willing to see any patient whose $v_{ji}(i)$ is non-negative, such that her optimal level of utility is:

$$U_j^*(1, \dots, k) = \sum_{i: v_{ji}(i) \geq 0} v_{ji}(i)$$

In the context of our doctor-patient model, where physician utility is increasing in κ_i , selection is achieved by the doctor by choosing a κ_j^* which excludes all patients i whose $\kappa_i < \kappa_j^*$. Supposing our patients are well-ordered in κ_i , the choice of such a κ_j^* would be one where the marginal consumer i affords a non-negative $v_{ji}(i)$, and the inframarginal consumer $i + 1$ fulfills $v_{j,i+1}(i + 1) < 0$. Ignoring for a moment that patients themselves have a *choice* of visiting – depending upon a second dimension γ –, we would then have:

$$U_j^*(1, \dots, k) = \sum_{i: \kappa_i \geq \kappa_j^*} v_{ji}(i)$$

If instead of a discrete set we consider a mass of consumers \mathcal{I} characterized by their level of κ_i , and we make the simplifying assumption that v_{ji} takes on the same form v_j for every $i \in \mathcal{I}$, our $U_j(\cdot)$ could be expressed as:

$$U_j^*(\mathcal{I}) = \int_{\kappa_j^*}^{\infty} v_j(k) dF(k)$$

$U_j^*(\mathcal{I})$ represents the optimal value of $U_j(\mathcal{I})$, where doctor j only sees patients who provide her with non-negative marginal utility, i.e. such that $\kappa_i \geq \kappa_j^*$. We can find this optimal value κ_j^* by looking at *threshold* equilibria, where doctor utility is also dependent on the threshold $\bar{\kappa}_j$ over which she's willing to see patients:

$$U_j(\mathcal{I}, \bar{\kappa}_j) = \int_{\bar{\kappa}_j}^{\infty} v_j(k) dF(k)$$

The optimal value of threshold $\bar{\kappa}_j$ is κ_j^* . Assuming $U_j(\cdot)$ is twice differentiable and concave in $\bar{\kappa}_j$, such a solution may be arrived at through the FCO:

$$\frac{\partial U_j(\mathcal{I})}{\partial \bar{\kappa}_j} \equiv -v_j(\bar{\kappa}_j)f(\bar{\kappa}_j) = 0$$

Solving for this would yield $\bar{\kappa}_j = \kappa_j^*$.

? is an example of just such a treatment, which specifies the physician's additive utility by patient in the following manner:

$$v_{ji}(\kappa_i) \equiv R_j + \beta_j h(\kappa_i)$$

where R_j is a parameter standing for revenue by visit, and $\beta_j h(\kappa_i)$ represents the physician's "altruistic" utility over the health impact of a prescription drug to a patient with "pain level" κ_i .

The optimal threshold κ_j^* is then obtained out of the maximization¹:

$$\max_{\bar{\kappa}_j} \int_{\bar{\kappa}_j}^{\infty} R_j + \beta_j h(k) dF(k)$$

Which gives out the following FOC:

$$R_j = -\beta_j h'(\bar{\kappa}_j)$$

which, as is immediately apparent, doesn't depend upon the behavior of other doctors—more specifically, *their* choice of $\bar{\kappa}_j$. It merely establishes that, at the threshold, marginal benefit by patient—revenue R_j —must equal marginal "cost"—altruistic "cost" $\beta_j h(\bar{\kappa}_j)$ —. A way to interpret this is that doctors will be willing to see any and all patients which render them positive marginal utility, unconcerned with their total market share, and thus, what other physicians may do to take away clientele.

Such a treatment is rendered inviable by our choice of utility function. Schnell's parameter of revenue would in our model imply the linearity of our revenue *function* $R_j(\cdot)$ and our $P(\cdot)$ function over *aggregate* licenses granted. Strict convexity of $P(\cdot)$ would forestall its formulation as Schnell-like $\beta_j h'(\bar{\kappa}_j)$ terms for each patient, because

¹Once again, ignoring patient choice and γ_i . We're presenting a *simplified* version for illustrative purposes.

the impact on doctor j 's utility in granting patient i a license would no longer independent from the granting of licenses of other patients. Likewise, strict concavity of $R_j(\cdot)$ belies a simple "r" parameter such that $R'_j(Q_j) = rQ_j$.

More formally, when $U_j(1, \dots, k)$ *isn't* additively separable across patients, the value κ_j^* such that if $\kappa_i \geq \kappa_j^*$ patient i provides positive marginal utility, isn't independent of current clientele, because what before was a properly defined object, marginal utility by patient i , $v_j(\kappa_i)$, can no longer be so identified. The marginal utility i provides to j as the k th client (assuming some order over clients) is not necessarily the same he'd provide as the $k + 1$ th client, and so, as the k th client he could provide 0 utility, implying $\kappa_i = \kappa_j^*$, whereas as the $k + 1$ th he could be inframarginal, such that $\kappa_i < \kappa_j^*$.

κ_j^* is not longer independent of clientele mass \mathcal{I} as before, but a function of it, $\kappa_j^*(\mathcal{I})$. More specifically, in the models we consider it will depend on the *cardinality* of current clientele, $|\mathcal{I}|$, such that our physician's choice of marginal consumer will depend on her aggregate level of patient demand, where before it didn't. This effect is introduced through the *strict non-linearity* of our physician utility function $U_j(\cdot)$, either through the strict concavity of $R_j(\cdot)$ over expected patient demand Q_j , or the strict convexity of $P_j(\cdot)$ over total expected sick leaves granted.

When either of those is the case, *aggregate* levels enter into the equation and form part of the optimality condition. Our general FOC reflects this:

$$R'_j(Q_j) \frac{\partial Q_j}{\partial \bar{\kappa}_j} = P'_j(X_j) \frac{\partial X_j}{\partial \bar{\kappa}_j} \quad (1)$$

where either or both of $R'_j(\cdot)$ and $P'_j(\cdot)$ are a non-constant function over aggregates.

When such aggregates, either Q_j or X_j , come into play, physicians come to consider their *market share*, which doesn't depend exclusively on their own choice of $\bar{\kappa}_j$. Each patient's strategy S_i is constructed taking into account the whole of $\{(V_j, \bar{\kappa}_j)\}_{i=1}^J$.

Imagine equation (1) holds for some doctor j , and some doctor $l \neq j$ decides to lower her $\bar{\kappa}_l$, enough that it changes the value of s_{ij} for some mass of clients. The value of Q_j would then change, and therefore that of $R'_j(Q_j)$. If $P'_j(X_j)$ didn't vary by the same amount, (1) would no longer be an equality, leading j to modify her choice of $\bar{\kappa}_j$ to make equality hold.

This intelligible line of reasoning links the presence of a "strategic effect" to the non-additive separability of $U_j(\cdot)$: doctor j takes into account other physicians' strategy in her own choice of $\bar{\kappa}_j$ because of the present of *aggregate* amounts of clientele in her optimality conditions, which is so because utility isn't additively separable across clients.

A.2 ? with Logit Choice

To prove our point that it is additive separability which accounts for a possible strategic effect, we reformulate ? in the manner of a McFadden Logit – with some quirks.

The way in which Schnell devises her physician's utility formula is implicitly Bernoulli-like:

$$\int_{\kappa} \int_{\gamma} u(\kappa, \gamma) \cdot p(\kappa, \gamma) dG(\gamma) dF(\kappa)$$

where $u(\kappa, \gamma)$ is the utility function of the physician from patients characterised by a given (κ, γ) tuple, and $p(\kappa, \gamma)$ stands for the proportion of clients atomized in such a tuple the physician expects to have visit her.

$u(\kappa, \gamma)$ we'll leave as Schnell defined it: $\beta_j h(\kappa) + R_j$. $p(\kappa, \gamma)$ lends itself nicely as the s_{ij} we have been using thus far, which implicitly depends on the (κ_i, γ_i) tuple which characterizes patient i :

$$\int_{\kappa} \int_{\gamma} [\beta_j h(\kappa) + R_j] \cdot s_{ij}(\kappa, \gamma) dG(\gamma) dF(\kappa)$$

In our modeling section, our "implicit" search model was a left-censored Logit choice model, which gave null probability of assignment to physicians from which patient i expected non-positive utility. It was defined as:

$$s_{ij} = \frac{\alpha_{ij}}{\sum_{k=1}^J \alpha_{ik}}, \text{ where } \alpha_{ij} = \begin{cases} e^{\lambda u_{ij}}, & \text{if } u_{ij} > 0 \\ 0, & \text{if } u_{ij} = 0 \end{cases}$$

Schnell's opioid-focused physician model provides an additional simplification: patients which aren't given a drug prescription, i.e. those such that $\kappa_i < \bar{\kappa}_j$, don't garner positive utility from a visit. As such, in the original model as in this reformulation, patients "below" $\bar{\kappa}_j$ have a null probability of visit, such that the inferior limit of integration for κ is $\bar{\kappa}_j$.

As for γ , the limit of the inner integral remains the same as in Schnell in the absence of a secondary market, a value of γ_i such that $u_{ij} = 0$, i.e. $h(\kappa_i) + \gamma_i - \tau^d - \tau^o = 0$.²

The double-integral maximized as physician utility is then as follows:

$$\max_{\bar{\kappa}_j} \int_{\bar{\kappa}_j}^{\infty} \int_{\tau^d - \tau^o - h(\kappa)}^{\infty} [\beta_j h(\kappa) + R_j] \cdot \frac{e^{\lambda u_{ij}}}{\sum_{k: u_{ik} > 0} e^{\lambda u_{ik}}} dG(\gamma) dF(\kappa)$$

The FOC of such an equation is:

$$[\beta_j h(\bar{\kappa}_j) + R_j] \int_{\tau^d - \tau^o - h(\bar{\kappa}_j)}^{\infty} \frac{e^{\lambda u_{ij} | \bar{\kappa}_j}}{\sum_{k: u_{ik} > 0 | \bar{\kappa}_j} e^{\lambda u_{ik}}} dG(\gamma) f(\bar{\kappa}_j) = 0 \quad (2)$$

Where we use " $| \bar{\kappa}_j$ " to clumsily indicate that we integrate γ over patients where $\kappa_i = \bar{\kappa}_j$. As an integral over a strictly positive value and the atom of a density function,

²Schnell splits the costs a patient will face into costs of visit (τ^d), cost of purchase (τ^o) and search cost (τ^s)

respectively, the factors B and C in the equation are non-negative. For this reason, the only way for (2) to be fulfilled is the following condition:

$$R_j = -\beta_j h(\bar{\kappa}_j) \quad (3)$$

This is the same result as in the original model in ?? in the absence of a secondary market, a condition which stipulates that marginal utility in $\bar{\kappa}_j$ must be 0, i.e. that revenue (R_j) must equal "altruistic" loss ($\beta_j h(\bar{\kappa}_j)$), which pre-supposes that the marginal patient granted prescription opioids suffers a net loss in utility (the negative externalities outweigh its medical benefit as a palliative).

Condition (3) means a value κ_j is chosen irrespective of the strategies employed by other doctors, it quite literally doesn't enter into the equation. As we have argued, additive separability over clients means the *total* demand for physician j 's services doesn't influence marginal utility by a given patient i , and so has no sway in the optimality condition. Doctor j states simply that she won't grant a prescription (or sick leave, as in our case) below $\bar{\kappa}_j$, *come what may*. In order for her to care about *aggregate* values, like her total expected demand, making her care about her market share and thus about the strategies of other doctors, *strict non-linearity* must be introduced into her utility function.

A.3 Strategic Complementarity of $\bar{\kappa}_j$'s (Proof of Proposition ??)

We defined the components s_{ij} of S_i as:

$$s_{ij} \equiv g_i(u_{ij}, u_{i,-j})$$

where $g_i(\cdot)$ is a continuous function weakly increasing in the first argument u_{ij} , weakly decreasing in $u_{i,-j}$. Our defining s_{ij} this way has two interlinked corollaries:

Corollary A.1.

$$s_{ij} \mid \kappa_i < \bar{\kappa}_j \leq s_{ij} \mid \kappa_i \geq \bar{\kappa}_j \quad (\text{with strict inequality if } \gamma_i > 0).$$

Proof. For a fixed value of V_j and κ_i , for all i , the value of $U_i(V_j, \bar{\kappa}_j)$ is $V_j \kappa_i - \tau_j$ if $\kappa_i < \bar{\kappa}_j$, and $\gamma_i + V_j \kappa_i - \tau_j$ if $\kappa_i \geq \bar{\kappa}_j$, where $\gamma_i \geq 0$. Given that s_{ij} is weakly increasing in u_{ij} , and we see that u_{ij} is weakly higher if $\kappa_i \geq \bar{\kappa}_j$, the corollary follows. \square

Corollary A.2.

$$\frac{\Delta s_{ij}}{\Delta \bar{\kappa}_j} \leq 0 \qquad \frac{\Delta s_{ij}}{\Delta \bar{\kappa}_l} \geq 0, \forall l \neq j$$

Proof. From the argumentation in corollary 1 follows that u_{ij} is weakly decreasing in $\bar{\kappa}_j, \forall j$. Take some $l \neq j$, then s_{ij} is defined in turn as weakly decreasing in u_{il} , which implies it is increasing in $\bar{\kappa}_l$. \square

Both corollaries hinge upon our definition of $U_i(\cdot)$ as a step function over κ_i , such that it is discontinuous at $\kappa_i = \bar{\kappa}_j$, where there's a discrete jump of magnitude $\gamma_i \geq 0$. We use them in the next proposition.

Proposition A.3.

$$\frac{\partial Q_j}{\partial \bar{\kappa}_j}, \frac{\partial X_j}{\partial \bar{\kappa}_j} \leq 0 \qquad \frac{\partial Q_j}{\partial \bar{\kappa}_l}, \frac{\partial X_j}{\partial \bar{\kappa}_l} \geq 0, \forall l \neq j$$

Proof. We recall our function of patient demand for physician j is:

$$Q_j(\bar{\kappa}_j, \bar{\kappa}_{-j}) = \int_0^\infty \int_0^\infty s_{ij}(k, \gamma) dG(\gamma) dF(k)$$

Were physician j to increase her threshold from $\bar{\kappa}_j$ to $\bar{\kappa}_j' = \bar{\kappa}_j + \epsilon, \epsilon > 0$, for the mass of patients whose $\kappa_i \in [\bar{\kappa}_j, \bar{\kappa}_j + \epsilon)$, utility would weakly decrease and thus so would their s_{ij} , falling to $s_{ij}' \leq s_{ij}$ (see first corollary, think of s_{ij}' as $s_{ij} \mid \kappa_i < \bar{\kappa}_j$ as opposed to $s_{ij} \mid \kappa_i \geq \bar{\kappa}_j$).

The difference that would make for patient demand *caeteris paribus* given the $\bar{\kappa}_{-j}$ strategies of the other physicians (omitted in our notation) is:³

$$\Delta Q_j = Q_j(\bar{\kappa}_j + \epsilon) - Q_j(\bar{\kappa}_j) = \int_{\bar{\kappa}_j}^{\bar{\kappa}_j + \epsilon} \int_0^\infty \{s_{ij}' - s_{ij}\} dG(\gamma) dF(k)$$

By the definition of a partial derivative:⁴

$$\begin{aligned} \frac{\partial Q_j}{\partial \bar{\kappa}_j} &= \lim_{\epsilon \rightarrow 0} \frac{\int_{\bar{\kappa}_j}^{\bar{\kappa}_j + \epsilon} \int_0^\infty \{s_{ij}' - s_{ij}\} dG(\gamma) dF(k)}{\epsilon} \\ &= \int_0^\infty \{s_{ij}(\bar{\kappa}_j, \gamma)' - s_{ij}(\bar{\kappa}_j, \gamma)\} dG(\gamma) f(\bar{\kappa}_j) \end{aligned}$$

where the derivative is negative if s_{ij}' is strictly lower than s_{ij} , meaning a shift in leniency would affect the utility and optimal strategy of some positive mass of patients around $\bar{\kappa}_j$; or null, if $s_{ij}' = s_{ij}$.

In a similar vein, consider some physician $l \neq j$ shifting her threshold from $\bar{\kappa}_l$ to $\bar{\kappa}_l' = \bar{\kappa}_l + \epsilon, \epsilon > 0$. The fall in patient strategies in $[\bar{\kappa}_j, \bar{\kappa}_j + \epsilon)$ from s_{il} to $s_{il}^* \leq s_{il}$ could provide a windfall for j (and all other physicians), raising s_{ij} to $s_{ij}^* \geq s_{ij}$ (see previous corollary). In that case:

$$\Delta Q_j = \int_{\bar{\kappa}_l}^{\bar{\kappa}_l + \epsilon} \int_0^\infty \{s_{ij}^* - s_{ij}\} dG(\gamma) dF(k)$$

³Besides simplifying $Q_j(\bar{\kappa}_j, \bar{\kappa}_{-j})$ into $Q_j(\bar{\kappa}_j)$, we also forego the arguments of $s_{ij}(k, \gamma)$, as we've done many times already, to avoid notation clutter.

⁴The notation for $s_{ij}(\bar{\kappa}_j, \gamma)'$ is to be taken to mean the strategy $s_{ij}' \leq s_{ij}$ of the mass of patients at different levels of γ atomized at $\kappa_i = \bar{\kappa}_j$.

thus rendering:

$$\begin{aligned}\frac{\partial Q_j}{\partial \bar{\kappa}_l} &= \lim_{\epsilon \rightarrow 0} \frac{\int_{\bar{\kappa}_l}^{\bar{\kappa}_l + \epsilon} \int_0^\infty \{s_{ij}' - s_{ij}\} dG(\gamma) dF(k)}{\epsilon} \\ &= \int_0^\infty \{s_{ij}(\bar{\kappa}_l, \gamma)^* - s_{ij}(\bar{\kappa}_l, \gamma)\} dG(\gamma) f(\bar{\kappa}_l)\end{aligned}$$

As for X_j , the steps taken are almost the same, only that after raising the threshold by ϵ the amount of sick leaves granted goes around $\bar{\kappa}_j$ goes to 0, thus giving out:

$$\frac{\partial X_j}{\partial \bar{\kappa}_j} = - \int_0^\infty s_{ij}(\bar{\kappa}_j, \gamma) dG(\gamma) f(\bar{\kappa}_j)$$

such that it is simply required that j has positive demand for the mass of patients whose $\kappa_i = \bar{\kappa}_j$ for this derivative to be strictly negative, else it is null.

Likewise:

$$\frac{\partial X_j}{\partial \bar{\kappa}_l} = - \int_0^\infty s_{ij}(\bar{\kappa}_l, \gamma) dG(\gamma) f(\bar{\kappa}_l)$$

□

Before dealing with Proposition ?? we need one last intermediary proposition.

Proposition A.4.

$$\frac{\partial^2 Q_j}{\partial \bar{\kappa}_j \partial \bar{\kappa}_l} = 0 \quad \text{and} \quad \frac{\partial^2 X_j}{\partial \bar{\kappa}_j \partial \bar{\kappa}_l} = 0, \quad \forall j \text{ and } l, \bar{\kappa}_j \neq \bar{\kappa}_l$$

Proof. Our proof will be heuristic. Consider

$$\frac{\partial Q_j}{\partial \bar{\kappa}_j} = \int_0^\infty \{s_{ij}(\bar{\kappa}_j, \gamma)' - s_{ij}(\bar{\kappa}_j, \gamma)\} dG(\gamma) f(\bar{\kappa}_j)$$

Patient strategies s_{ij} are taken at the atom $\kappa_i = \bar{\kappa}_j$. For any other physician l such that $\bar{\kappa}_l \neq \bar{\kappa}_j$, an infinitesimally small change to $\bar{\kappa}_l$ doesn't affect the utility of patients at $\bar{\kappa}_j$, who will remain above or below l 's threshold same as before. Thus their strategy s_{ij} also remains unaffected. If $\bar{\kappa}_l$ does equal $\bar{\kappa}_j$, then the following limit is not properly defined:

$$\lim_{\epsilon \rightarrow 0} \frac{\frac{\partial Q_j(\kappa_l + \epsilon)}{\partial \bar{\kappa}_j} - \frac{\partial Q_j(\kappa_l)}{\partial \bar{\kappa}_j}}{\epsilon}$$

because as ϵ approaches 0 from the right the limit is weakly positive (≥ 0), whereas approaching from the left it's strictly 0. Meaning the derivative $\frac{\partial^2 Q_j}{\partial \bar{\kappa}_j \partial \bar{\kappa}_l}$ doesn't exist for j and $l \neq j$ when $\bar{\kappa}_j = \bar{\kappa}_l$.

□

Proof of Proposition ??.

Consider some two physicians j, l , such that $\bar{\kappa}_j \neq \bar{\kappa}_l$. If we breakdown the mixed partial derivative of U_j over $\bar{\kappa}_j$ and $\bar{\kappa}_l$, we get:

$$\begin{aligned}
\frac{\partial^2 U_j}{\partial \bar{\kappa}_j \partial \bar{\kappa}_l} &= \underbrace{R''(Q_j(\bar{\kappa}_j, \bar{\kappa}_{-j}))}_{\leq 0} \cdot \underbrace{\frac{\partial Q_j}{\partial \bar{\kappa}_l}}_{\geq 0} \cdot \underbrace{\frac{\partial Q_j}{\partial \bar{\kappa}_j}}_{\leq 0} + \underbrace{R'(Q_j(\bar{\kappa}_j, \bar{\kappa}_{-j}))}_{\geq 0} \underbrace{\frac{\partial^2 Q_j}{\partial \bar{\kappa}_j \partial \bar{\kappa}_l}}_{=0} \\
&\quad - \underbrace{P''(X_j(\bar{\kappa}_j, \bar{\kappa}_{-j}))}_{\geq 0} \cdot \underbrace{\frac{\partial X_j}{\partial \bar{\kappa}_l}}_{\geq 0} \cdot \underbrace{\frac{\partial X_j}{\partial \bar{\kappa}_j}}_{\leq 0} - \underbrace{P'(X_j(\bar{\kappa}_j, \bar{\kappa}_{-j}))}_{\geq 0} \underbrace{\frac{\partial^2 X_j}{\partial \bar{\kappa}_j \partial \bar{\kappa}_l}}_{=0} \\
&= \underbrace{R''(Q_j(\bar{\kappa}_j, \bar{\kappa}_{-j})) \cdot \frac{\partial Q_j}{\partial \bar{\kappa}_l} \cdot \frac{\partial Q_j}{\partial \bar{\kappa}_j}}_{\geq 0} - \underbrace{P''(X_j(\bar{\kappa}_j, \bar{\kappa}_{-j})) \cdot \frac{\partial X_j}{\partial \bar{\kappa}_l} \cdot \frac{\partial X_j}{\partial \bar{\kappa}_j}}_{\leq 0} \geq 0
\end{aligned}$$

and positive mixed derivative of physicians' utility over their strategy is the definition of strategic complementarity. □

A.4 Optimal Reserve Utility (Proof of Equation ??)

We follow the argument of ?. Let for the moment $\tilde{F}_i(U) = \Pr\{u_{ij} \leq U\}$ be the distribution of utility patient i receives from doctor visits, with $\tilde{F}_i(0) = 0$, $\tilde{F}_i(B) = 1$, for $B < \infty$. Each period, the patient draws an 'offer' U from \tilde{F}_i , which is to say, his search lead him to a physician j such that $u_{ij} = U$. He may either accept and have physician j assigned to him, receiving utility U per period henceforth, or look for a new physician next period.

Let u_t be the patient's utility for period t , where it's 0 if he doesn't visit a physician and U if he has accepted an assigned physician which renders him utility $u_{ij} = U$. This patient will seek to maximize $\mathbb{E}[\sum_{t=0}^{\infty} \beta^t u_t]$, where $0 < \beta < 1$ is his discount factor.

Let $V(U)$ be the expected value of $\sum_{t=0}^{\infty} \beta^t u_t$ of a patient with an offer U in hand. Assuming no recall, under optimal behavior the value function $V(U)$ satisfies the Bellman equation:

$$V(U) = \max \left\{ \frac{U}{1-\beta}, \beta \int V(U') d\tilde{F}_i(U') \right\} \quad (4)$$

The patient chooses an optimal value \bar{U}_i , such that offers $U \geq \bar{U}_i$ are accepted (the visit takes place). As such, the solution takes on the following form:

$$V(U) = \begin{cases} \frac{\bar{U}_i}{1-\beta} + \beta \int V(U') d\tilde{F}_i(U') & \text{if } U \leq \bar{U}_i, \\ \frac{U}{1-\beta} & \text{if } U \geq \bar{U}_i. \end{cases} \quad (5)$$

Using equation (5), we can convert the functional equation (4) into an ordinary equation in the reservation utility \bar{U}_i . Evaluating $V(\bar{U}_i)$ and using equation (5), we have:

$$\frac{\bar{U}_i}{1-\beta} = \beta \int_0^{\bar{U}_i} \frac{\bar{U}_i}{1-\beta} d\tilde{F}_i(U') + \beta \int_{\bar{U}_i}^B \frac{U'}{1-\beta} d\tilde{F}_i(U')$$

or

$$\begin{aligned} \frac{\bar{U}_i}{1-\beta} \int_0^{\bar{U}_i} d\tilde{F}_i(U') + \frac{\bar{U}_i}{1-\beta} \int_{\bar{U}_i}^B d\tilde{F}_i(U') \\ = \beta \int_0^{\bar{U}_i} \frac{\bar{U}_i}{1-\beta} d\tilde{F}_i(U') + \beta \int_{\bar{U}_i}^B \frac{U'}{1-\beta} d\tilde{F}_i(U') \end{aligned}$$

or

$$\bar{U}_i \int_0^{\bar{U}_i} d\tilde{F}_i(U') = \frac{1}{1-\beta} \int_{\bar{U}_i}^B (\beta U' - \bar{U}_i) d\tilde{F}_i(U').$$

Adding $\bar{U}_i \int_{\bar{U}_i}^B d\tilde{F}_i(U')$ to both sides gives

$$\bar{U}_i = \frac{\beta}{1-\beta} \int_{\bar{U}_i}^B (U' - \bar{U}_i) d\tilde{F}_i(U') \quad (6)$$

Finally, for our purposes, we discretize $\int_{\bar{U}_i}^B (U' - \bar{U}_i) d\tilde{F}_i(U')$ as a summation over the countable set of J doctors. The discrete equivalent of equation (6) is:

$$\bar{U}_i = \frac{\beta}{1-\beta} \sum_{j=1}^J \left\{ \frac{\mathbb{1}[u_{ij} \geq \bar{U}_i] \cdot (u_{ij} - \bar{U}_i)}{\mathbb{1}[u_{ij} \geq \bar{U}_i]} \right\} \quad (??)$$

Which is the function we say characterizes patient thresholds in the explicit search model.

A.5 More Figures

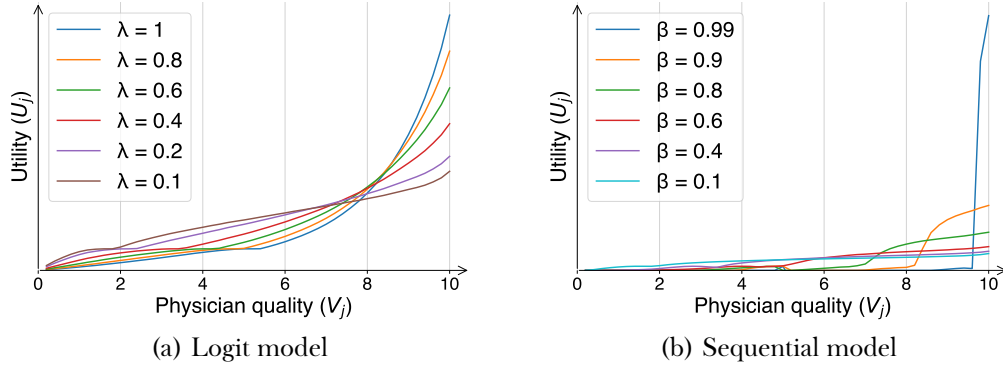


Figure 1: Equilibrium physician utility (U_j) by quality (V_j) for different model parameters, equilibrium $\bar{\kappa}^*$

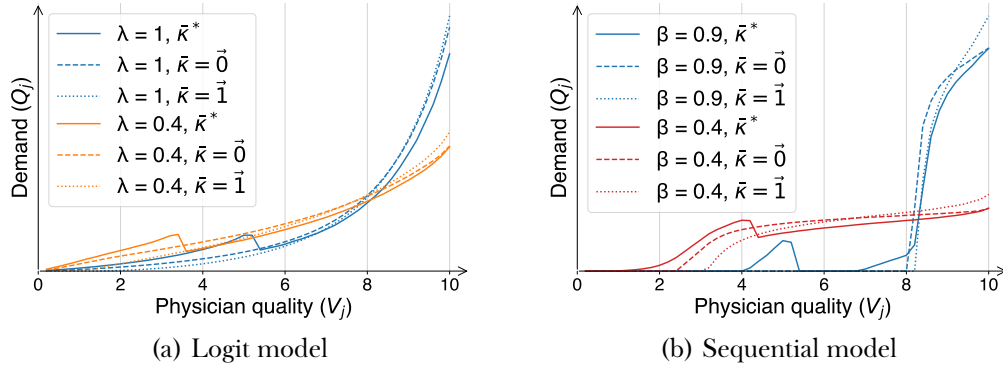


Figure 2: Comparison of patient demand (Q_j) by physician quality (V_j) for different model parameters and threshold vectors $\bar{\kappa}$

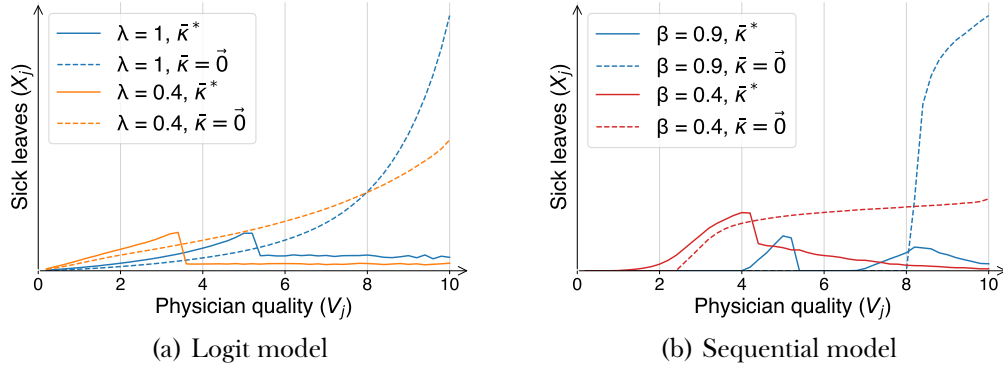


Figure 3: Comparison of sick leaves issued (X_j) by physician quality (V_j) for different model parameters and threshold vectors $\bar{\kappa}$

A.6 Identification Panels

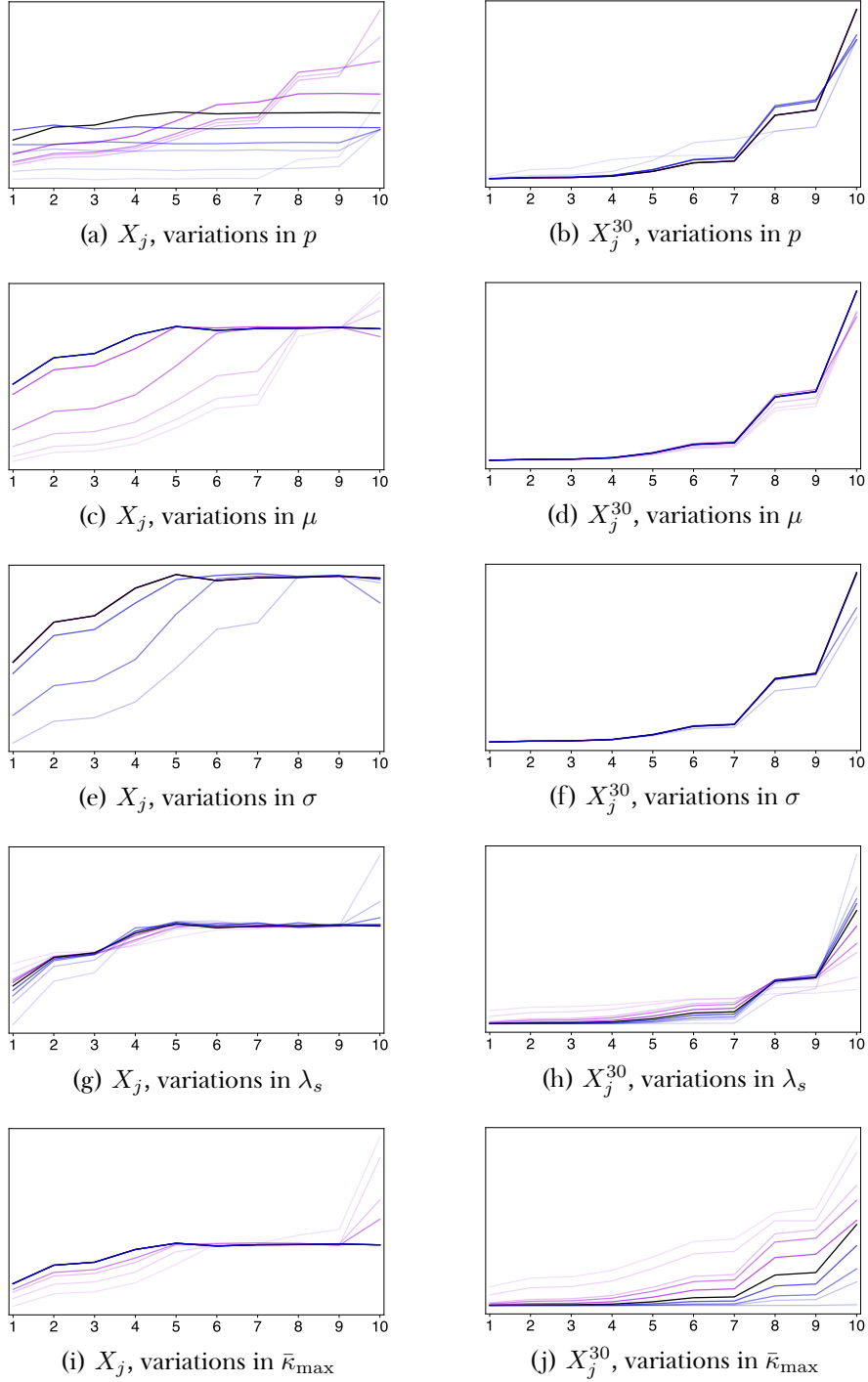


Figure 4: Sick leaves issued by quality bin as parameters vary.

Black: Estimated value. Violet: Lower. Blue: Higher.

Transparency increasing with distance from estimated value

A.7 Parameter Sources

Physician quality by bins ($V_1 \dots V_{10}$)

As mentioned in the main text, three criteria are considered for the *quality score*:

- i Average duration of sick leaves issued.
- ii Percentage of sick leaves of 30+ days over total in sampled period.
- iii Amount of sick leaves of 30+ days issued.

For each of the criteria the *percentile rank* which each physician occupies is recorded, all in increasing order, i.e. from lowest to highest average duration, from lowest to highest percentage/amount of ≥ 30 days sick leaves. Call the percentile rank which physician j occupies in each category p_j^i , p_j^{ii} and p_j^{iii} . The *quality score* of physician j is the simple average of these three, that is:

$$q_score_j = \frac{1}{3}p_j^i + \frac{1}{3}p_j^{ii} + \frac{1}{3}p_j^{iii}$$

The quality bins are then set up from the decile ranks of physicians in their *quality score*. Bin 1, for example, is simply the first decile rank of q_score , the lowest 10% of physicians according to their quality score. Each bin is therefore equally sized.

The parameters $V_1 \dots V_{10}$ associated with each bin are then to be estimated in our GMM exercise, subject to the constraint that they increase in alignment with quality. Simply put: $V_{10} > V_9 > \dots > V_1$.

Revenue by visit (r_j) and cost of visit (τ_j)

We use a single r and τ for all physicians on this occasion. In the future a proper match to revenue bins would be a way to further square parameter estimation. Our procedure is arbitrary, but an alternative method would nonetheless stay within the same degree of magnitude as our final values for r and τ , so in this case arbitrariness is not all too relevant.

We select the ten most frequent *cie10* categories in our sample, the international standard classification of medical conditions. These ten, as well as non-categorized conditions (seen as *empty* in the Table), account for 47.91% of all sick leaves in our database. We then match the conditions to a particular field of practice, though strictly speaking physicians aren't reduced to their own field when issuing sick leaves, so matching is fuzzy.

We then take a *full price* and the fee paid by FONASA affiliates in the Free Choice Modality (MLE) as a reference price, from a tariff book assembled by FONASA itself (?). We take this to correspond to the physician's revenue by visit (r) and the patients' cost of visit (τ), respectively.

Our final value for r and τ is the weighted average of this prices, weighted by the relative frequency of each category and its matched full and benefit price. This amounts to taking the dot product of the ‘%’ column with the ‘Full Price’ and ‘Aff. Fee’ columns in the Table below, respectively.

The resulting values are: $r = 21,182$ and $\tau = 8,944$. For simplicity, we select to use them in the thousands for estimation, i.e. 8.944 instead of 8,944. See the Table below for the referenced variable columns.

<i>cie10</i> cat.	Instances	%	Informal Description	Matched Field	Full Price	Aff. Fee
M54	379,332	0.20	Back pain	Traumatology	\$ 18,130	\$ 7,250
F32	304,399	0.16	Depression	Psychiatry	\$ 27,510	\$ 11,000
F41	284,129	0.15	Anxiety	Psychiatry	\$ 27,510	\$ 11,000
F43	244,468	0.13	Stress	Psychiatry	\$ 27,510	\$ 11,000
J20	191,615	0.10	Bronchitis	General	\$ 14,270	\$ 7,440
A09	186,535	0.10	Gastroenteritis	General	\$ 14,270	\$ 7,440
<i>empty</i>	152,239					
M75	115,585	0.06	Shoulder	Traumatology	\$ 18,130	\$ 7,250
J00	92,660	0.05	Common cold	General	\$ 14,270	\$ 7,440
M51	54,800	0.03	Intervertebral disc	Traumatology	\$ 18,130	\$ 7,250
K52	49,182	0.03	Gastroenteritis	General	\$ 14,270	\$ 7,440

Table 1: Most common health conditions reported by physicians in sick leaves issued, matched to corresponding fees of service