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Mapping out the arguments for and against patient non-attendance fees in healthcare: an analysis of public consultation documents

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ABSTRACT

Background Patients not attending their appointments without giving notice burden healthcare services. To reduce non-attendance rates, patient non-attendance fees have been introduced in various settings. Although some argue in narrow economic terms that behavioural change as a result of financial incentives is a voluntary transaction, charging patients for non-attendance remains controversial. This paper aims to investigate the controversies of implementing patient non-attendance fees.

Objective The aim was to map out the arguments in the Norwegian public debate concerning the introduction and use of patient non-attendance fees at public outpatient clinics.

Methods Public consultation documents (2009–2021) were thematically analysed (n=84). We used a preconceived conceptual framework based on the works of Grant to guide the analysis.

Results A broad range of arguments for and against patient non-attendance fees were identified, here referring to the acceptability of the fees' purpose, the voluntariness of the responses, the effects on the individual character and institutional norms and the perceived fairness and comparative effectiveness of patient non-attendance fees. Whereas the aim of motivating patients to keep their appointments to avoid poor utilisation of resources and increased waiting times was widely supported, principled and practical arguments against patient non-attendance fees were raised.

Conclusion A narrow economic understanding of incentives cannot capture the breadth of arguments for and against patient non-attendance fees. Policy makers may draw on this insight when implementing similar incentive schemes. The study may also contribute to the general debate on ethics and incentives.

INTRODUCTION

When patients miss their appointments without giving notice, resources that could have benefited others remain unused if walk-in patients do not replace the absentee.^{1–3} For this reason, patient non-attendance may cause longer waiting times, poorer clinical outcomes and increased financial costs for providers because of a loss of income and unplanned healthcare.^{1 4–12} In addition, waiting longer for healthcare may affect the patients' ability to participate in the working force.¹ Patient non-attendance in healthcare is not a trivial challenge for policy makers. A recent systematic literature review comprising studies from both primary and secondary care reported an average patient non-attendance rate of 23%, though there were differences across healthcare

settings, populations and countries.⁸ Another study concluded that the non-attendance rate in somatic healthcare amounted to 5%–10% when accounting for cancellations by providers and users.¹³

Policy makers have noted the viability of implementing patient fees as a means of reducing the rate of patients not attending their appointments without notice.^{113–18} The expectation is that a fee will make the monetary costs of non-attendance exceed the benefits for the patient and discourage them from not keeping their appointments.¹ However, charging patients for non-attendance remains controversial and an issue within the public discourse. Two main arguments contribute to explain this controversy. First, it is not well documented if a patient non-attendance fee actually reduces the rate of non-attendance, and the effectiveness of this measure in meeting the goal of efficient use of healthcare resources is debated.^{13 16–18} Second, concerns have been raised whether the fee may disproportionately affect socially less advantaged groups in society.^{13 19–22} Thus, it has been claimed that '[p]atient sanctions such as charging a no-show fee are a less desirable solution because they can limit access to care to patients with restricted income' (Daggy *et al*, p247).²⁰

Nonetheless, non-attendance fees have been introduced in various settings as patient incentives. In health policy and other policy areas, the authorities are increasingly using incentives to obtain the desired outcomes.²³ The use of incentives as a policy tool is of particular interest because the introduction of incentives can have ethical implications that are less well understood. To gain a deeper understanding of the normative controversies surrounding the implementation of a patient non-attendance fee, we set out to investigate the arguments used in the public debate about non-attendance fees in Norway.

In the present paper, we report on a study using data retrieved from public hearings, that is, public consultation documents (2009–2021). To the best of our knowledge, this is the first study to systematically and empirically map out the arguments for and against implementing patient non-attendance fees in healthcare. Therefore, the current study can inform the ongoing debate about using such fees and be of interest to policy makers, health professionals, patients and citizens in general. The study may also contribute to the general debate on ethics and incentives.

CONCEPTUAL FRAMEWORK

Incentives (and disincentives), for example, a monetary benefit (or a cost), are intentionally designed



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to supply extrinsic reasons to make a particular choice.²³ Thus, incentives may be used as a tool in regulative policies to motivate behavioural change and steer citizens' behaviour.^{24,25} Grant has presented two different approaches to how incentives are best conceptualised and understood.^{23,26–29} In the most prevalent view, incentives are perceived as a form of trade. According to economic thought, an incentive '[...] alter[s] the balance of the costs and benefits of a particular choice so as to alter a person's course of action' (Grant, p35).²⁸ Individuals are seen as rational beings capable of acting consistently with their preferences and who are free to choose between alternatives. When a voluntary economic transaction occurs, it is because all parties think they are better (or not worse) off than they were before.²⁷ Thus, the pivotal question is whether this exchange between the parties is voluntary, in the sense that they are free to reject the offer. Incentives understood as a voluntary economic transaction appear inherently ethical; all parties are better off.²⁷

However, the design and use of incentives may raise important ethical issues beyond voluntariness that the economic approach to incentives cannot answer. For example, a minimalist conception of rationality and freedom makes it difficult to recognise attacks on autonomous choice that are more broadly construed to include the capacity to set one's own ends. Incentives may be used in ways that are paternalistic, manipulative or exploitative, even if the individual is free to refuse them. To see how this may happen, Grant suggests that incentives should be analysed as a form of power. Thus, the use of incentives is one possible answer to the question, 'How can one person get another person to do what he wants him to do?' (Grant, p29)²⁷

Grant argues that the use of incentives can be more or less normatively defensible as a legitimate means of altering behaviour.^{23,27,28,30} To judge the legitimacy of a particular use of an incentive, we should assess whether incentives serve a rationally defensible purpose; allow for a voluntarily response; and are in line with requirements of moral character or institutional culture. Moreover, taking into account the broader context in which the incentive operates, the incentive under investigation must be compared with alternative available measures. Three additional factors must be considered: fairness, effectiveness and the absence of undue influence.

In Grant's analysis, these factors are construed as normative standards to evaluate the legitimacy of incentives. In the following, we have used the conceptual framework as descriptive categories to examine and organise the arguments identified in the data. Importantly, the factors were adapted and, to some

extent, modified to be applicable for our analysis. The conceptual framework is presented in [table 1](#).

METHODS

Study design

We designed the current study to be a qualitative document analysis. Data were retrieved from public consultation documents and analysed thematically using the predetermined conceptual framework described.³¹

Study setting

Norway has a universal and tax-financed healthcare system serving approximately 5.4 million people.³² Outpatient specialist visits at public hospitals include a user fee of NOK 375/EUR 35 until the patient reaches a set ceiling. The patient non-attendance rate in public outpatient clinics is estimated to be 3%–4% but varies between different treatments and hospitals.³³

Since 2001, patients can be charged a non-attendance fee if they do not attend their outpatient appointment and have not given notice within 24 hours before the scheduled appointment time.³⁴ The scheme was formally implemented for all health professionals in 2009. The fee has increased from being equivalent to the user fee to fourfold the user fee. In 2023, the government increased the non-attendance fee to NOK1500/EUR139.³⁵ Patients in outpatient care within psychiatry or substance abuse treatment are exempt from paying the full non-attendance fee and can only be charged a fee for non-attendance limited to the size of the user fee. Recently, the Norwegian Healthcare Investigation Board has reported that the implementation and use of the patient non-attendance fee vary considerably across public hospitals and outpatient clinics.³⁶

Data

The proposal issued by the government to implement a patient non-attendance fee and various proposals to amend the non-attendance fee scheme have been subject to public consultations. The data consisted of public consultation documents (consultation papers and responses).

In the Norwegian context, a public consultation means that a proposal by the government, a ministry or any other public authority to amend a law or regulation is presented to the public to receive feedback. This is a method for citizen participation and hearing, where citizens can comment on proposals and, ideally, inform and influence policy decisions.^{37–39} Relevant government agencies, organisations, institutions and associations are invited to submit a written response to the consultation paper, which presents the policy proposal and informs about how and when to respond. The paper is also published openly so that citizens can respond. As a result, the consultation documents provide unique insights into the government's policy-making process, including a variety of responses to policy proposals from different stakeholders.

The consultation documents were collected from the digital archives of the Norwegian Government (Regjeringen.no), except for one consultation (2009), where we had to contact the Ministry of Health and Care Services to retrieve the consultation responses. Since the implementation of a standardised patient non-attendance fee for all outpatient specialist appointments in 2009, the Ministry of Health and Care Services has undertaken five consultations on the subject (until January 2023). We chose to include all five consultations in the analysis.

The data corpus consisted of consultation documents (n=153). Consultation responses with no (n=45) or irrelevant comments

Table 1 The conceptual framework is based on the works of Grant^{23,27,28,30}

Factor	Operationalisation
Purpose	What is the purpose of the fee and is it acceptable to the parties involved?
Voluntariness	Does the fee allow for an informed and voluntary response?
Character	Does the fee affect the individual character or institutional culture, including effects on altruism, responsibility or the intrinsic motivation to act?
Fairness	Is the fee administrated fairly so that people who are similarly situated are treated alike?
Effectiveness	Is the fee an effective means of achieving the goal compared with the alternatives?
Undue influence	Is the fee issued by decision-makers with legitimate authority in the sphere in which the fee is issued? Does the fee induce people to act against their better judgement or principles?

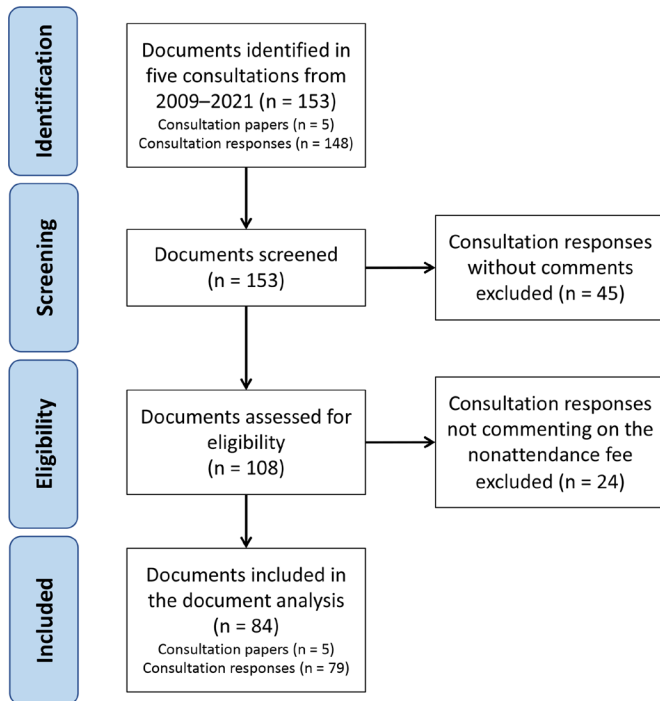


Figure 1 Flow diagram showing the selection of consultation documents for the analysis.

(n=24) were excluded. Accordingly, we ended up with a data set (n=84) consisting of consultation papers and responses, which included comments on the introduction and use of the patient non-attendance fee (figure 1). Online supplemental appendix A shows the included consultation documents.

Data analysis

The documents were analysed in NVivo (V.12). The first author read every consultation document in full. The conceptual framework served as preconceived categories to organise the data, and the text sections that discussed the patient non-attendance fee were coded and sorted into themes and subthemes. The authors discussed the coding process to improve the consistency and reliability. Eventually, the first author translated the chosen illustrative quotations from Norwegian into English.

RESULTS

In the following, we report the results covering five consultations (table 2). A broad range of arguments for and against the use of a non-attendance fee were found in the data, here referring to five of the six factors of the conceptual framework (the acceptability of the purpose, the voluntariness of the responses, the effect on individual character or institutional norms, fairness and effectiveness). We did not identify concerns about decision-makers transgressing the boundaries of their authority in the design and use of non-attendance fees.¹ Thus, arguments referring to the factor of undue influence were not identified in the data. Table 3 summarises the findings and provides illustrative quotations. The references to the consultation documents cited are listed in online supplemental appendix A.

¹For example, neither criticism of the health authorities' exercise of this type of power in the healthcare sphere, nor concerns that the nonattendance fee unduly induces patients to attend their outpatient appointments (imagining that attendance had been against their better judgement or principles) were identified in the data.

Table 2 An overview of the five consultations (2009–2021) included in the analysis

Consultation	Year	Proposal
C1	2009	To charge non-attendance from all health professionals at outpatient clinics, either <ul style="list-style-type: none"> ▶ the non-attendance fee being standardised equal to the user fee of specialists or ▶ the non-attendance fee being set according to the user fee of the type of health professional.
C2	2016	To exempt patients in psychiatric and substance abuse outpatient care (after the non-attendance fee had been increased to twice the user fee in 2015), either <ul style="list-style-type: none"> ▶ these groups of patients should be charged no more than the user fee of specialists, or ▶ these groups of patients should be exempt when absence is because of their state of health.
C3	2019	To increase the non-attendance fee to three times the user fee of specialists.
C4	2020	To charge non-attendance from video and telephone appointments similarly as with ordinary consultations.
C5	2021	To permit private laboratory and radiography companies that have an agreement with the regional health authority to charge the non-attendance fee as in public outpatient clinics.

The acceptability of the purpose

The goal of introducing the patient non-attendance fee in outpatient clinics was explicitly stated in several of the consultation papers, namely to motivate patients to keep their appointments with the outpatient clinics. This purpose was widely supported in the data. The arguments typically pointed to the obligation of public healthcare to avoid the poor utilisation of resources and increased waiting time. The opinion that the fee would motivate patients to keep their appointments and, thus, contribute to efficient resource utilisation was reiterated throughout the consultation papers and responses. One consultation response indicated that a fee should be in accordance with the costs of non-attendance and be planned as provider compensation, yet this argument was never explicitly emphasised in other sources.

Notably, principled objections to the patient's non-attendance fee did not appear until the second consultation (2016). One interpretation of this is that, when the non-attendance fee exceeded what patients would have to pay if they received treatment (the user fee), this infringed on the perceived importance of a symmetry between rights and duties.

The voluntariness of choices

One of the most frequently stated arguments against the use of the fee revolved around the concerns of the voluntariness of the response. Although some perceived patient non-attendance (and, in effect, the response to the fee) to be a deliberate and voluntary choice, others disagreed sharply with this view. These critical voices pointed to factors such as lack of information and knowledge about the non-attendance scheme and the consequences of non-attendance as reasons not to increase the non-attendance fee. Unforeseeable events, such as transport problems and sudden illness, were mentioned for explaining why the fee might be futile. In addition, factors such as reduced capabilities, including the lack of capacity to keep appointments, were discussed.

The effect on institutional culture and patient character

Moreover, using the non-attendance fee was feared as having negative effects on institutional norms. Some highlighted that

Table 3 Results of the analysis as organised in accordance with the conceptual framework

Theme	Subtheme	Illustrative quotation
Purpose What is the purpose of the fee, and is it acceptable to the parties involved?	The common good	'(M)any patients (...) do not attend their appointments. This causes poor utilisation of resources and increased waiting times for others'. (C3, 1)
	Patient motivation	'The purpose (...) is to motivate the patients to keep their appointments with the outpatient clinic'. (C2, 1)
	Provider compensation	'We believe that increased fees for absence should be justified by the inconveniences to the hospitals and the health service'. (C4, 8)
	Rights-duties symmetry	'The patient can perceive the size of the fee as unreasonable if this is much higher than the user fee (...). For the therapists and service providers, it can be perceived as unreasonable if the size of the fee is much lower than the user fee'. (C1, 9)
Voluntariness Does the fee allow for an informed and voluntary response?	Free choice	'(T)he ministry (should) (...) reduce the number of unused appointments as a result of patients deciding shortly before the scheduled appointment that they will spend their time on other activities'. (C2, 16)
	Knowledge and information	'The treatment unit must make sure that the patient has understood the agreement and assess that the patient has a real opportunity to plan for and carry out the appointment'. (C4, 9)
	Unforeseeable events	'(...) patients are not charged when the reason for cancellation (under 24 hours before) is considered to be beyond the patient's control'. (C3, 23)
	Capabilities	'(I)t is important that the health trusts make it easy for patients to cancel and/or move scheduled appointments'. (C3, 19)
Individual character or institutional norms Does the fee affect the individual character or institutional culture?	Self-responsibility	'It will also be good (...) to have to take responsibility for following up on the treatment appointments'. (C2, 2)
	Perverse incentives	'Can the fee actually work against its purpose? The fee will change the financial consequences for the hospital when the patient is absent from the appointment. What incentives does this provide for the hospital's efforts to increase attendance rate?' (C3, 21)
	Relationship patient-provider	'Leaving it to the therapist to decide whether the fee should be charged or not could affect the relationship between therapist and patient'. (C2, 2)
Fairness Is the fee administered fairly so that people who are similarly situated are treated alike?	Social inequality	'A high fee hits socially unevenly. It is often people with low socioeconomic status who have the worst health (...)'. (C4, 11)
	Arbitrary exemption	'(We) note that limiting the exemption only to this group of patients (substance abuse and psychiatry) is contrary to the equality ideal of the healthcare system and that there are several groups of patients who should have been protected from increased fees'. (C3, 8)
Effectiveness Is the fee an effective means of achieving the goal compared with the alternatives?	Efficacy	'(...) it is not necessarily the amount of the fee, or the absence of a fee, that prevents someone from showing up'. (C5, 9)
	Administrative costs	'(H)health trusts (...) do not find it expedient to impose (...) a nonattendance fee because this triggers a lot of administration without the fee being able to be collected in practice'. (C1, 10)
	Comparative effectiveness	'SMS notifications and other notification systems ahead of the appointment are probably a better means of preventing absence than the use of nonattendance fees per se'. (C2, 14)

the hospitals would have fewer incentives to increase attendance in other ways. Others worried that the relationship between patient and health professional could be negatively affected if the decision of whether or not to charge was left to the professional's discretion. In addition, it was pointed out that some patients might perceive the fee as a punishment from the therapist. Such examples of negative impacts on the institutional culture were perceived as a threat. Furthermore, we identified an argument referring to the fee's possible impact on the character of the patient, such as increased self-responsibility for treatment. However, there were no occurrences of alluding to patients' responsibility to ensure efficient health services for fellow citizens.

Fairness

A range of unintended consequences harming the least socially advantaged groups was highlighted. These kinds of arguments were typically linked to arguments regarding the unfairness of placing an additional monetary burden on the socially disadvantaged. For example, there were worries that patients experiencing economic strain may not seek help or drop out of an ongoing treatment. Some referred to a social gradient in health and worried that a fee increase would make healthcare relatively more costly for socioeconomically low status groups because these groups relatively more often have healthcare needs and, thus, a greater risk of non-attendance. Therefore, increasing fees would contribute to increasing social inequalities in health. Additionally, a couple of responses indicated that non-attendance fees might be detrimental to equal access to healthcare because of

their impact on those with strained finances and low socioeconomic status.

Many warned against the negative consequences for particular patient groups when it came to understanding non-attendance (and accepting the fee) as a voluntary choice. They often underscored the need to introduce exceptions for patients with reduced capabilities not attending their appointments because of factors beyond their control. Although the proposal to exempt patients in substance abuse and psychiatric outpatient care from paying the full fee was supported, it was pointed out that other groups, for example, patients with cognitive impairments and several chronic diseases, should be included in the exemption policy as well. In addition, it was noted that patients suffering from substance abuse and psychiatric disorders often have an increased risk of physical disorders, yet they were not exempt from paying non-attendance fees when being treated in somatic outpatient clinics. This fact was perceived as unfair to these patient groups.

Effectiveness

Although many responses seemed to take the effectiveness of a non-attendance fee for granted, some pointed out that there was little evidence of the alleged efficacy and comparative effectiveness of this measure on a reduction of non-attendance. They questioned the presumption that patients do not keep their appointments because they lack the motivation to do so and, in particular, questioned the claim that a further increase of the fee would enhance the motivation for patients to keep their appointments. Moreover, several of the responses underscored

the administrative costs of the non-attendance fee as an argument against the use of such fees.

DISCUSSION

The findings of the present study suggest that patient non-attendance fees are broadly supported and accepted in the Norwegian public debate. The explicit purpose of introducing the fees was to reduce non-attendance and shorten waiting times, thus making more efficient use of resources. There was little disagreement regarding the acceptability of this aim in the data. Nonetheless, a range of principled and practical arguments against the use of non-attendance fees was identified. We comment on the most important arguments below.

The belief that patient non-attendance can be reduced to a strict minimum if non-attendance is made costly in monetary terms is grounded in the view that non-attendance is a motivational problem.²³ Our data suggest that many believed that there are factors causing patient non-attendance going beyond individual control. Some pointed out that there is little evidence of the effectiveness of non-attendance fees and made the claim that patient non-attendance is inevitable because of unforeseeable events in patients' lives. This argument is in line with previous studies.^{13 16–18} There is no agreement in the literature regarding how much non-attendance rates can be expected to be reduced.¹³

At the same time, the data suggested that many shared the view that non-attendance fees are administratively burdensome to implement in practice. This finding resonates with studies showing that the use of non-attendance fees has been considered challenging and resource demanding to implement.^{14 40–43} As such, although the principled argument against non-attendance fees was the disbelief of a lack of motivational reasons for non-attendance, the practical concerns regarding implementation costs were used as an additional argument against a presumed effectiveness of the fee.

Concerns about the unequal distribution of the burden of non-attendance fees in such a way that socially vulnerable patients are disproportionately affected have been discussed in the literature.^{13 19–22} This discussion was also identified in the data. Several consultation responses debated the claim that, because socially vulnerable groups of patients have an increased risk for poor health, they will statistically have more contact with the health service and have a higher probability for non-attendance. These responses worried that the financial burden of non-attendance fees might be relatively heavier on these groups compared with others, and some even indicated that this fact threatened equal access to healthcare. Moreover, the claim that socially vulnerable groups more often than other groups would be unable to attend their appointment and, thus, be relatively more negatively affected by such fees was found in the data. The argument that fees are unfair to patients who are unable to avoid non-attendance has also been reported in the previous literature.^{19 22 44}

Some worried that outpatient clinics had fewer incentives to reduce non-attendance rates because they had earnings from non-attendance. This argument related to the claim that a non-attendance fee is a 'perverse incentive', unintendedly incentivising wrong behaviour, which is a danger pointed out in previous studies.⁴⁵

Others have argued that non-attendance fees can decrease or crowd out patients' intrinsic motivation to attend appointments and backfire,⁴² in the sense that it brings about another outcome than desired, for example, effectively increasing instead of

decreasing the rates of non-attendance. We did not find arguments regarding the crowding-out effect in our data.

In some countries, including Denmark, appeals to a particular form of 'civic duty' have been highlighted in the public debate about non-attendance fees.⁴⁶ The introduction of the fee can be understood as a means of making patients aware of the societal costs of not attending their appointments. More generally, there have been appeals to patients' duties to protect the interests of fellow patients in contributing to effective and efficient use of resources in publicly funded healthcare systems.⁴⁷ However, we did not identify arguments about patients' social responsibility to ensure efficient healthcare in our data.

Strengths and limitations

The current study contributes to the discussion surrounding the arguments for and against the use of non-attendance fees in healthcare by using a conceptual framework based on the works of Grant.^{23 27 28 30} Others studying various normative arguments for and against the use of financial incentives may employ the framework, and the arguments we found may be relevant when evaluating other economic means in different settings.

The findings of the study must, however, be interpreted with some limitations in mind. The use of predetermined frameworks entails the risk of overlooking important data that do not fit the framework.⁴⁸ At the same time, a framework helps organise the data in a specific way, making the findings comparable to other empirical studies and aiding in theoretical development.

A limitation is that the documents were exclusively from a Norwegian context. Arguments for and against using non-attendance fees are probably, to some extent, biased by the country's health system and its financing structures, as well as factors like ideology, demography and economy. The responses were also answers to particular policy proposals that framed their focus. Thus, we do not know whether the findings can be transferable to other settings. On the other hand, many of the responses were general comments about the non-attendance fee not confined to the specific Norwegian setting.

Although the consultation process is open to everyone, citizens themselves rarely submit responses. Health professionals' and patients' views and opinions about using non-attendance fees have been understudied.^{22 49 50} Further studies should provide data from health professionals and patients. Moreover, there is a need for theorising how the arguments identified in this study should be weighed against each other to provide practical guidance.

CONCLUSION

The current study has contributed to the debate about patient non-attendance in healthcare. It has provided a systematic mapping of the arguments for and against health authorities' use of non-attendance fees to motivate behavioural change by imposing a monetary cost on patients not attending their appointments. A narrow economic understanding of incentives does not capture the breadth of arguments identified in the public debate about the introduction and use of non-attendance fees in Norway. We believe policy makers may draw on this insight when implementing similar incentive schemes. We also hope that the study contributes to the general debate on ethics and incentives.

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Contributors JRF conceived the idea of this paper, designed the study, selected

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