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Policy-makers' conception of patient non-attendance fees in specialist healthcare: a qualitative document analysis

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ABSTRACT

Objectives Patients missing their scheduled appointments in specialist healthcare without giving notice can undermine efficient care delivery. To reduce patient non-attendance and possibly compensate healthcare providers, policy-makers have noted the viability of implementing patient non-attendance fees. However, these fees may be controversial and generate public resistance. Identifying the concepts attributed to non-attendance fees is important to better understand the controversies surrounding the introduction and use of these fees. Patient non-attendance fees in specialist healthcare have been extensively debated in Norway and Denmark, two countries that are fairly similar regarding political culture, population size and healthcare system. However, although Norway has implemented a patient non-attendance fee scheme, Denmark has not. This study aimed to identify and compare how policy-makers in Norway and Denmark have conceptualised patient non-attendance fees over three decades.

Design A qualitative document study with a multiple-case design.

Methods A theory-driven qualitative analysis of policy documents (n=55) was performed.

Results Although patient non-attendance fees were seen as a measure to reduce non-attendance rates in both countries, the specific conceptualisation of the fees differed. The fees were understood as a monetary disincentive in Norwegian policy documents. In the Danish documents, the fees were framed as an educative measure to foster a sense of social responsibility, as well as serving as a monetary disincentive. The data suggest, however, a recent change in the Danish debate emphasising fees as a disincentive. In both countries, fees were partly justified as a means of compensating providers for the loss of income.

Conclusions The results demonstrate how, as a regulative policy tool, patient non-attendance fees have been conceptualised and framed differently, even in apparently similar contexts. This suggests that a more nuanced and complex understanding of why such fees are debated is needed.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study offers a novel theory-driven analysis of the normative ideas underpinning the politico-administrative debates surrounding patient non-attendance fees in specialist healthcare.
⇒ The conceptual framework, which details three different framings of patient non-attendance fees, provides a more nuanced understanding of patient non-attendance fees in a public healthcare setting.
⇒ The study only reports findings from public documents and does not investigate hidden policy agendas or attitudes in the process of implementing fees.

BACKGROUND

Patients missing their appointments without giving notice burden healthcare systems because unplanned non-attendance often results in unused appointments and unproductive health personnel.[1 2] To minimise patient non-attendance in healthcare by making it costly not to meet at the scheduled appointment time and compensate healthcare providers for a loss of income, policy-makers may opt to introduce a non-attendance fee.[1 3–10]

However, in universal and tax-financed healthcare systems where patients receive healthcare at no or a minimal cost, the introduction of non-attendance fees may be controversial and generate public resistance. Arguments referring to the perceived ineffectiveness and unfairness of such fees have been identified as a source of concern in public debate.[4] Prior research suggests that an actual reduction in the rate of non-attendance corresponding to the introduction of these fees is not well documented.[3 10] Moreover, these fees may disproportionally affect the less advantageous groups.[3 4 11 12]

Indeed, in Scandinavian countries such as Norway and Denmark, where specialist healthcare is free at the point of access and equal access to care is a cornerstone, patient fees for non-attendance in specialist care have become a difficult issue for policy-makers.[1 3 4] In Norway, patient non-attendance fees were

introduced in 2001 in public hospitals. Nonetheless, the design of the scheme has been repeatedly debated over the years.[4] A possible introduction of a similar scheme has been discussed in Denmark, but Danish health authorities have so far hesitated to introduce patient non-attendance fees in public hospitals.

The introduction of regulative policies that seek to change citizen behaviour requires public support. Consequently, it is important to understand why patient non-attendance fees are controversial in public healthcare systems. Empirical studies of the normative ideas underpinning the politico-administrative debates surrounding patient non-attendance fees in such settings and the possible discussions that arise are lacking. We wanted to gain insights into the ideas that underpin these debates about patient non-attendance fees in Norway and Denmark. The two countries are fairly similar regarding political culture, population size and healthcare system. However, as we discuss, the politico-administrative debates about non-attendance fees have been different in the two countries.

The present study aimed to identify and compare how policy-makers in Norway and Denmark have articulated patient non-attendance. Our contribution lies in two areas. First, we elaborate on the notion of patient non-attendance fees in a theoretical manner. We develop a conceptual framework that aids in analysing how patient non-attendance fees may be conceptualised and framed. Second, we provide an empirical analysis of the conceptualisations and framings of patient non-attendance fees found in Norwegian and Danish policy documents over the past three decades.

Conceptual framework

To aid in our document analysis, we developed and used a conceptual framework detailing three different framings of patient non-attendance fees: (1) as patient incentive, (2) as patient education and (3) as provider compensation (table 1). We understand these framings as ideal types. In the Weberian sense, an ideal type is an analytical tool whose purpose is to develop knowledge and understanding about the empirical phenomenon or situation under study.[13] Importantly, an ideal type should neither be understood as a moral ideal nor a representation of reality.[14] Ideal types are instead 'mental constructs' that accentuate one or more points of view and synthesise components of these points of view into a 'unified construction'.[15]

Accordingly, the three constructs should be seen as condensed and cultivated representations of conceivable justifications for introducing patient non-attendance fees that can be observed in more or less pronounced forms in the real world. They are not intended to be exhaustive or mutually exclusive; that is, the three constructs may operate simultaneously in the same empirical case.

Ruth W. Grant's work on the ethics of incentives inspired the development of the first two constructs.[16–18] Incentives (and disincentives), such as a monetary benefit (or cost), are intentionally designed to supply extrinsic reasons for making a particular choice.[17 18] Thus, incentives may be employed as a tool in regulative policies to motivate behavioural change and steer citizens' behaviours in desired directions.[19 20]

Grant discusses two contrasting attitudes that policy-makers can embrace when debating public policy formation. According to the economic attitude, what matters is the net utility, which is the outcome of individual choices. The traditional economic model of human behaviour conceives of individuals as utility maximisers driven by extrinsic and self-interested motivation.[18 19] Individuals are seen as rational beings who are 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.[17]

In Grant's analysis, the historical alternative to the economic attitude is the 'moralistic' or civic attitude, which holds that public concerns should be the cultivation of moral character and civic virtues of the individual. Society can only function at its best if the individual acts for the right reason, meaning that the quality of motivation matters.[17] Human actions are understood as normatively motivated; individuals' conceptions of right and wrong guide their behaviour, and people are capable of acting contrary to their own self-interest.[21 22]

Against this backdrop, we developed two constructs of patient non-attendance fees based on contrasting assumptions of (1) the purpose of patient non-attendance fees, (2) public concern and (3) the assumptions of human behaviour underpinning them. The economic-oriented understanding

Table 1 Three constructs of patient non-attendance fees

	Non-attendance fees as patient incentive	Non-attendance fees as patient education	Non-attendance fees as provider compensation
Purpose	To motivate patients to attend appointments by increasing the monetary costs of non-attendance	To educate patients to attend appointments by transmitting social responsibility norms	To compensate (parts of) the providers' costs incurred from patient non-attendance
Public concern	The aggregate utility of individual choices	The cultivation of civic virtues, fostering a sense of social responsibility	Financial predictability or reciprocal fairness
Assumptions of human behaviour	Patients seen as utility maximisers, driven by extrinsic and self-interested motivation	Patients seen as guided by conceptions of right and wrong, capable of being driven by moral motivation	Undetermined regarding assumptions of human behaviour

of patient non-attendance fees conceptualises the fee as a patient incentive (a monetary disincentive) that '[…] alter[s] the balance of the costs and benefits of a particular choice so as to alter a person's course of action'.[18(p.35)] The civic-oriented understanding of fees, on the other hand, frames the fee as an educational tool through which broader social responsibility norms are transmitted. As such, this view conceptualises the fee as appealing to patients' duties to contribute to effective and efficient health services for fellow citizens[23] by making patients aware of the societal costs of missing scheduled appointments. The transmission of these norms might occur by means of social learning, social expectations and social conformity because people in general are strongly influenced by what most people do,[24] as well as the situational expectations for appropriate behaviour.[25]

The first coding of the data led us to see that we needed a third construct. The purpose of non-attendance fees was sometimes justified as a means of compensating providers for the costs of non-attendance, rather than as a means of altering individual patient behaviour through disincentives or education. Thus, a third construct of patient non-attendance fees is provider compensation. The three constructs are detailed in table 1.

METHODS

Study design

We designed the present study to be a qualitative document analysis[26] with a multiple-case design.[27] The Preferred Reporting Items for Systematic Reviews and Meta-Analyses checklist was used to report the process of identifying policy documents as far as possible (online supplemental file 1).

Patient and public involvement

Patients and/or the public were not involved in the design, conduct, reporting or dissemination plans of the present research.

Study setting

Norway (population: 5.5 million) and Denmark (population: 5.9 million) are high-income countries in Northern Europe. Hospital services are funded through taxes and are provided to all at no or minimal cost. The differences between Norway and Denmark regarding payment for health services at public hospitals are described in table 2.

Sample and data collection

The data consisted of Norwegian and Danish policy documents (1990–2023). To identify relevant policy documents, we searched the governmental web pages and digital archives in the two countries for documents about non-attendance fees in hospitals. We used the following search terms (here translated to English): fees, non-attendance fees, non-attendance, missing patients, waiting time, waiting lists, outpatient, outpatient care and hospitals (online supplemental file 2). The Norwegian documents were retrieved from the digital archives of the Norwegian Government (Regjeringen.no) and Norwegian Parliament (Stortinget.no). Danish documents were retrieved from the digital archives of the Danish Government (Regeringen.dk) and Danish Parliament (Folketinget.dk). Figure 1 shows the selection process.

Data analysis

We applied the 'READ approach' for conducting the analysis, which is a systematic procedure to document analysis in health policy research for collecting documents and gaining information from them.[26] The READ approach entails four steps: (1) ready your materials, (2) extract data, (3) analyse data and (4) distill your findings. The first step—identification and selection of data—is described above. In the second step, the selected documents were uploaded to NVivo (V.R1). The first author read the documents in full and marked the sections about non-attendance fees. In the third step, these sections were read carefully several times, and the data were coded

Table 2 Comparison of Norway and Denmark regarding patient payment at public hospitals[3 4 40–42]

Country	User fees	Non-attendance fees
Norway	User fees for outpatient services at hospitals (NOK 386* for specialist consultations, NOK 275 for X-rays, ultrasounds and nuclear medicine examinations). There are cost ceiling schemes for co-payments, as well as exemption polices for some groups of patients.	A non-attendance fee of NOK 1544 for not attending outpatient appointments and not having given notice within 24 hours before the scheduled appointment time. The non-attendance fee has increased several times in recent years, from being equal to the size of the user fee for specialist consultations in 2009. Patients within psychiatric and substance abuse outpatient care are exempted from paying a non-attendance fee on no more than the size of the user fee for specialist consultations.
Denmark	Hospital treatment (including outpatient services) is free of charge.	A non-attendance fee pilot scheme (DKK 250) was initiated in 2013 and implemented for 6 months at an orthopaedic outpatient clinic in 2015. No effect on the rates of patient non-attendance was found, and non-attendance fees have not been implemented at Danish hospitals.

*The user fees in Norway were price adjusted on 1 July 2023. The user fee for specialist consultations was increased from NOK 375 to NOK 386, which also affected the patient non-attendance fee because this user fee defines the size of the non-attendance fee (today four times the size of the user fee for specialist consultations).
DKK, Danish krone; NOK, Norwegian krone.

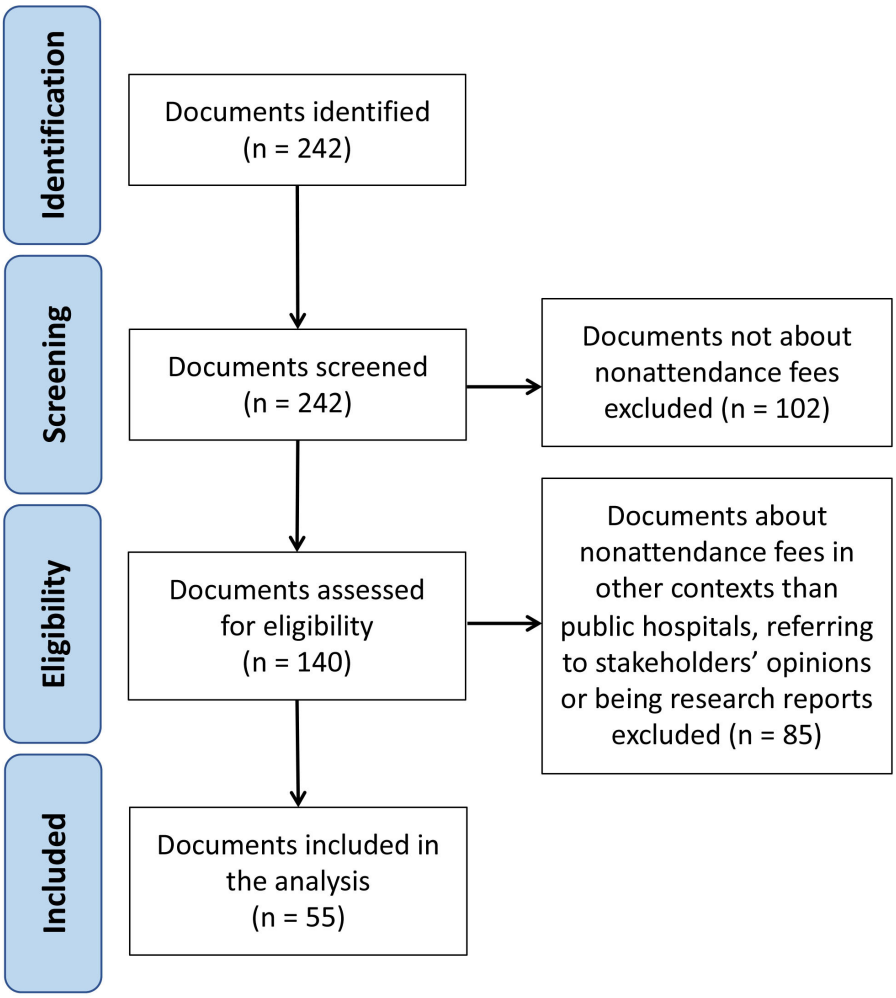

Figure 1 Flow diagram showing the selection of policy documents for analysis.

under the headings of purpose, public concern and assumptions of human behaviour. Thereafter, the codes were sorted thematically using the conceptual framework and the three constructs of patient non-attendance fees. After this initial coding and organising of the codes, both authors assessed and discussed the preliminary findings for reliability and consistency until an agreement was reached (the fourth step). Because qualitative document analysis is an iterative and nonlinear process, we had to reread the documents and refine the codes and their placement in the constructs several times before completing the data analysis. Finally, we compared the findings from the two countries. The first author translated illustrative quotations from Norwegian and Danish into English.

RESULTS

Data

There were national asymmetries in the types and numbers of documents (table 3). In Norway, where non-attendance fees have been implemented for many years, parliamentary propositions, proposals to amend regulations and the public consultation papers following

Table 3 An overview of the identified and included policy documents in the analysis

Document type	Documents identified*	Documents included*
Parliamentary papers (propositions, private member's motions and standing committee recommendations)	21 (20/1)	13 (12/1)
Parliamentary questions	28 (2/26)	19 (2/17)
Reports (working groups, official Norwegian reports and commissioned reports)	8 (2/6)	1 (0/1)
Bills, regulations and agreements	9 (2/7)	9 (2/7)
State budgets	7 (7/0)	6 (6/0)
Government platforms	16 (4/12)	2 (0/2)
Consultation papers	5 (5/0)	5 (5/0)
Consultation responses	148 (148/0)	0 (0/0)
Sum	242 (190/52)	55 (27/28)

*Documents in total (Norwegian documents/Danish documents).

these proposals were the main part of the corpus. The Danish document corpus showed that there has been a long-standing debate about whether non-attendance fees should be implemented, consisting mainly of questions to the parliament, government platforms and various reports. In total, 55 documents were included in the analysis, of which 27 were Norwegian and 28 Danish.

Problem definition

The overall aim of introducing patient non-attendance fees was similarly articulated in both countries. Non-attendance fees were understood as a means to combat the waste of resources and health loss because of unused appointments:

> [Patient non-attendance] results in the poor utilisation of resources and longer waiting times for others[28(p.5)] [and, as stated elsewhere,] those who do not show up take the place of another patient.[29(p.10)]

> It is a waste of staff's time, expensive technology and operation rooms when patients are absent from their appointments. At the same time, they prevent other patients from getting help earlier.[30(p.46)]

However, the more concrete conceptualisation and framing of patient non-attendance fees was different. In the following sections, we present the findings of the Norwegian and Danish data separately.

Patient non-attendance fees: Norway

Patient incentive

A legal basis for introducing non-attendance fees at outpatient clinics was proposed in the draft legislation of the Specialist Healthcare Act (1999). The fee was described as an incentive:

> This [monetary cost] will be an incentive for the patient to keep their appointment.[31(p.93)]

The arguments used in the early phases of the discussions about non-attendance fees remained stable over time. Almost two decades later, in 2016, the purpose of the non-attendance fee was stated as motivating patients to attend their appointments:

> The purpose of the non-attendance fee is to motivate patients to keep their appointments at the outpatient clinic.[32(p.17)]

Furthermore, the rationale for increasing the non-attendance fee seemed to be that an increase in the fee would further strengthen the motivation for patients to keep their appointments:

> The purpose of the increase in the fee is to reduce the incidence of unused outpatient appointments.[28(p.5)]

In a comment on user payment that revolved around the paragraph that regulates the non-attendance fee, it was emphasised that imposing monetary costs on patients can affect patient behaviour though price mechanisms and that the following changes in individual choices may result in aggregated utility for health services:

> […] [I]t is a central consideration for the authorities that the existence and design of regulations on patients' payment can affect the patients' demand for publicly funded services. To a certain extent, the regulations on patients' payment can be used as a control measure to limit the overuse of health services.[33(p.24)]

Provider compensation

Arguments referring to the perceived need to compensate for a loss of income for healthcare providers were also identified in the data. These arguments were already evident in 1999, though only alluded to when it was commented that non-attendance would imply a financial loss as an additional argument in support of introducing a fee scheme at outpatient clinics:

> In addition, non-attendance […] means a loss of income for the services.[31(p.93)]

Patient education

There were no appeals to the patients' social responsibility for caring about their fellow citizens and ensuring the efficient use of healthcare resources in the data.

Patient non-attendance fees: Denmark

Patient education

The reasons for considering implementing fees for not attending scheduled appointments in the public sector, including public hospitals, were introduced on a government platform in 2003. Here, basic respect for the time and resources of others was demanded:

> There must be respect for the time and resources of others. Citizens who are absent from appointments in the public sector waste the staff's time and unnecessarily burden public resources.[34(p.18)]

In a report from a governmental working group the year after, it was evident that one of the purposes of introducing non-attendance fees was to educate patients to respect others' time and resources. The need to cultivate civic virtues so that society can work at its best was also explicitly stated:

> The second purpose of non-attendance payment is to ensure that citizens face consequences if they do not keep appointments with public authorities, etc., to ensure respect for others' time and resources. […] It is central to a well-functioning society that appointments are respected and that citizens, as well as authorities, show respect for the time of others.[35(p. 20–1)]

Provider compensation

Instances of framing non-attendance fees as partial compensation to the hospitals in the case of patients missing their appointments were also identified:

> As the collected fee accrues the individual hospital, the use of non-attendance fees will immediately mean an additional income for the hospitals […] The income functions as a partial compensation for costs/lost income in the event of non-attendance.[35(p.61)]

Patient incentive

Arguments referring to non-attendance fees as a patient incentive were already evident in the early phases, where another purpose of introducing non-attendance fees was expressed as ensuring the most effective use of public resources. On this occasion, patients were depicted as being driven by considerations of which costs non-attendance had for them:

> [Introducing non-attendance fees] is a matter of the appropriate use of public resources. […] The Danish welfare system is based on a number of services being free of charge for users. However, the system of comprehensive free services entails the risk that users may be absent from this type of appointment without valid reasons or without cancelling because it 'costs nothing'. In this regard, non-attendance fees can be seen as a kind of 'user payment for non-attendance' […].[35(p. 19)].

Notably, the framing of non-attendance fees as patient education appeared to be toned down in recent years because statements such as the one that missing patients must face consequences to ensure respect for the public services' time and resources were absent. As a result, the understanding of non-attendance fees as a patient incentive has become more dominant.

DISCUSSION

The findings of the current study indicate that the politico-administrative debates in Norway and Denmark surrounding the use of patient non-attendance fees at public hospitals have differed regarding the purpose of these fees, public concern and the assumptions of human behaviour underpinning them. Although patient non-attendance fees have been seen as a measure to reduce non-attendance rates in both countries, the specific conceptualisation of the fees has differed. The fees were understood as a monetary disincentive in Norwegian policy documents. In the Danish documents, the fees were framed as an educative measure to foster a sense of social responsibility, as well as serving as a monetary disincentive. The data suggest, however, a recent change in the Danish debate emphasising fees as a disincentive. In both countries, fees were partly justified as a means of compensating providers for the loss of income. In this section, we comment on the most important findings.

Our analysis supports the interpretation that there has been a convergence in the justifications that Norwegian and Danish policy-makers have employed over the past decade. The framing of fees as a patient incentive has dominated in Norway and has become more dominant in Denmark over time. However, although conceptualising patient non-attendance fees as a measure for educating patients to attend their appointments by transmitting social responsibility norms by means of social learning, social expectations and social conformity have been absent in the Norwegian debate, the emphasis on patient education was central in the early phases of the Danish debate. This finding marks a striking difference between the two countries. Another difference is that, although Norway has implemented a patient non-attendance scheme, Denmark has not. Which factors can possibly contribute to explaining the differences?

As noted in evolutionary psychology, people are disposed to react negatively emotionally to descriptions of free riders, as well as to what is presented to them as unfair behaviour.[36] When decision-makers are focusing on the motivational quality of the citizens' behaviour and are vindicating the importance that citizens face consequences in case of non-attendance, this might give the impression that non-attenders have acted morally wrong and, hence, deserve a reaction from society.[37] Accordingly, the presence of this type of policy narrative might contribute to explaining a more vivid and comprehensive policy debate on the issue in Denmark than what has been the case in the Norwegian context and to explaining the reluctance to implement patient non-attendance fees in the Danish context.

At the same time, several other factors might account for the differences regarding fee policies between the two countries studied. First, considerations of the wider policy context could inform the decision-making process. National policies, such as entitlements to sick leave to attend healthcare appointments for employees, might shape whether a patient meets at the scheduled appointment. As a result, differences in national policies might contribute to explaining why Norway and Denmark have reached different conclusions regarding the implementation of patient non-attendance fees. However, the two countries have similar sickness benefits schemes,[38] as well as healthcare and welfare systems in general. Employees are (usually) allowed to attend outpatient appointments during working hours. We did not identify any considerations of the wider policy context as such in the documents.

Second, considerations about public attitudes towards the welfare state more broadly might play a role in the decision-making process. One study found that, in the Danish media discourse on the future of the welfare state, citizen accountability and tackling financial fraud have been put forward as solutions to maintaining the welfare state, whereas the ethos of solidarity and ensuring a sustainable workforce have been more emphasised in the Norwegian media discourse.[39] These findings resonate with the framing of non-attendance fees as patient education in the Danish data, emphasising individual responsibility, the qualities of motivation and civic virtues and the conceptualisation of non-attendance fees as patient

incentive to attend appointments and combat the waste of resources in the Norwegian data.

Third, although there are long traditions of charging user fees in specialist healthcare in Norway,[40] there are no such user fees at Danish hospitals.[41] The presence of fee schemes might pave the way for implementing non-attendance fees because patients and providers are already used to patient payment systems. In another study, we found that stakeholders seemed to accept—or at least not oppose—the implementation of patient non-attendance fees in public hospitals in Norway as long as the user fees and non-attendance fees were balanced. However, when the non-attendance fees were raised above the user fees, arguments against the non-attendance fee were observed.[4]

Fourth, considerations of patients' circumstances and reasons for non-attendance could have been given different weights in the decision-making processes in the two countries, thus contributing to accounting for why the framing of the non-attendance fees differed between the countries. However, we found little discussion regarding the reasons for patient non-attendance in the data, and when discussed, there were no systematic differences between the datasets in understanding the reasons for patient non-attendance.

A final consideration is that, when patient non-attendance fees in specialist healthcare are framed and justified as mere instruments for reducing non-attendance rates, it may be expected that the effectiveness of using these fees would have been examined. Despite the emphasis on the instrumental side of non-attendance fees in the Norwegian policy-making debate, because the fees have been understood as a patient incentive, it is instead Denmark that has conducted an experimental study of the effectiveness of charging non-attendance fees at public outpatient clinics.[3 42] One explanation for this apparent paradox might be that the more vivid politico-administrative debate that was evident in the Danish data, as ignited by the partial framing of non-attendance fees as patient education, has underscored the need for empirical testing of the effect of non-attendance fees. When relying on an economic rationale, as seems to have been the case in Norwegian policies, its effectiveness may be taken for granted according to traditional economic theory.[1]

Strengths and limitations

In the literature, non-attendance fees are usually described as an instrument to reduce patient non-attendance rates at outpatient clinics.[1 3 4 10] As such, the present study broadens the perspective we may have for (not) introducing non-attendance fees. Our study may provide important knowledge for policy-makers in other countries that are considering implementing similar fee schemes for patient non-attendance. Although the findings may not be transferred to healthcare systems other than Scandinavian ones, the conceptual framework that we developed can nonetheless be applied for analyses in different settings.

The findings should, however, be interpreted with some limitations in mind. First, the data were limited because many of the included documents were brief on the subject of patient non-attendance fees and the document corpus differed between the two countries. In one sense, it may be expected that reports from working groups (exclusively from the Danish debate) will explore the issue more carefully than technical consultation papers that propose amendments of regulations (exclusively from the Norwegian debate). At the same time, the presence of different types of documents tells us something about the debates themselves, as pointed out earlier. Second, because the Norwegian and Danish languages are alike but still differ, nuances in the language might have been misinterpreted or taken out of context. Third, the findings do not provide direct insights into the ideas and conceptions of the policy-makers, instead reflecting the content of the policy documents, which might have been affected by several sources, for example, the type of document and political situation at the time a policy document was written.

Related to the last point, the data consisted of public-facing documents, written with the purpose of being made available to the general public. We did not include documents from the preceding policy process, such as earlier drafts and working papers, in the datasets. Thus, we do not know if ideas and attitudes have been discussed that policy-makers did not (want to) reveal in the final drafts. Accordingly, further studies should investigate how policy-makers, as well as most people, conceive of non-attendance fees and which factors affect their judgements.

Conclusion

The present study has demonstrated how patient non-attendance fees as a regulative policy tool have been conceptualised and framed differently, even in apparently similar contexts. In Norway, non-attendance fees were unambiguously articulated as a patient incentive. In the Danish debate, particularly in the early phases, patient non-attendance fees were understood as patient education. This understanding might have contributed to the more vivid and comprehensive Danish debate, which here considers that the non-attenders were presented as having acted morally wrong and deserving a societal sanction. We can speculate whether this framing activated a more emotionally negative response than mere technical description of the non-attenders that was identified in the Norwegian debate. The results may be taken to suggest that a more nuanced and complex understanding of why such fees are debated is needed.

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PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	n/a
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	3–4
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	4
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	7–8
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	7–8
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	7–8
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	7–8
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	8
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	n/a
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	n/a
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	8
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	n/a
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	n/a
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	n/a
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	8
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	8
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	n/a
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	n/a
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	15–16
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	n/a

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	8–9
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	n/a
Study characteristics	17	Cite each included study and present its characteristics.	n/a
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	n/a
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	n/a
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	n/a
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	n/a
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	n/a
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	n/a
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	n/a
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	n/a
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	12–15
	23b	Discuss any limitations of the evidence included in the review.	15–16
	23c	Discuss any limitations of the review processes used.	15–16
	23d	Discuss implications of the results for practice, policy, and future research.	15–16
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	n/a
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	n/a
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	n/a
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	17
Competing interests	26	Declare any competing interests of review authors.	17
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	17

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71
For more information, visit: http://www.prisma-statement.org/

Search strategies for identifying the policy documents

Norway

Information source	Search terms
Regjeringen.no [Norwegian Government]: https://www.regjeringen.no/no/sok/id86008/?ownerid=421&term=	1: fraværsgebyr [nonattendance fees] 2: «manglende oppmøte/fremmøte» [nonattendance/missing patients] 3: ventetid [waiting time] 4: ventelister [waiting lists] 5: poliklinsk helsehjelp [outpatient care]
Stortinget.no [Norwegian Parliament]: (https://www.stortinget.no/no/sok/?query=)	1: fraværsgebyr/ikke-møtt-gebyr [nonattendance fees] 2: gebyr AND sykehus [fees AND hospital] 3: gebyr AND poliklinisk [fees AND outpatient] 4: manglende oppmøte/frammøte [nonattendance]

Denmark

Information source	Search terms
Regeringen.dk [Danish Government]: https://www.regeringen.dk/soeg/?q=	The search function was not sophisticated enough to make systematic searches, so we had to perform handsearching, which made us aware of different reports and agreements that we retrieved through targeted searches.
Folketinget.dk [Danish Parliament]: https://www.ft.dk/da/search?sf=dok	1: udeblivelse AND hospital [nonattendance AND hospital] 2: udeblivelse AND sygehus [nonattendance AND hospital] 3: udeblivelse AND gebyr [nonattendance AND fees]
Høringsportalen.dk [website containing an archive of Danish public consultations]: https://hoeringsportalen.dk/Hearing?FormAreas=Sundhed	1: udeblivelse [nonattendance] 2: gebyr [fees] 3: sygehus [hospital] 4: ambulant [outpatient] 5: ventetid [waiting time] 6: ventelister [waiting lists] No public consultations concerning nonattendance fees in hospitals or healthcare in general were identified and, hence, no documents were retrieved from this website.