# Danish patients are positive towards fees for non-attendance in public hospitals. A qualitative study

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## ABSTRACT

**INTRODUCTION:** Patients' non-attendance is a significant problem in modern healthcare. Non-attendance delays treatment, reduces efficiency and increases healthcare costs. For several years, the introduction of financial incentives such as a non-attendance fee has been discussed in Denmark. Set in the context of a tax-financed, free-for-all healthcare system, the political hesitance to introduce fees relates to concerns that additional fees may be badly received by tax-paying citizens and may undermine the political priority of patient equity. The aim of this qualitative sub-study was to investigate patients' attitudes towards a fee for non-attendance.

**METHODS:** Six semi-structured focus group interviews were conducted with a total of 44 patients who had been informed about being charged a fee for non-attendance. Data were transcribed verbatim and analysed using a qualitative content analysis.

**RESULTS:** Overall, patients' attitudes towards the non-attendance fee were positive. Non-attendance was viewed as evidence of disregard for the common free-for-all healthcare, and a fee was expected to motivate non-attendees to show up. However, most patients argued that certain groups (e.g. the mentally disabled) should be exempted from the fee. Furthermore, an implementation of fees should be easy to manage administratively and should not increase bureaucracy.

**CONCLUSION:** In general, patients' attitudes towards implementing non-attendance fees are positive.

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Patients' failure to attend a scheduled hospital appointment is a common problem in modern healthcare. Non-attendance is a significant problem as it delays treatment and disrupts continuity of care. Furthermore, non-attendance reduces efficiency, increases healthcare costs and is a source of frustration for health professionals [1, 2].

Studies show significant national differences in non-attendance rates [3, 4] as well as intra-national differences between regions and across medical specialties. Bech [5] reports non-attendance rates in Denmark to be relatively low with an average of 3-4%, compared, for example, with a UK estimate of 12% non-attendance rate for hospitals [6]. However, studies of non-attendance rates are relatively limited. Patients' reasons for non-attendance include forgetfulness, diminished symptoms and missed communication [3].

Interventions aimed at reducing non-attendance have included reminders, reducing perceived barriers and increasing motivation [3]. Research has primarily focused on the effects of reminders, whereas the motivational effects of a fee for non-attendance remain underexamined [7, 8]. One study [9] found that patients were positive towards paying a refundable, pre-appointment booking fee; however, patients' attitudes to post-appointment non-attendance fees have not been explored.

For several years, Danish politicians and healthcare administrators have debated how to reduce non-attendance; so far, initiatives have primarily been various reminders and open-access booking [7]. In 2004, the legislative foundation was changed to give public and private healthcare providers the right to issue non-attendance fees. This right, however, was not carried into effect in public hospitals. A main reason was concern about patient equity and vulnerable groups, as a fee is supposed to have greater impact on lower-income and lower-resource patients. Other concerns were charging tax payers with additional fees, as well as the potential undermining of the doctor-patient relationship, which in Denmark is valued as being independent of financial interests [10].

However, in 2014, after much public and political debate [11], the Danish government and the Danish Regions decided to investigate further the effects and consequences of introducing a fee for non-attendance in public hospitals in Denmark. Accordingly, an observational study was set up in two hospital departments [12]. Patients randomised to the intervention group of the study receive an attachment with their appointment letter explaining that a fee of 250 DKK (approx. 30 euro) will be issued without prior notice in the case of non-attendance. Patients assigned to the control group follow usual practice (same system but no letter attachment and no fee). This ongoing study offers a unique opportunity to investigate patient support and resistance with respect to the implementation of non-attendance fees in public hospitals.

ORIGINAL ARTICLE

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TABLE 1

Participant characteristics.

| | |
|---|---|
| *Gender, n* | |
| Female | 21 |
| Male | 23 |
| *Age, yrs* | |
| Average | 60.1 |
| Median | 65 |
| Range | 19-91 |
| *Occupation, n* | |
| Retired | 23 |
| Working | 17 |
| Unemployed | 4 |

On this backdrop and in the context of a tax-financed, free-for-all healthcare system, the aim of this qualitative study was to investigate patients' attitudes towards a fee for non-attendance.

## METHODS

### Sample and setting

Study participants were recruited from the intervention group at one of the hospital departments in the study (sub-acute orthopaedics). Patients who had an appointment in June through September 2015 were subsequently invited by letter to participate in focus group interviews. A total of 75 potential participants responded with interest. Of these, 50 participants were purposively sampled [13] based on age, gender and employment status (**Table 1**). Following cancellations, 44 patients participated in a total of six semi-structured focus group interviews.

### Focus group interviews

Focus group interviews held as a 'planned discussion' are particularly relevant when investigating public attitudes. Participants challenge and encourage each other, allowing a breadth of information and diverse perspectives to be gathered [14].

The interviews were held at the regional hospital and lasted approximately one hour. They were conducted by a moderator and an assistant (SL, MF and/or UV), who relied on a semi-structured interview guide. The interview guide explored participant's perceptions of the Danish healthcare system in general and attitudes towards and experiences with non-attendance and non-attendance fee in particular. The questions were open-ended and the participants were encouraged to speak freely and to raise issues not covered by the themes of the interview guide. The moderator promoted discussions and challenged emerging consensus in the group. The full interview guide can be obtained from the corresponding author.

### Data analysis

The interviews were digitally recorded and transcribed verbatim. The transcribed interviews were read carefully and subsequently coded and organised in thematic clusters of meaning using qualitative content analysis [15]. After a discussion of themes among the authors and identification of potentially disconfirming evidence, three themes of attitudes were settled upon: 1) Non-attendance and non-attendance fees, 2) Exemptions and exceptions and 3) Mutual obligations. Examples of quotations related to each theme are presented in **Table 2**.

### Ethical approval

The study was approved by the Danish Data Protection Agency (R. No. 1-16-02-288-15). Approval by The Central Denmark Regional Committees on Biomedical research was not required as there was no biomedical intervention.

*Trial registration:* not relevant.

## RESULTS

In all focus groups, participants reported an overall positive attitude towards hospitals and the healthcare sector. The discussions revealed a general sympathy and leniency towards the hospital system and an understanding of the hospital system as under-funded and under pressure. These understandings served to explain why optimal use of resources should be a main concern and priority for all.

### Non-attendance and non-attendance fee

In all focus groups, non-attendance was viewed as unacceptable, and non-attendees were initially identified as lazy, ignorant and disrespectful. There was consensus that non-attendees lacked respect for 'our' healthcare system - particularly in light of the above-mentioned cut-backs.

All but one participant considered non-attendance fees an appropriate attempt to reduce non-attendance. The dissenting participant was of the opinion that a tax-financed healthcare system should not charge tax payers additional fees. The participant furthermore feared that a fee would have unequal impact as it would affect marginalised groups more than non-marginalised groups. While most participants shared this concern, it did not cause them to reject non-attendance fees. Instead, the fee was considered reasonable and timely to introduce also at public hospitals as non-attendance fees are common in the semi-private healthcare sector, e.g. at dentists, medical specialists and physiotherapists.

The size of the fee was discussed in all focus groups; however, no agreement could be reached as to a precise amount of the fee. All agreed that it was unrealistic to

let fee size reflect the actual expenses of the particular hospital procedure. What was most important was the signalling effect of the fee: It should make people think and adjust their behaviour. Moreover, all groups agreed that it was important to develop a system that would not use extra resources or add bureaucracy. This was a commonly articulated reason for not differentiating the size of the fee according to socio-economic group; it was expected that this would be difficult to implement in an economically sustainable manner.

Finally, many participants stressed the importance of easy cancellation procedures. Several participants shared experiences of having difficulties when trying to cancel an appointment. Participants called for the possibility of cancelling and changing appointments via text message or self-service; digital booking was endorsed as an easy and flexible solution.

### Exemptions and exceptions

All interviews included a discussion of situations and of groups of people for whom non-attendance could reasonably be excused. These discussions included situations where non-attendance was accidental and unintended.

A common concern was marginalised groups who may lack sufficient resources to fulfil appointments in general, e.g. people with mental disabilities. Other groups suggested for exemption were the homeless, children, addicts and people in institutions. When discussing who should rule on a potential exemption for a patient, all groups spontaneously suggested and agreed on the general practitioner as the most appropriate person for making such a judgement.

Acute and unforeseen circumstances that may result in unintended non-attendance were also discussed, but no consensus was reached. All agreed that these situations were difficult to assess and wondered who should have the authority to assess and decide on valid and invalid excuses. There was a general concern to limit potential bureaucracy and operational costs.

### Mutual obligations

All groups addressed mutual obligations and responsibilities between patients and hospital, and all participants had very clear opinions that patients were responsible for and obliged to attend their hospital appointments. It was articulated as a civic duty, a demonstration of patients' consideration of and responsibility towards the common privileges of having tax-financed healthcare.

Ideally, the hospital was responsible for and obliged to deliver high-quality services within an acceptable timeframe. As interviews made apparent, this is not always the reality encountered, and participants offered different narratives of hospital failure to live up to this obligation, e.g. extreme waiting time or last-minute cancellation.

In all interviews, the question of mutual obligations and reciprocity was discussed: When hospitals charge fees for non-attendance, should patients then have compensation when hospitals fail to meet their obligations?

Only one participant maintained his right to financial compensation for a hospital's failure to meet appointments. The main attitude was that such a failure was an unavoidable, adverse event in a system dealing with people and unpredictable illness. The participants did not expect financial compensation (in addition to existing patient rights) as that would require more funding and more bureaucracy. However, there was a general call for the importance of being continually informed while in the waiting room and that the patients' frustrations of waiting, delay and cancellation should be met with understanding and respect.

## DISCUSSION

Overall, the findings add new perspectives to the debates regarding the introduction of a non-attendance fee in public hospitals. This qualitative study found that

**TABLE 2**

Quotations from focus group interviews.

| Theme | Quotes |
|---|---|
| Non-attendance and non-attendance fee | "The question is how to motivate people so that those who don't show up feel ashamed about wasting other people's time" (Participant 22) |
| | "Well, we pay our taxes and we want a well-functioning … healthcare system, free for all. So we all have to behave well when we are customers in that system" (Participant 27) |
| | "I think it's a disgrace [when patients stay away] because then someone else could have been treated. At least when it's intentional" (Participant 43) |
| | "The 250 DKK, it's purely symbolic. A way to signal: Remember to cancel if anything comes up. It's not the kind of money the hospital will get rich on … And you could also ask: All right, what kind of bureaucracy does this imply?" (Participant 8) |
| Exemptions and exceptions | "I think it's a problem with dementia and the like. There, you have to find some sort of exemption" (Participant 40) |
| | "There are also some mentally ill people who you can't expect to manage it either" (Participant 22) |
| | "And then there's also those who stumble around the system and well … there will always be some who are ... on the margins" (Participant 11) |
| Mutual obligations | "Essentially, it's our society that will pay the bill … The only way to get more out of our taxes is perhaps that we start taking responsibility for our own lives" (Participant 20) |
| | "If you want to introduce a fee for non-attendance, then you also need compensation … to the person who spends a whole day away from the labour market and loses his income … Because you can't demand something without giving something – that's how I've been raised" (Participant 13) |
| | "No, I think it would be too intense if your … surgery is cancelled, for instance if there are 2 acute surgeries or something, that you should then be paid ½ a day's wages. I think that would be inappropriate … and difficult to manage" (Participant 9) |
| | "It's obvious that just as the patient has an obligation to inform of a deviation … then the hospital has the exact same obligation towards the patient. You need to remember that: To inform is a reciprocal obligation" (Participant 8) |

Danish patients are positive towards fees for non-attendance in public hospitals. Drawing: *Sine Claudell.*

patients' attitudes towards the non-attendance fee were positive. Participants viewed non-attendance as a lack of respect for the common good of free-for-all healthcare and expected a fee to motivate non-attendees to reconsider their behaviour. However, participants also stressed that the hospitals were responsible for delivering easy cancellation procedures. Thus, reducing non-attendance was cast as a mutual responsibility between patients and hospitals. All groups argued that certain groups (e.g. the mentally disabled) should be exempted from non-attendance fees. Furthermore, an implementation of fees should be easy to manage administratively and should not increase bureaucracy.

Thus, participants did not disagree that a tax-financed healthcare system should charge tax payers with additional fees for failing to attend. Rather, participants viewed fees as an appropriate initiative in line with similar measures introduced in other areas of public and private healthcare.

Interestingly, the introduction of financial penalties for patients did not raise expectations of financial reciprocity; the participants did not expect imbursements (beyond existing regulation), e.g. for extreme waiting or for last-minute cancellations. Thus, participants upheld an understanding of public health as a citizen's privilege rather than a consumer right.

The findings suggest public support for the political concern with patient equity and vulnerable groups, but simultaneously indicate that patient attitudes may be in favour of implementing non-attendance fees.

When considering the findings of this study, some methodological issues must be taken into account. First, the focus groups recruited participants from a provincial, non-urban setting and from only one medical specialty. Thus, we cannot rule out that patients in other settings (e.g. urban, chronic care) may have different attitudes towards introduction of non-attendance fees. In addition, the participants volunteered to participate and may have been more interested in voicing their views than patients in general. However, despite different blends of participants and different group dynamics in the focus groups, the discussions and the opinions agreed on were strikingly similar. No new themes emerged after the fourth focus group interview, and we claim that saturation was obtained within the group setting.

Finally, as all participants had, in fact, attended their appointments, the present study does not include the attitudes of non-attendees. These patients are essential for understanding both reasons for non-attendance and motivations that may change this behaviour. Another qualitative sub-study is currently being conducted to investigate non-attendees' perspectives. In addition, the results of the observational study will show if fees may impact non-attendees' behaviour or if other interventions must be considered.

## CONCLUSIONS

Patients expressed positive attitudes towards implementing non-attendance fees in the Danish healthcare system. Non-attendance was perceived as unacceptable and as a lack of respect for the common goods of the welfare system. It was stressed as important that such implementation should have documented effect and should not add further bureaucracy to the healthcare administration.

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