









RESEARCH ARTICLE

A descriptive study of potential participant preferences for the design of an incentivised weight loss programme for people with type 2 diabetes mellitus attending a public hospital in Lima, Peru [version 1; peer review: 2 approved with reservations]

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Abstract

Background: Weight loss is important for the control of type 2 diabetes mellitus but is difficult to achieve and sustain. Programmes employing financial incentives have been successful in areas such as smoking cessation. However, the optimum design for an incentivised programme for weight loss is undetermined, and may depend on social, cultural and demographic factors.







Methods: An original questionnaire was designed whose items addressed respondent personal and health characteristics, and preferences for a hypothetical incentivised weight loss programme. One hundred people with type 2 diabetes mellitus were recruited to complete the questionnaire from the endocrinology clinic of a public hospital in Lima, Peru. A descriptive analysis of responses was performed.


Results: Ninety-five percent of subjects who had previously attempted to lose weight had found this either 'difficult' or 'very difficult'. Eighty-five percent of subjects would participate in an incentivised weight loss programme. Median suggested incentive for 1 kg weight loss every 2 weeks over 9 months was PEN 100 (~USD \$30). Cash was preferred by 70% as payment method. Only 56% of subjects would participate in a deposit-contract scheme, and the median suggested deposit amount was PEN 20 (~USD \$6). Eighty percent of subjects would share the incentive with a helper, and family members were the most common choice of helper.

Conclusions: The challenge of achieving and sustaining weight loss is confirmed in this setting. Direct cash payments of PEN 100 were generally

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preferred, with substantial scope for involving a co-participant with whom the incentive could be shared. Employing direct financial incentives in future weight loss programmes appears to be widely acceptable among people with type 2 diabetes mellitus.

Keywords

Diabetes, Obesity, Motivation, Weight loss, Public health

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Any reports and responses or comments on the article can be found at the end of the article.

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Introduction

Weight control is critical for both prevention and treatment of type 2 diabetes mellitus (T2DM)^{1–4}. Self-management programmes for people with T2DM commonly include the promotion of lifestyle changes, such as dietary modifications and increasing physical activity, to reduce weight^{5–7}. However, sustained weight loss is a challenge to both patients and providers^{8,9}. Failure to sustain weight loss in formal diet programmes varies between 21–54%, and many people fail repeatedly^{10–12}.

A major challenge in any lifestyle intervention programme is the willingness to join, and sustain, participation. Better understanding of what motivates people to engage with such programmes is therefore fundamental to their design¹³. Financial incentives have emerged as strategies which can initiate and sustain positive health behaviours during the incentive period and beyond. Sustained changes have been achieved through incentivization in the field of smoking cessation, although this remains a challenge to weight loss interventions^{14–16}.

Social and cultural factors influence participants' engagement with weight control^{17–19}. Successful completion of both short- and long-term weight loss programmes has been associated with age, ethnicity, family structure, educational level and employment^{20,21}. Additionally, a recent study testing a behavioural weight loss intervention for Latinos in the United States concluded that companionship for physical activity appears to support weight loss²². To direct the design of a future incentivised weight loss programme for people with T2DM in Lima, Peru, we performed a questionnaire study of potential participants with the aim of defining their demographic, social, cultural and health characteristics, and the optimal amount and delivery method for the incentive.

Methods

Design and data collection

We performed a cross-sectional exploratory study using an original questionnaire, consisting of 82 items (see [Supplementary Material](#) for the instrument in Spanish) addressing socio-economic circumstances, health characteristics and preferences relating to a proposed incentivised weight loss programme. Items relating to the programme included a suggested incentive amount and identifying a threshold incentive amount. Two methods were employed to identify threshold incentive amounts for participation in a weight loss reduction programme: direct questioning and fixed-increment questioning ([Supplementary Table 1](#) and [Supplementary Table 2](#)).

For the first method, a hypothetical situation was explained to the participant, which consisted of inviting them to participate in a 9-month programme whose purpose was to pay a monetary incentive only if they lost 1 kilogram every two weeks, and that we were interested in knowing the exact amount of money that would motivate them to lose that kilogram. For the second method, amounts of money from 0 PEN to 250 PEN in fixed increments of 50 PEN were specified and the participant was asked whether each of these amounts would motivate them to lose 1 kilogram over two weeks.

Participants were also asked about their willingness to participate in a hypothetical 'deposit-contract' programme in which they would be required to deposit a certain amount of money in a saving account and such amount would be doubled if they lost 1 kilogram over a two-week period, but would lose the deposited amount if they failed to reach the weight loss goal.

Finally, participants were asked if they would be willing to share the money won in a weight loss programme with a co-participant, defined as a relative or friend selected by the participant to support their efforts to lose weight, their preferred co-participant, and the proportion of the incentive that the participant would be willing to share with this co-participant.

Participants

Patients were recruited by convenience sampling from the Hospital Nacional Arzobispo Loayza, a public tertiary hospital serving mostly low-income people from Lima, the capital city of Peru, whose endocrinology department provides over 2500 outpatient appointments annually to patients with T2DM²³.

Inclusion criteria were age ≥ 18 years and self-reported diagnosis of T2DM. Incapacity to provide written informed consent was the only exclusion criterion. Due to the exploratory nature of the study, only 100 subjects were invited to participate. Participants were recruited in the waiting room of the Endocrinology Department during April 2016, and the questionnaires were administered by a trained fieldworker.

Data analysis

A descriptive analysis of questionnaire items was undertaken, employing 95% confidence intervals for selected items whose measurement was considered particularly important. For non-parametric continuous variables, a bootstrap confidence interval of the median was attempted. Hypothesis testing was not performed due to the large number of possible comparisons relative to the sample size and the consequently elevated risk of type 1 error. Statistical analysis was performed using R version 3.4.3²⁴.

Ethics

This study was approved by the Institutional Review Boards of the Universidad Peruana Cayetano Heredia (SIDISI 64789) and the Hospital Nacional Arzobispo Loayza (Expediente 04974-2015), in Lima, Peru. Written informed consent for participation was obtained from all subjects.

Results

One hundred people with T2DM participated in the study. Two subjects did not respond to questions relating to incentives; the data were otherwise complete. Demographic and socioeconomic characteristics are presented in [Table 1](#). Health-related responses are presented in [Table 2](#). Measures previously taken to improve health are presented in [Table 3](#).

Ninety-eight subjects (98%) responded to questions about financial incentives. Ninety-two subjects (94%; 95% CI 87 – 97%) responded that they would participate in an unincentivised

Table 1. Demographic and socioeconomic characteristics of patients with type 2 diabetes included in the study.

Characteristic		Count (%) or Mean (Standard deviation)
Female sex		67 (67%)
Age		55 years (11.8)
Education	Primary completed	7 (7%)
	Secondary incomplete	4 (4%)
	Secondary completed	46 (46%)
	Further non-university incomplete	19 (19%)
	Further non-university completed	13 (13%)
	University incomplete	9 (9%)
	University completed	2 (2%)
Employed		55 (55%)
Household monthly income	< PEN 750 [< US \$228]	3 (2%)
	PEN 751 – 1500 [US \$228 – 456]	14 (14%)
	PEN 1501 – 2000 [US \$456 – 608]	22 (22%)
	PEN 2001 – 2500 [US \$608 – 760]	24 (24%)
	> PEN 2501 [> US \$760]	11 (11%)
	Refused to answer	26 (26%)
	Health insurance	None
Sistema Integral de Salud (most basic insurance)		64 (64%)
Essalud (state-provided insurance for the employed)		2 (2%)
Self-rated economic status	Very bad	1 (1%)
	Bad	19 (19%)
	Fair	47 (47%)
	Good	33 (33%)

weight loss programme. Eighty-three (85%; 95% CI 76 – 91%) would participate in a 9-month incentivised weight loss programme. Reasons given for not participating included: insufficient time to attend biweekly follow-up visits; because they thought 9 months was a long time to avoid “antojitos” (cravings); or because the participant did not think they needed to lose weight.

Seventy-eight subjects (78%) answered the question “how much money would motivate you to lose 1 kg every 2 weeks?”. Responses were positively skewed with median PEN 100 (≈ USD \$30) and range PEN 50 to 500 (≈ USD \$15 to 150) (Figure 1). Bootstrap confidence intervals could not be constructed because all resampled medians = PEN 100 (10,000 simulations).

Subjects were then asked whether they would participate in an incentivised weight loss programme with incentive amounts

from PEN 50 to 250 in PEN 50 increments. Six subjects (6%) would not participate for any amount, while 91 (93%) would participate for all amounts. One subject changed from a positive to negative response at the PEN 200 threshold.

Asked about their preferred method of payment, 69 subjects preferred (70%) cash, 24 (25%) deposit into a bank account, 3 (3%) as vouchers and the remainder not responding.

Fifty-five subjects (56%; 95% CI 46 – 66%) would participate in a deposit-contract scheme whereby their deposit would be doubled if they succeeded but lost if their failed to lose weight. Ninety-seven (97%) subjects answered a question on preferred deposit amount. Preferred deposit amount was positively skewed with median PEN 20 (≈ USD \$6) and range PEN 0 to 50 (≈ USD \$0 to 15) (Figure 2). Again, equality of all resampled median precluded construction of bootstrap confidence intervals.

Table 2. Health characteristics of patients with type 2 diabetes included in the study.

Variable		Count (%) or Mean (standard deviation)
Self-rated health status	Very bad	11 (11%)
	Bad	52 (52%)
	Fair	37 (37%)
Time since diagnosis of diabetes		6.9 years (5 years)
Most recent blood glucose measurement (self-reported)	Reported (n = 94)	151 mg/dL (49 mg/dL)
	Did not know	6 (6%)
Most recent HbA1c measurement (self-reported)	Reported (n = 59)	8.9% (1.6%)
	Did not know	41 (41%)
Current medical treatment for diabetes	Any	95 (95%)
	Insulin	10 (10%)
	Metformin	71 (71%)
	Glibenclamide	32 (32%)
	Glimepiride	1 (1%)
	Weight loss tablets	1 (1%)
Monthly expenditure on medical treatment for diabetes	PEN [US \$]	63 (44) 19 (14)

Table 3. Measures previously taken to control health of patients with type 2 diabetes included in the study.

Health control measures attempted since diagnosis of diabetes		Count (%) or Mean (standard deviation)
Regular exercise		53 (53%)
Difficulty of attempt to regularly exercise	Easy	1 (3%)
	Difficult	12 (35%)
	Very difficult	21 (62%)
Reduction of sugar intake		75 (75%)
Difficulty of attempt to reduce sugar intake	Easy	1 (2%)
	Difficult	32 (49%)
	Very difficult	32 (49%)
Quit alcohol		31 (31%)
Difficulty of attempt to quit alcohol	Easy	1 (3%)
	Difficult	9 (31%)
	Very difficult	19 (66%)
Reduce fat intake		77 (77%)
Difficulty of attempt to reduce fat intake	Easy	0
	Difficult	38 (58%)
	Very difficult	27 (42%)
Increase vegetable intake		57 (57%)
Difficulty of attempt to increase vegetable intake	Easy	17 (30%)
	Difficult	8 (14%)
	Very difficult	32 (56%)

Health control measures attempted since diagnosis of diabetes		Count (%) or Mean (standard deviation)
Weight loss		42 (42%)
Difficulty of attempt to lose weight	Easy	2 (5%)
	Difficult	23 (55%)
	Very difficult	17 (40%)
Methods for weight loss control (all participants asked to name three)	Alternative medication	1 (1%)
	Attend appointments	4 (4%)
	Avoid appointments	1 (1%)
	Exercise	72 (72%)
	Foot care	6 (6%)
	Glycaemic control	13 (13%)
	Healthy diet	38 (38%)
	Intake control	17 (17%)
	Medications	38 (38%)
	Obey doctors	2 (2%)
	Reduce alcohol	1 (1%)
	Reduce carbohydrate	36 (36%)
	Reduce fat	19 (19%)
	Reduce protein	1 (1%)
	Relaxation	3 (3%)

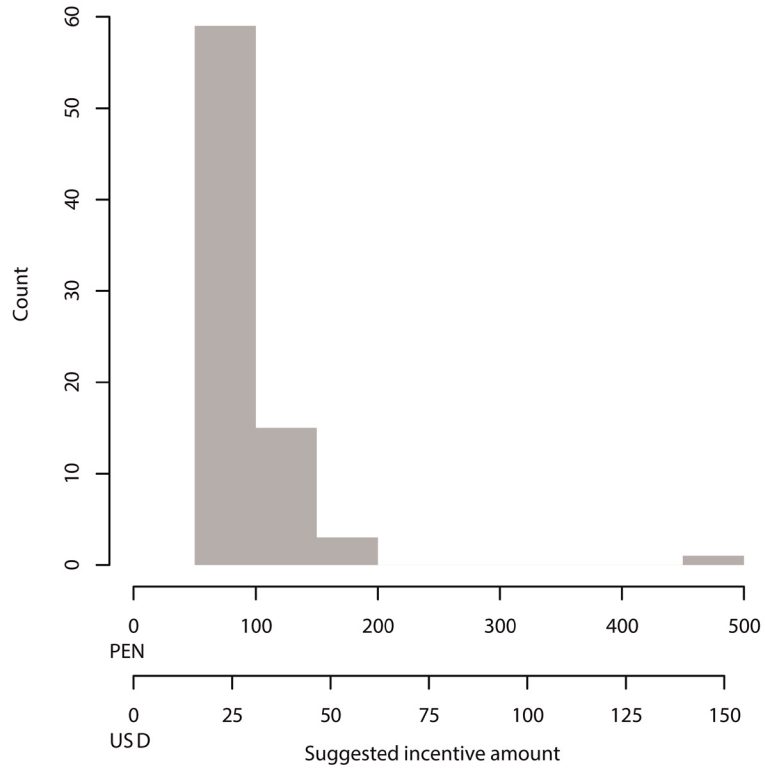


Figure 1. Suggested simple incentive amounts.

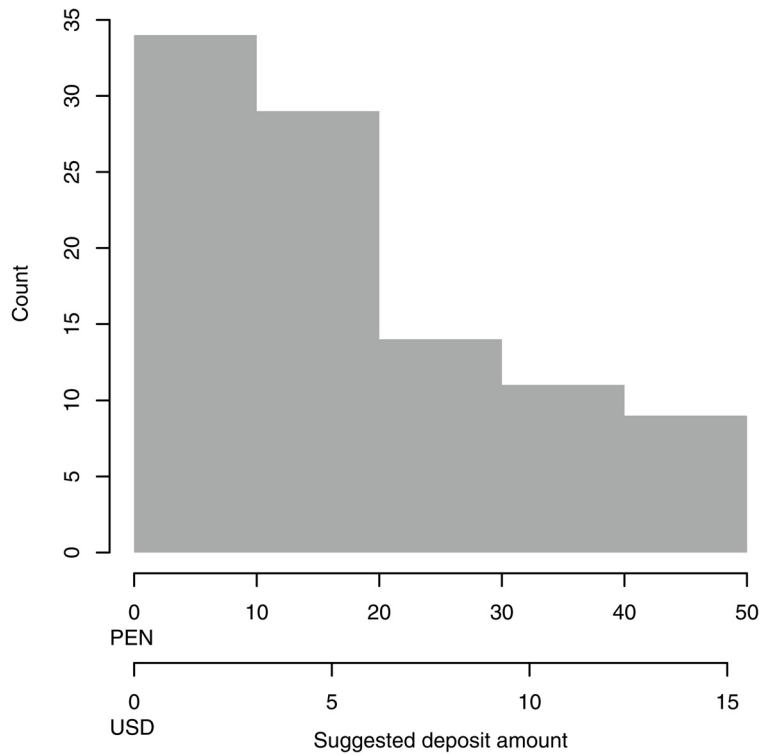


Figure 2. Suggested deposit amounts.

Subjects were then asked whether they would participate in a deposit-contract scheme with deposit amount in increments between PEN 25 – 250. Forty-three subjects would participate with any deposit amount (43%); 32 would not participate with any deposit amount (32%); and 22 identified a threshold deposit amount for participation (22%). Among subjects who identified a threshold deposit amount above which they would not participate, the maximum acceptable amount was positively skewed with median PEN 25 (range PEN 25 to 100).

Regardless of their answers to the previous questions, subjects were also asked for their views of participating in such a program. Out of the 73 who responded, 14 (19%) considered that it was not good to receive money for taking care of their own health, with one saying that this would be “like selling yourself”, since people should lose weight for their own sake and not for money. Sixteen (22%) said it was a good idea and were even excited at the prospect of participating in the program. Six (8%) found it amusing that such a program was even possible, and five (7%) were concerned that such a program will achieve only short-term results that would not be sustained after the program ended. Other answers revolved about the doubts they had about the program, or they did not understand the idea behind receiving money, that it was a good idea for “poor” people but not for everybody or that it might not work since not all diabetics needed to lose weight.

Subjects were asked who they would choose to help them to lose weight. Five (5%) chose a friend; 42 chose a partner (42%); 23 chose a child (23%); 1 chose a neighbour (1%); 4 chose a sibling (4%); and 12 would not choose a helper (12%). Eighty subjects would share the incentive with a helper (80%). Eight (10%) of these would share less than half, 71 (89%) half exactly, and 1 (1%) more than half of the incentive.

Discussion

This pilot study aimed to characterise people with T2DM attending a public hospital in Lima, Peru, and their preferred amount and delivery method for a financial incentive to be used in a future incentivised weight loss programme.

Median suggested incentive amount was PEN 100. Based on a national disposable income of USD \$175.7bn²⁵ and population of 30,565,431 in 2013²⁶, a maximum reward of PEN 100 every 2 weeks for 9 months would represent 10% of personal disposable income (PDI). Previous interventions have employed a broad range of incentive sizes (from 0.2% to 10.2% of PDI¹⁶), and experimental evidence suggests that insufficient incentives may paradoxically produce less motivation than no incentive at all²⁷. The suggested amount therefore appears adequate and appropriate for an intervention in this setting.

The second method employed to identify a suitable incentive amount (asking whether the participant would accept amounts of increasing PEN 50 increments) was not successful. Sixty-two percent of participants in a previous study felt that financial incentives undermined individual responsibility for health²⁸, and participants may have been reluctant to engage with these

questions to avoid weighing a moral position against financial advantage.

Fewer respondents would participate in a deposit-contract scheme. Because such schemes weigh a certain short-term price against a possible long-term advantage, they fail to take advantage of the established health economic principle that individuals overvalue present relative to future costs²⁹. In contrast, an approach described as *asymmetric paternalism*, which aims to assist individuals with health-improving behaviours without limiting freedom³⁰, might produce in an intervention in which individuals commit to future behaviours without present costs, such as receiving up-front an incentive which would be returned or doubled depending on achievement of a future weight goal. Cash or bank transfer were generally preferred over vouchers. This is in accordance with the finding that rewards are more motivating when separated from larger payments, such as household shopping (in the case of vouchers) and insurance premiums (in the case of discounts)³¹.

Our findings show that most participants had found it challenging to adopt health-improving behaviours. In particular, 42% of participants had previously attempted to lose weight but 95% found this “difficult” or “very difficult”, suggesting that people with failed previous weight loss attempts will constitute a substantial subgroup of this population. The question of what makes behavioural change difficult has been addressed by Kelly & Barker, who note the mistakes which policy-makers commonly make in understanding the drivers of behaviour³². One of these mistakes is the economic utility theory which presumes that individuals make rational choices to maximise gain and minimise loss. The theory behind the use of financial incentives is essentially an extension of this. However, health behaviours are frequently automatic responses to social and environmental cues, not subject to particular conscious reflection, and often in spite of adequate understanding of health implications^{33–35}. These findings inform interventions that target ‘choice architecture’, comprising the “interaction between individual human agency and both the immediate and broader environment that make up the social structure”³⁶. Financial incentives are much more likely to achieve persisting behavioural change in synergy with such interventions.

Asked about who they would choose to help them to lose weight, most selected a family member. In prospective studies, family support was associated with reduced HbA1c in males, but increased HbA1c in females. Informal support seeking is often different in males and females. Females seek and receive more support from friends and extended family, while males often seek and receive more support from their spouse³⁷. Other studies found that seeing friends more frequently, having a well-functioning social network and a sense of good social support from the social network was associated with higher patient activation levels, less diabetes-related emotional distress and more health-promoting self-management behaviours among patients with T2DM. When providers felt more emotionally engaged, their support exerted a large, positive effect on their well-being, as well as on recipients’ well-being^{38,39}. These findings imply that the

incorporation of social support into an intervention may be crucial for its success, but also that its precise form may need to adapt to the sex (and potentially other characteristics) of the participant.

The novelty of the proposed approach was highlighted by several participants and although many appeared interested and excited about the possibility of enrolling, a small proportion were sceptical. This confirms the need to have a better understanding of the role that incentives have in behavioural change, and in particular which ones are appropriate in resource-limited contexts such as Peru.

Limitations

The sampling approach employed may have exposed the study to participation bias. Most participants were female, middle-aged, and had at least completed secondary education. Although most rated their economic status as at least ‘fair’, almost all had either the most basic or no health insurance at all. Although the prevalence of T2DM is greater in males than females worldwide⁴⁰, the higher proportion in our study may be explained by the fact that females are more likely than males to engage with healthcare seeking behaviours and respond to questionnaires^{41,42}. The study setting in a Peruvian public hospital is likely to have determined participants’ socioeconomic profile, which should not be interpreted as representative of people with diabetes in Peru more generally. However, the prevalence of T2DM is inversely proportional to socioeconomic status^{43,44}, and therefore the majority of people with T2DM in Peru will fall into the low-income group surveyed in this pilot and targeted by our planned intervention. Higher-educated subjects have previously been found to make more attempts to lose weight⁴⁵, which may imply a greater need for intervention in this low-income group.

Important parameters for an incentivised weight loss programme were not explored in our questionnaire. A ‘lottery’ form for payments, in which successful weight loss would allow entry into a regular lottery for a larger payment (and which is anticipated to be more motivating than direct payments because people tend to over-value small odds of large rewards^{31,46}) was not proposed to participants. Participants were also not asked about their preferred frequency of payment. Higher-frequency payment have been shown to be more effective in the drug-abstinence setting⁴⁷, and the finding that experimental subjects prefer to segregate than to integrate gains has been used to

support the argument for direct rewards over insurance premium adjustment^{31,48}. These factors are important for the planning of any intervention and the preferences of potential participants should be the subject of future investigation. Although multivariate associations could not be investigated due to insufficiency of sample size and sampling design, the study was not designed to investigate these, but rather to develop an improved understanding of the potential use of incentives in this setting.

Conclusion

Employing direct financial incentives in future weight loss programmes appears to be widely acceptable among people with T2DM in Lima, Peru.

Data availability

Original and translated data files are available on Open Science Framework: <http://doi.org/10.17605/OSF.IO/8NQVW>⁴⁹

Data are available under the terms of the [Creative Commons Zero “No rights reserved” data waiver](#) (CC0 1.0 Public domain dedication).

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Supplementary material

Supplementary Table 1: Questions asked to identify the maximum amount participants would accept as a financial incentive for weight loss [English translation].

[Click here to access the data.](#)

Supplementary Table 2: Questions asked to identify the maximum amount participants would be willing to invest, in order to double their money upon meeting the weight loss target [English translation].

[Click here to access the data.](#)

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? **Ramfis Nieto-Martínez** 

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This article explores the acceptability and preferences of a group of 100 patients with type 2 diabetes who attended the endocrinology service in a public hospital in Peru, regarding a hypothetical monetary-incentivized weight loss program to be applied in the future. One of the gaps that, in the view of the authors, warrant obtaining this information is the necessity of strategies that increase the adherence to and sustainability of a weight loss intervention. Considering the innovation of the information based on an original questionnaire this article deserves publication. However, several important observations need to be considered:

INTRODUCTION

1. Number and quality of references

The authors should avoid loading the introduction of references. The introduction 22 references. All of them are necessary? 4 to 5 good quality (primary sources, review or meta-analyses) references is enough. For example:

a) **Page 3, left column, paragraph 1, line 2:** "Weight control is critical for both the prevention and treatment of type 2 diabetes mellitus (T2DM) (1-4)."

There are 4 references supporting it. The first reference is a report. The second is appropriate. References 3 and 4 are secondary sources belonging to sections of the American Diabetes Association Guidelines. I suggest looking for a systematic review supporting the importance of weight control in the prevention and treatment of T2D.

b) **Page 3, left column, paragraph 1, line 2-5.** "Self-management programs for people with T2DM commonly include the promotion of lifestyle changes, such as dietary modifications and

increasing physical activity, to reduce weight (5-7)."

There are 3 references but none of them is a primary source. The reference 5 is ADA guidelines and the other 2 are web-pages containing information for patients. I suggest retiring these references (5,6,7) and include primary sources of studies demonstrating the effectiveness of structured weight loss interventions (not only self-management programs) on diabetes management. The most important structured interventions evaluating the effect of lifestyle changes on T2D management are the Look AHEAD study using HbA1c as main outcome and the Why Wait Study whose primary outcome was the weight^{1,2}.

c) **Page 3, left column, paragraph 1, line 5-6.** "However, sustained weight loss is a challenge to both patients and providers (8,9)."

References 8 and 9 do not mention directly a sustained weight loss as a challenge. Both studies are interviews with physicians. In the reference 8, 14 GP were interviewed in focus groups. Five dilemmas were identified for primary physicians, but none of the 5 referred to difficulties of their patients in losing or maintaining weight loss. Reference 9 was an interview to 19 physicians to understand their challenges when treating social and emotional difficulties in T2D patients, but not the challenge of sustained weight loss to both patients and providers.

It is very laborious as a reviewer to check all references one by one. I strongly recommend that all references be carefully reviewed to establish if they are relevant, useful and what is more important if they support the written statements.

2. Background

In the introduction, the authors have to create a strong background that explains the reasoning behind why the study goal was built. In the introduction, the authors broadly mention sustainability as one of the possible benefits of adding incentives to a weight loss program. However, a probably greater sustainability of the loss of weight generated by the addition of incentives should not be proposed without bases that sustain it.

Page 3, left column, paragraph 2, line 7-9. "Sustained changes have been achieved through in the field of smoking cessation, although this remains a challenge to weight loss interventions."

I consider that the comment regarding that sustainability in weight loss interventions is a challenge is very conservative. Two of the references cited deserves attention. In the reference 15, financial incentives in 66 US veterans with BMI between 30 and 40 and age between 30 and 70 years produced significant weight loss over an 8-month intervention; however, participants regained weight post-intervention. The reference 16 is a systematic review included nine randomized controlled trials of behavioral treatments for obesity and overweight involving the use of financial incentives with reported followup of at least 1 year. No study was analyzed on an intention to treat basis, participants were mostly women recruited through media advertisements, mean age ranged from 35.7 to 52.8 years, and mean body mass index from 29.3 to 31.8 kg/m⁻². Results from metaanalysis showed no significant effect of the use of financial incentives on weight loss or maintenance at 12 months and 18 months.

With this background (under-registered in the article), the first important question in the introduction would be: In previous studies, monetary incentives have shown some benefit in patients who are in a weight loss program? If the answer is NO. Is it justified to evaluate it in this population since it has very different characteristics than those evaluated previously, and the results could be different? The same participants question the usefulness of the incentives to increase the willingness to participate since 92% of them reported agreeing to participate in a

weight loss program without incentives. Also, 19% considered that. This aspect should be mentioned in the discussion.

3. The gap of knowledge

In the introduction, the authors must highlight the existing knowledge gap that this study will fill and the relevance of the research question. What is the gap? The need a questionnaire (or the generated information) to determine the acceptance of incentives or to explore the opinion of potential patients regarding the incentives? This gap must be the prelude the research question and the aim.

4. The aim

It should be brief and should make clear what is the question that your study tries to respond.

The need for a questionnaire to determine the acceptability of monetary incentives and their characteristics within a weight loss plan? Although the introduction was designed to create the need for information on the design of a monetary incentive program for diabetic patients who would join a weight loss program, the first objective mentioned was the characterization of the population. I believe that they should be more direct and go to the main objective. Reconsider: we performed a questionnaire study of potential participants with the aim of defining their demographic, social, cultural and health characteristics...

METHODS

- a) I suggest including a sub-heading to explain the structure of the questionnaire and a summary of how was developed.
- b) Inclusion criteria should be T2D diagnosed by laboratory tests available in the files of the endocrinology clinic and / or the use of antidiabetic drugs, and not only by self-report of the participant
- c) Considering that the program is aimed at overweight and obese patients, why you did not consider a BMI <25 as an exclusion criterion? The perspective of the problem is different in a person of normal weight with respect to an overweight / obese person. How many of the included participants have a normal weight?

RESULTS

- a) The results describe the demographics and socioeconomic characteristics of the T2D patients commonly seen in the endocrinology clinic, considering that was a convenience sample
- b) Table 2 should include BMI, most recent glucose and HbA1c measurement taken from the hospital files instead of self-reported data
- c) Table 3 shows that 53 participants reported regular exercise as a health control measure attempted, but when the frequency of difficulty of attempt to regular exercise is reported, the total of participants is 34. I observed the same discrepancy, in the reduction of sugar intake (75/65), to quit alcohol (31/29), to reduce fat intake (77/65). In the case of the increase of vegetable intake (57/57) and weight loss (42/42) no discrepancies between the number of participants reporting the behavior and the total of the three

categories of difficulty. Please, correct it if it is a mistake.

d) In table 3 methods are included for weight loss control (3 for each participant). Why to avoid appointments and foot care are included? These methods have not a relationship with weight loss.

DISCUSSION

The discussion includes 1. How much the intervention (incentives) represent the proportion of personal disposable income (PDI)? 2. Explanation of the answers of participants about the methods of payment, 3. Comparison with other studies regarding the effect of a helper. I recommend:

- a) Re-organize the discussion
- b) Explain the economic utility theory more clearly
- c) Consider including in the discussion important topics below

1. Topic 1. Potential implementation

To provide some clues about the implementability, could you include a paragraph mentioning how is the usual care of the diabetic in the hospital and if the endocrinology clinic has a structured program of weight loss? How would monetary incentives be inserted into that program? Who could be the provider of the funds? If you plan to start as a research project?

A Mayo Clinic group proposed a multispecialty outpatient Obesity Treatment Research Program for weight loss to be implemented in the next 5 years that initially will start with research funds³.

Future implementation of a monetary incentive strategy for weight loss must consider different elements. Identification of stakeholders and funding is essential. The Reach, Effectiveness, Adoption, Implementation, Maintenance (RE-AIM) Model for the evaluation of the effectiveness of interventions can be a proper framework to estimate the future impact of the incentive program. RE-AIM elements follow a sequence beginning with adoption and reach, followed by implementation and efficacy and finally maintenance. For this, it is important to establish the difference between the weight loss program and the incentive program. Please [find attached](#) a table summarising the possibilities of RE-AIM components being met by the incentives included in the weight-loss program.

2. A model of behavioral changes to explain the effect of the intervention

Obesity is a chronic disease that, as hypertension or diabetes, must be treated for life. *The article does not mention the components of the future intervention.* Assuming that the intervention will be guided by current Obesity Clinical Practice Guidelines, lifestyle and behavioral changes (dietary and physical activity) and the use of obesity medications should be included. Behavioral changes are one of the cornerstones of the obesity management.

The Stages of Change Model initially developed based on the experience of smokers who quit, propose that change in behavior occurs continuously through a process with several steps. Each step has a duration: pre-contemplation (6 mo), contemplation (6 mo), determination (1 mo), action (6 mo) and maintenance (6 mo). There are strategies that are more effective for each stage of change, and the goal is to reach the maintenance, the ideal stage of behavior. In the maintenance

stage, people have sustained their behavior change (e.g. weight loss) for more than 6 months and intend to maintain the behavior and avoid relapsing. *Monetary incentives for 9 months as is proposed in the article could accelerate the initial steps but do not guarantee maintenance of behavioral changes that effectively let them maintain a healthy weight.* This is related to the comments about sustainability mentioned above. Please [find attached](#) a figure depicting the Stages of Change Model.

3. Obesity as a complex disease

The present article is exploring the possible components of program but fail to mention the complexity of factors involved in the process of implementing this strategy to increase the adherence. The obesity per se is a complex disease with multiple pathways controlling individual feeding behavior. Also, there are physiological adaptations occurring after weight loss such as changes in body composition, hormonal environment, energy expenditure, and control of food intake that predispose to regain the weight loss. The only options showing sustainable results and low food availability and access that have occurred during crisis and famine periods, and the forced modification of gastrointestinal anatomy by bariatric surgery. To offer money to participants to stimulate their adherence need to be tested in the future compared with a group without incentives in a well-designed randomized clinical trial. It is possible that the strategy can be effective for a short time but difficult to maintain.

CONCLUSION

The conclusion is very direct and only mentions that incentives seem to be a strategy widely accepted by the diabetic population of Lima. This is an excessive generalization considering the sampling and the observations I made in the last paragraph on the background.

Remembering: Participants question the usefulness of the incentives to increase the willingness to participate since 92% of them reported agreeing to participate in a weight loss program without incentives. Also, 19% considered that is not good to receive money for taking care of the own health.

LIMITATIONS

Based on my previous observations, review the limitations again. I leave it to your discretion to reconsider the need to include some additional aspect.

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Is the work clearly and accurately presented and does it cite the current literature?

Yes

Is the study design appropriate and is the work technically sound?

Partly

Are sufficient details of methods and analysis provided to allow replication by others?

Partly

If applicable, is the statistical analysis and its interpretation appropriate?

Yes

Are all the source data underlying the results available to ensure full reproducibility?

Yes

Are the conclusions drawn adequately supported by the results?

Partly

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Obesity, diabetes prevention, cardiovascular health, cardio-metabolic risk factors, nutrition

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 22 Sep 2018

Harold Akehurst, Universidad Peruana Cayetano Heredia, Lima, Peru

Dear Dr Nieto-Martinez,

Many thanks for taking the time to offer your review of our paper. We have revised the manuscript and hope that we have addressed your concerns. We have revised the references in the introduction largely in accordance with your suggestions. We did not revise refs 5-7 (in the version you reviewed), which are intended to support the assertion that self-management programmes do incorporate lifestyle changes, rather than their efficacy, which is the subject of the preceding sentence. You express very understandable concern that anthropometric and laboratory data are not reported. We agree entirely that these are desirable. Our study did not have access to medical records, and to do so would have required significantly more manpower than could justifiably be expended for a small pilot study (the setting does not benefit from electronic medical records). The decision to restrict to a questionnaire was pragmatic. We have nonetheless elaborated on this limitation in the revised manuscript. Although the absence of independent verification of diabetes disease status does mean that theoretically respondents might not have actually been diabetic, we do consider this unlikely given their recruitment from a diabetes clinic, and that 95% were able to state that they were taking antidiabetic treatment. We are especially grateful for your scrutiny of Table 3, in which there were indeed a number of numerical errors which have been corrected. We have also corrected an error which you noticed in Table 3 about participants suggested methods for health control. You ask specifically about the response "Avoid appointments", which I must confirm is correctly rendered. The logic is the participant's own. You kindly offer three additional topics for discussion, some of which you will find included in the revised manuscript. Your

suggestions about the logistics of weight loss interventions, the RE-AIM model, and the holistic management of obesity are clearly critical to the design and evaluation of an intervention such as that planned by our research group. Nevertheless, it is difficult to integrate these issues into a discussion of the data which our questionnaire study has generated. The discussion section is already as long as the introduction, methods and results combined, and out of concern not to 'bury the lede' we are reluctant to expand it beyond the scope of our exploration of participant preferences. Again, we are very grateful for your kind review.

Yours sincerely, Harold Akehurst

Competing Interests: No competing interests were disclosed.

Reviewer Report 02 July 2018

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The present report deals with a patient survey on potential monetary incentives to increase adherence in future weight loss programs to address type 2 diabetic in poorer section of the population in Peru. To address the topic is thoughtful as well as important and it clearly deserves publication.

Nevertheless, the survey itself leads to no clear solution. On one hand it shows clear results on the missing attractiveness of the deposit-contract scheme and that cash/bank transfer is preferred over vouchers. But on the other hand it offers also important insights into the prejudices towards monetary incentives as well as its potential benefits. Interestingly, the participants themselves addressed the potential short-lived nature of monetary incentives during the weight loss without addressing incentives to maintain weight afterwards. These results, therefore, are ambiguous and not disputed in the discussion section. The discussion and conclusion parts do not sufficiently address major points of the result section. In hindsight the authors might have designed the questionnaire differently, offering more options, possibly also ones that address intrinsic motivation and not only extrinsic motivation, as shown in this report.

Major points:

Ad 2) Study design:

- Anthropometric data of the participants are missing. What was the mean BMI (standard deviation)? As BMI was not an inclusion criterion: How many respondents were in the normal weight, overweight, obese I, II and III range?

- There was a bias in the selection of participants, which was addressed in the discussion section. Apparently those who intended to lose weight agreed more often to participate in the survey as seen by the 94 %age who agreed to the unincetivised weight loss program and the skewed, high percentage of participating women. The selection bias might be unavoidable but means, that the researchers addressed “the converted” in the survey and not those who do not want to lose weight but, nevertheless, might motivated by the monetary payment. It might also mean, that motivation to participate in a weight loss program might not be achieved by alone by “money for kilos”. We miss the dispute on this issue in the discussion part. It there a way to reach the so far unreachable group and can it be achieved by monetary incentives at all?
- Weight loss is not linear but more at the beginning and less later on. The main weight loss is expected to happen in the first 3 months. Therefore, the rationale for the bi-weekly payment for 1 kg weight loss is not self-explanatory. It might demotivate at the beginning (when more than 1 kg is lost in the 2-week period) and at the end of the program (when weight loss slows down). Participants with higher BMI and more kg of potential meaningful weight loss can “earn” more money than participants in the overweight range, in whom a weight loss of 5-10 kg is adequate and this should be achieved in max. 20 weeks = 5 months according to the suggesting scheme (which is in line with international guidelines). Meaning that it is achieved prior to the program end. Is this motivating? We miss the discussion about these issues in the discussion part.
- Results mention that 85% would participate in an incentivized weight loss program, but even more (92%) responded that they would participate in an UNincetivised weight loss program anyway (page 3, right column, last two lines). This result should be mentioned in the abstract (and discussed in the discussion part).
- Who is going to provide the monetary incentive? Is it realistic that the money will be available in long-term? Also this should be mentioned somewhere in the manuscript.

Ad 3) Methods – details:

- The main questionnaire is only available in the Spanish language – translation to the English language would be helpful
- The structure of the method section should be improved, for example there should be an extra bullet point for the questionnaire development
- The explanations about the questionnaire are sometimes confusing, maybe an overview/figure about the questioning techniques (direct and fixed increment) and the related issues could be helpful.
- Who conducted the interviews or were parts of the questionnaire completed by the participants themselves?
- Inclusions criteria: Why self-reported T2DM? The recruitment took place in the endocrinology department, so blood values could have been recorded (e.g. HbA1c)
- The body height and body weight was not documented and not asked?

Ad 6) discussion

The discussion does not address all major results,. E.g. Results mention that 85% would participate in an incentivized weight loss program, but even more (92%) responded that they would participate in an unincetivised weight loss program (page 3, right column, last two lines). 14 participants (19%) further considered that it was not good to receive money for taking care of their own health and one explained that it was like “selling ourself” (page 7, left col, para 2, L3-109). Especially for women, being poor and “selling yourself” implies critical and serious connotations. Surprisingly, only 16 participants thought that payment was a good idea. We think these are rather unexpected and important results, which were not addressed in the discussion part. Furthermore, five participants addressed that payment will achieve only short-term results and this was also not mention in the discussion section. It is opening an important

discussion if “payment per kilo” or incremental payment DURING weight loss is indeed a promising solution or if other models might be more promising (payment AFTER achieving weight loss goals or payment (or reduction /or extra money for health care costs) during the maintenance period and on long-term. We miss discussions and critical reflections on these issues in the discussion part.

Also the conclusion is irritating and does not reflect the results.

Minor comments:

Abstract:

- The exact formulation of objectives is missing.
- Result on the 92% that responded that they would participate in an unincentivised weight loss program (page 3, right column, last two lines) should be added.
- Add “each” between “incentive for” and “1 kg”, otherwise it is unclear if the incentives incremental and paid every 2 weeks and not as one payment after 9 months.
- Conclusion is irritating and does not reflect results (see also above ad 6.)

Introduction:

- First paragraph focusses mainly on sustainability of weight loss, which is not addressed by the survey.
- At the beginning or rather in the rationale, it is initially not clear that the questionnaire deals with financial incentives
- You quoted an interesting systematic review about the financial incentive in treatment of obesity and overweight (John KL, et al., J Gen Intern Med 2011). Which results or conclusions were reached by the review?
- You say social and cultural factors influence the participant’s engagement with weight control, what exactly are the consequences?
- It would also be interesting to know how the T2DM patients are normally cared for in Peru in addition to medical treatment. Are there any dietetic interventions by dietitians? Are there accompanying weight loss programs common? What does basic health insurance cover and what have patients normally pay by themselves?
- Reading the title and the manuscript as a whole, the main aim as to our understanding was to investigate the attractiveness of monetary incentives in weight loss programs, whereas defining the demographic, social, cultural and health characteristics was secondary and only accessory (and therefore rather rough). Therefore, the phrasing of the aims is irritating to us.
- It is unclear if the incentivized weight loss program is intended for research purposes first and for integration in a regular health care program later on OR is it intended for research purposes only OR is it intended to start straight with a regular health care program? Information on this would be helpful.

Results:

- As already mentioned in major comment 1) we miss the BMI/body weight data of the participants.
- Page 4, left col, L4-5: wording “because they thought 9 months was a long time to avoid craving” is unclear
- Table 2: Why weren't the laboratory values taken from the hospital patient records?
- Table 3: it would have been also interesting to know the reason WHY the participants found it difficult to implement the health control measures, if they tried and even if they have not yet tried. We miss this point in the limitation section of the discussion. We also wondered about some answers on the methods for weight loss control. Why are “avoid appointment” and “foot care” listed? A short explanation would be helpful

Discussion:

- See also major point 6. Major issues are not discussed and the conclusion is irritating.
- Page 7, left col, last para: What is meant by “the second method”?

The discussion remains vague, for example it is nice to read about the different theories about behavior change, but where is the link to the results or the conclusion?

Is the work clearly and accurately presented and does it cite the current literature?

Yes

Is the study design appropriate and is the work technically sound?

Partly

Are sufficient details of methods and analysis provided to allow replication by others?

Partly

If applicable, is the statistical analysis and its interpretation appropriate?

Yes

Are all the source data underlying the results available to ensure full reproducibility?

Yes

Are the conclusions drawn adequately supported by the results?

No

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Human Nutrition, Nutrition Assessment, Clinical Nutrition, Nutritional and Metabolic Diseases, Clinical Trials, Malnutrition, Applied Nutrition, Cardiovascular Risk Nutritional Status, Functional Food, Nutrition Therapy, Functional Foods

We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however we have significant reservations, as outlined above.

Author Response 22 Sep 2018

Harold Akehurst, Universidad Peruana Cayetano Heredia, Lima, Peru

Dear Professor Valentini,

Thank you very much for taking the time to offer your helpful report on our paper. We have revised the manuscript and hope that we have addressed your concerns.

You raise a very interesting point about how identical payments at equal intervals with the same target for all participants do not correspond to the non-linearity of weight loss over time, or to the differential weight loss requirements of people with different BMI. I have alluded to this in this revision but held back from a more detailed discussion which I think would exceed the scope of our

results, which do not provide much material on which to base such a discussion.

Yours sincerely,
Harold Akehurst

Competing Interests: No competing interests were disclosed.