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Review

Acceptability of financial incentives for encouraging uptake of healthy behaviours: A critical review using systematic methods

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ABSTRACT

Objective. Financial incentives are effective in encouraging healthy behaviours, yet concerns about acceptability remain. We conducted a systematic review exploring acceptability of financial incentives for encouraging healthy behaviours.

Methods. Database, reference, and citation searches were conducted from the earliest available date to October 2014, to identify empirical studies and scholarly writing that: had an English language title, were published in a peer-reviewed journal, and explored acceptability of financial incentives for health behaviours in members of the public, potential recipients, potential practitioners or policy makers. Data was analysed using thematic analysis.

Results. Eighty one papers were included: 59 pieces of scholarly writing and 22 empirical studies, primarily exploring acceptability to the public. Five themes were identified: fair exchange, design and delivery, effectiveness and cost-effectiveness, recipients, and impact on individuals and wider society. Although there was consensus that if financial incentives are effective and cost effective they are likely to be considered acceptable, a number of other factors also influenced acceptability.

Conclusions. Financial incentives tend to be acceptable to the public when they are effective and cost-effective. Programmes that benefit recipients and wider society; are considered fair; and are delivered to individuals deemed appropriate are likely to be considered more acceptable.

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Contents

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Introduction

Poor engagement in healthy behaviours is a key determinant of morbidity and mortality and results in social, healthcare and economic costs (Swann et al., 2010). Despite efforts to encourage healthy behaviours, unhealthy behaviours remain common (Department, Of Health, 1998, 2004).

Providing financial incentives to encourage healthy behaviours is one method to encourage uptake of healthy behaviours. Health promoting financial incentives (HPFI) are cash or cash-like rewards provided contingent on performance of healthy behaviours (Adams et al., 2013). Our recent systematic review of the effectiveness of HPFI found that financial incentives were around 1.5 to 2.5 times more effective for promoting healthy behaviours than no intervention or usual care (Giles et al., 2014).

In the United States of America (USA), the 2010 Affordable Care Act allowed employers to offer rewards, or impose penalties, for those meeting healthy behaviour targets such as quitting smoking (Madison et al., 2011). Similar HPFI operate within the German social health insurance scheme (Schmidt, 2008). In the United Kingdom (UK), the current government has signalled their interest in using HPFI as part of their 'nudge' agenda (Department, Of Health, 2010). Despite this empirical and political support for HPFI, the acceptability of HPFI interventions has been questioned (Cookson, 2008; Popay, 2008).

Acceptability of public health interventions must be considered from the point of view of a number of stakeholders. In relation to HPFI, these include potential recipients, professionals and policy makers responsible for intervention implementation, and the general public who may finance interventions through taxation. All of these groups must be willing and able to engage with an intervention (Craig et al., 2008), if HPFI are to be widely implemented.

Acceptability of interventions can be explored in primary research. However, scholarly critique also constitutes valuable evidence, as it is likely to reflect the opinion of important stakeholders. We conducted a review to bring together both empirical evidence and scholarly writing on the acceptability of HPFI. We were particularly interested in what features of HPFI have been identified as potentially acceptable and unacceptable, the range of methods that have been used to determine acceptability, and the range of individuals in which acceptability has been explored.

Methods

This review is reported in accordance with the Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines (Moher et al., 2009). Given the non-standard nature of the inclusion criteria and data collected, we did not register our protocol in advance. A copy of the *a-priori* protocol is available from the authors on request. No substantive changes to the protocol were made.

Information sources

Electronic databases were searched from the earliest date available (indicated in brackets below) until 1st October 2014, for primary research and scholarly writing, exploring the acceptability of HPFI. Databases searched were: Medline (1946), Embase (1980), Web of Knowledge (1970), Cumulative Index to Nursing and Allied Health Literature (1981), PsycINFO (1806), Applied Social Science Index and Abstracts (1970), Sociological Abstracts (ProQuest, 1952), Scopus (1960), The Philosopher's Index (OVID, 1940), the Cochrane library (Issue 3), Social Science Citation Index (1970) and the International Bibliography for the Social Sciences (1951). An example of the full electronic search used in Medline is shown in Appendix A. The search was adapted as required for other databases. All studies included in our systematic review of the effectiveness of HPFI (Giles et al., 2014) were considered for inclusion, and reference and citation searches of included papers as well as relevant reviews identified in the search were conducted.

Eligibility criteria

Papers that met the following criteria were included: had an English language title; were published in a peer-reviewed journal; and explored the acceptability of HPFI from the perspective of: members of the public, potential recipients, potential practitioners who may be involved in delivering HPFI, or policy makers. Specifically, all included papers used the term 'acceptable', 'accept', 'acceptability', 'unacceptable' 'ethics', 'moral' or some variation of these. HPFI were defined as cash or cash-like rewards, which were provided contingent on change in a healthy behaviour. Only papers exploring acceptability of HPFI delivered to adults living in high income economies (defined by the World Bank as those countries with a Gross National Income of $12,276 or more per capita in 2010) were included. Empirical studies were defined as papers reporting primary data. Scholarly writing was defined as referenced writing; for example, position papers and editorials (Cookson, 2008; Madison et al., 2011; Popay, 2008; Schmidt, 2008).

Paper selection and data collection

After exclusion of duplicates, one researcher (ELG) screened titles and excluded those definitely not relevant. Next, the same researcher screened remaining titles and abstracts, again excluding those definitely not relevant. Finally, remaining full texts were screened by two researchers independently (ELG & JA) to identify those meeting the inclusion criteria. If in doubt, papers were retained at any stage for inspection by both reviewers, with disagreements resolved by discussion.

Quality assessment

Quality assessment of scholarly writing was not undertaken as no appropriate tool could be identified. The quality of empirical research papers using qualitative methods was assessed using a tool developed for this purpose (Barnard et al., 2010; Petticrew and Roberts, 2005). Papers using quantitative methods were assessed using the Effective Public Health Practice Project (EPHPP) Quality Assessment Tool (Effective Public Health Practice Project, 2009). Two researchers (ELG and JA) conducted quality appraisal independently and disagreements were resolved by discussion. Papers using mixed methods were appraised using both tools as appropriate.

Synthesis of results

Data was extracted by one researcher (ELG) and summarised in tabular form. Empirical studies were considered to be too heterogeneous for meta-analysis. Although three studies did use, or adapt, the same questionnaire,

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