



Parents' Willingness to Pay for Pediatric Weight Management Programs

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ABSTRACT

OBJECTIVE: To examine parents' interest in continuing and willingness to pay (WTP) for 2 pediatric weight management programs following their participation.

METHODS: Participants were parents of 2- to 12-year-old children with body mass index \geq 85th percentile who participated in the Connect for Health trial. One group received enhanced primary care (EPC) and the other received EPC plus individualized coaching (EPC+C). At 1 year, we assessed parents' self-reported WTP for a similar program and the maximum amount (\$/month) they would pay. We used multivariable regression to examine differences in WTP and WTP amount by intervention arm and by individual and family-level factors.

RESULTS: Of 638 parents who completed the survey, 85% were interested in continuing and 38% of those parents were willing to pay (31% in the EPC group and 45% in the EPC+C group). The median amount parents were willing to pay was

\$25/month (interquartile range, \$15–\$50). In multivariable models, the EPC+C parents were more likely to endorse WTP than the EPC parents (odds ratio, 1.53; 95% confidence interval, 1.05–2.22). Parents of children with Hispanic/Latino versus white ethnicity and those reporting higher satisfaction with the program were also more likely to endorse WTP.

CONCLUSIONS: Most parents of children in a weight management program were interested in continuing it after it ended, but fewer were willing to pay out of pocket for it. A greater proportion of parents were willing to pay if the program included individualized health coaching.

KEYWORDS: obesity; pediatrics; weight management program; willingness to pay

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WHAT'S NEW

Over a third of parents of overweight children were willing to pay for weight management programs, and the proportion was higher for programs that included individualized coaching.

PEDIATRIC OVERWEIGHT AND obesity remain highly prevalent, both in the United States and abroad. Several interventions to address obesity in children have been shown to be effective, some of which include individualized health coaching.¹ However, those interventions vary in both intensity and expense.² To scale these interventions broadly, cost sharing with families or other payers might be necessary, but little is known about what parents of children with overweight or obesity would be willing to pay for weight management programs.

Willingness to pay (WTP) is a commonly used metric to assess the value of a good or service and is used widely in the cost-benefit analyses of programs and policies.^{3,4} WTP analyses can provide valuable information to payers and policymakers about both the value of different policy targets as well as the financial viability of specific programs.⁵ One study in adults evaluated the WTP of participants to continue a lifestyle-based weight loss program they had been engaged in for 24 months.⁸ In this study, the intervention resulted in significant weight loss compared to control. The median amount participants were willing to pay out of pocket for the intervention at the end of the trial was \$45/month.⁸ This amount was higher than those found by other studies that surveyed a general population about hypothetical weight loss medicine or low-calorie diet (median WTP out of pocket of \$10–\$12/month),⁹ but was much lower than the median of \$1300/month out of pocket

found in another study surveying adults with obesity about WTP for an effective but hypothetical weight loss treatment.¹⁰

Several studies have examined WTP for pediatric obesity and overweight management. These studies have been limited, however, by evaluating WTP for the prevention of obesity rather than treatment,⁶ surveying a general population (rather than patients or parents with obesity),⁷ or using hypothetical treatment scenarios.⁶ In this study, we aimed to determine the factors associated with parental interest to continue and the WTP out of pocket for 2 pediatric weight management programs after completion of the Connect for Health trial.¹¹ We also aimed to determine factors associated with the amount parents were willing to pay. We specifically examined the extent to which intervention arm assignment was associated with WTP outcomes. We hypothesized that a majority of parents would be interested in continuing a weight management program and those who received individualized health coaching would be more willing to pay out of pocket to do so.

METHODS

The Connect for Health study was a randomized trial of pediatric weight management in 6 medical offices of a multispecialty group practice in Massachusetts conducted from June 2014 to March 2016. Details of the protocol and the main results of the trial can be found elsewhere.^{11,12} Briefly, participants were children ages 2 to 12 years with body mass index (BMI) \geq 85th percentile and their parents. Participants were randomized to either of 2 intervention arms: (1) enhanced primary care (EPC), or (2) enhanced primary care plus contextually tailored, individual health coaching (EPC+C). The 2 interventions resulted in improved family-centered outcomes and statistically significant improvements in child BMI: an improvement of -0.06 BMI z -score units (95% confidence interval [CI], -0.10 to -0.02) for the EPC group and -0.09 BMI z -score units (95% CI, -0.13 to -0.05) for the EPC+C group. Participants completed telephone surveys at baseline and 1 year later at the end of the trial. Study activities were approved by the Partners Health Care Institutional Review Board. The trial has been recorded in clinicaltrials.gov.

INTERVENTIONS

Connect for Health included 2 intervention arms. The enhanced primary care (EPC) arm consisted of flagging pediatric patients with BMI \geq 85th percentile in the electronic health records for primary care providers, clinical decision support tools for pediatric weight management, parent educational materials, a Neighborhood Resource Guide, and monthly text messages. The EPC+C arm included enhanced primary care as defined above plus contextually tailored, individual health coaching, including twice-weekly text messages and telephone or video contacts every other month to support behavior change and link families to neighborhood resources.

OUTCOME MEASURES

Our main outcome was parents' WTP for a weight management program. Using surveys at 1 year, we asked parents about their interest in continuing the program, their perceived worth of the program (\$/month), their WTP out of pocket for the program, and the amount they would be willing to pay per month for the program. Specifically, we first asked every parent: "Thinking about all the components of Connect for Health, which included text messages, information about community resources, and possibly health coaching, how interested would you be in continuing a program like this?" The 3 answer choices ("not at all interested," "somewhat interested," or "very interested") were then dichotomized to "not interested" versus "interested."

We then asked each parent about their perception of worth of the program by asking a single open-ended question: "How much do you think the Connect for Health program is worth in dollars per month?" To diminish the influence of outliers, winsorization of data to \$1000 was applied to 16 values that either were non-numerical (eg, millions) or were above the 95th percentile of the distribution ($>$ \$1000/month).

We then asked: "Thinking about your current monthly budget, would you be willing to pay out of pocket for a program like Connect for Health?" Similarly to other studies, the 3 possible answers ("yes," "no," or "unsure") were dichotomized to "yes" versus "no/unsure."⁸ For this outcome, we restricted our analysis to parents who were interested in continuing the program.

Finally, we asked parents how much they would be willing to pay per month for the program. For this outcome, we limited our analysis to participants who reported being willing to pay out of pocket in the previous question. There is ongoing debate in the literature as to the best method to elicit WTP.¹³ One technique used in other studies investigating the value of weight-control treatment⁹ is the open-ended question method, where participants are simply asked the amount they are willing to pay using a single, open-ended question.¹³ Others have instead advocated for using the bidding game, or WTP by iteration, which asks a series of binary questions, offering a first amount (eg, \$10). If participants are ready to pay at least that amount then a higher one is proposed (\$20), and this process is repeated until a maximum amount is found.^{13,14} When using the WTP by iteration method, it is common to randomize participants to start with either a lower bound (\$10) or an upper bound (\$100) and move in the other direction, in an effort to mitigate anchoring, or starting-point bias.^{8,14,15}

Given the lack of consensus in the literature on measuring WTP, in this study we first elicited willingness to pay using the WTP by iteration method (including randomization of the starting point), followed by an open-ended question format to clarify the maximum they would pay within the range they had selected. In the multivariable analysis, we adjusted for the starting point (\$10 or \$100) to which participants were randomized.

PREDICTORS AT BASELINE

In addition to the intervention arm, the following factors were considered as potential predictors of parents' interest in continued participation and WTP. Using surveys at baseline, we obtained the child's race/ethnicity, parent's age and educational attainment, and annual household income. Education was dichotomized for multivariable analyses. Also at baseline we obtained the child's sex, age, height, and weight (to calculate BMI) from the electronic health records. We categorized a child's BMI as overweight if the BMI was between the 85th and the 95th percentile, obesity if the BMI was between the 95th percentile and 120% of the 95th percentile, and severe obesity if the BMI was >120% of the 95th percentile.^{11,16,17}

MEDIATORS AT FOLLOW-UP

At 1 year we assessed changes in each child's BMI category and parental satisfaction with the program. A child was categorized as being either at a lower BMI category at follow-up than baseline or at the same or higher BMI category at baseline.¹¹ We determined parental satisfaction by asking, "Overall, how satisfied are you with your experience in the Connect for Health program?" The 4 possible answers ("very satisfied," "somewhat satisfied," "somewhat unsatisfied," or "very unsatisfied") were dichotomized to "somewhat or very satisfied" versus "somewhat or very dissatisfied."

STATISTICAL METHODS

We used Fisher's exact test to compare responses between intervention arms for the dichotomous outcomes of interest to continue participating in and willingness to pay out of pocket for the program. Given the non-Gaussian distribution of the perceived worth of the program and of the maximum dollar amount participants were willing to pay, we used Wilcoxon rank sum tests to compare the outcomes between intervention groups. We developed multivariable logistic regression models to evaluate the effect of the covariates on the odds of reporting interest to continue and WTP out of pocket. We developed a sequence of models, each including an additional set of predictors. Specifically, we first created models with only the baseline predictors (demographics with and without BMI category) and then added the mediators obtained at the end of the trial (BMI change, satisfaction with the program, perceived worth). We first built models using baseline characteristics in an attempt to approximate as closely as possible the information that would be available at the beginning of a weight management program offered outside of a clinical trial. We adjusted for baseline characteristics given that not all participants answered the question on interest to continue the program, thus not maintaining randomization. We also created median regression models to determine the contribution of each covariate on the perceived monetary worth of the program and the amount participants were willing to pay. Confidence intervals for these models were obtained by the

repeated sampling method. All statistical analyses were performed using SAS 9.3 (SAS Institute; Cary, NC).

RESULTS

A total of 721 participants enrolled in the trial, and 638 (88%) parents completed the 1-year follow-up survey including questions related to WTP. The mean age of the children was 8.0 years (standard deviation, 3.0), and 42% had household incomes < \$50,000/year. Details of the demographic characteristics for the sample are shown in [Table 1](#). There were no major differences between the 2 groups with regard to any of the demographic characteristics measured.

EFFECT OF HEALTH COACHING

Overall, the majority of parents (84.6%) were interested in continuing the program in which they participated. In bivariate analyses, parents in the EPC+C arm were more likely to report being interested in continuing the program than parents in the EPC arm (88.6% vs 80.8%; $P = .007$). The median amount parents perceived the program to be worth was \$30/month (interquartile range [IQR], \$10–\$100): \$20/month (IQR, \$5–\$100) for the EPC group, and \$50/month (IQR, \$20–\$150) for the EPC+C group ($P < .001$). Among those interested in continuing the program, parents in the EPC+C arm were more likely to report being willing to pay out of pocket for the program (44.6% vs 31.1%; $P < .001$). Among parents interested in continuing the program and who were willing to pay, the median amount they were willing to pay was \$25/month (IQR, \$15–\$50), and this amount was higher for parents in the EPC+C arm than for those in the EPC arm (median \$27.5 vs \$20; $P = .04$).

We examined the effect of the intervention arm on the outcomes using sequential multivariable regression models. The higher odds of reporting interest in continuing the program for parents in the EPC+C arm persisted after adjusting for baseline predictors and BMI category change. However, adjustment for satisfaction with each program attenuated the odds ratio such that we found no difference across the 2 intervention arms (odds ratio [OR], 0.87; 95% CI, 0.51–1.51) ([Fig. 1A](#) and [Table 2](#)).

With regard to perceived worth, participants in the EPC+C arm reported a higher median amount than participants in the EPC arm, in both the unadjusted and adjusted analyses, even after adjusting for satisfaction with the program (difference of \$17.90; 95% CI, \$7.03–\$28.77) ([Fig. 1B](#) and [Table 2](#)). Parents in the EPC+C arm also had higher odds of reporting being interested in paying out of pocket than parents in the EPC arm (adjusted OR, 1.53; 95% CI, 1.05–2.22) ([Fig. 2A](#) and [Table 2](#)). Finally, among parents willing to pay for the program, in both the unadjusted and the fully adjusted analyses, parents in the EPC+C arm were not willing to pay a statistically significant greater amount per month compared to parents in the EPC arm (difference of \$5.77; 95% CI, \$1.50–\$13.04) ([Fig. 2B](#) and [Table 2](#)).

Table 1. Characteristics of Participants in the Connect for Health Study

Characteristics	Study Arm		
	All (N = 638)	EPC (N = 323)	EPC+C (N = 315)
<i>Child's Characteristics</i>			
Age (y), mean (SD)	8.1 (3.0)	8.0 (3.0)	8.1 (3.0)
2–6 y, n (%)	165 (25.9)	87 (26.9)	78 (24.8)
6–12 y, n (%)	473 (74.1)	236 (73.1)	237 (75.2)
Gender, n (%)			
Female	329 (51.6)	170 (52.6)	159 (50.0)
Male	309 (48.4)	153 (47.4)	156 (50.0)
Race/ethnicity, n (%)			
Non-Hispanic white	228 (35.7)	123 (38.1)	105 (33.3)
Non-Hispanic black	216 (33.9)	100 (31.0)	116 (36.8)
Hispanic/Latino	132 (20.7)	71 (22.0)	61 (19.4)
Other	62 (9.7)	29 (9.0)	33 (10.5)
BMI category at baseline, n (%)			
85th to <95th percentile	230 (36.1)	110 (34.1)	120 (38.1)
95th to 120% of 95th percentile	267 (41.9)	142 (44.0)	125 (39.7)
>120% of the 95th percentile	141 (22.1)	71 (22.0)	70 (22.2)
BMI category change, n (%)			
Decreased	123 (20.4)	64 (21.2)	59 (19.7)
Stayed the same or increased	479 (79.6)	238 (78.8)	241 (80.3)
Mean BMI z-score at baseline (SD)	—	1.91 (0.56)	1.87 (0.56)
Mean BMI z-score change (95% CI)	—	−0.06 (−0.10 to −0.02)	−0.09 (−0.13 to −0.05)
<i>Parent and Household's Characteristics</i>			
Income category, n (%)			
≤\$50,000/y	262 (41.9)	119 (37.5)	143 (46.4)
>\$50,000/y	363 (58.1)	198 (62.5)	165 (53.6)
Parent educational attainment, n (%)			
8th grade or less (0–8 y)	1 (0.2)	1 (0.3)	0 (0.0)
Some high school (9–11 y)	12 (1.9)	5 (1.6)	7 (2.2)
High school graduate (12 y)	70 (11.0)	45 (13.9)	25 (8.0)
Some college or technical school (13–15 y)	221 (34.8)	113 (35.0)	108 (34.5)
College graduate (16 y)	208 (32.7)	97 (30.0)	111 (35.5)
Postgraduate training or degree (17+ y)	124 (19.5)	62 (19.2)	62 (19.8)
Satisfaction with the program, n (%)			
Somewhat, or very satisfied	560 (88.8)	254 (80.1)	306 (97.5)
Somewhat, or very dissatisfied	71 (11.2)	63 (19.9)	8 (2.6)

EPC indicates enhanced primary care; EPC+C, enhanced primary care plus coaching; BMI, body mass index; SD, standard deviation; and CI, confidence interval.

MEDIATORS AND OTHER PREDICTORS

In the same multivariable model, we explored factors, other than the intervention arm, associated with an interest in continuing the program. Independently, Hispanic/Latino ethnicity (vs white non-Hispanic) was associated with greater interest in continuing the program (Table 2). Satisfaction with the program was a strong mediator of being interested in continuing (OR, 12.77; 95% CI, 6.57–24.84) (Table 2).

For perceived worth, the age group of the child, non-Hispanic black ethnicity, and Hispanic/Latino ethnicity were significant predictors, while satisfaction emerged as a statistically significant mediator (Table 2). Next, we examined factors influencing parents' willingness to pay out of pocket. Again, Hispanic/Latino ethnicity (vs white non-Hispanic) and satisfaction with the program were associated with increased odds of reporting being willing to pay out of pocket (Table 2). There was no effect of perceived worth on this outcome.

Finally, none of the individual and family-level covariates (predictors or mediators) were associated with the

amount parents were willing to pay for the program (Table 2). However, we did find that parents who were first presented with the upper bound (\$100) of WTP by the iteration method reported a median amount of WTP that was \$22 higher (difference of \$22.19; 95% CI, \$15.62–\$28.76) in the open-ended format than parents who were randomized to seeing the lower bound (\$10) first. The perceived worth of the program was not a statistically significant mediator of the amount participants were willing to pay (Table 2).

DISCUSSION

In this study of 638 participants in a pediatric weight management randomized trial we found that, at the end of the trial, a majority of parents were interested in continuing the program their children took part in but many were hesitant to pay out of pocket for it. This interest in continuing the program was slightly higher for participants in the intervention arm that included individualized coaching, a

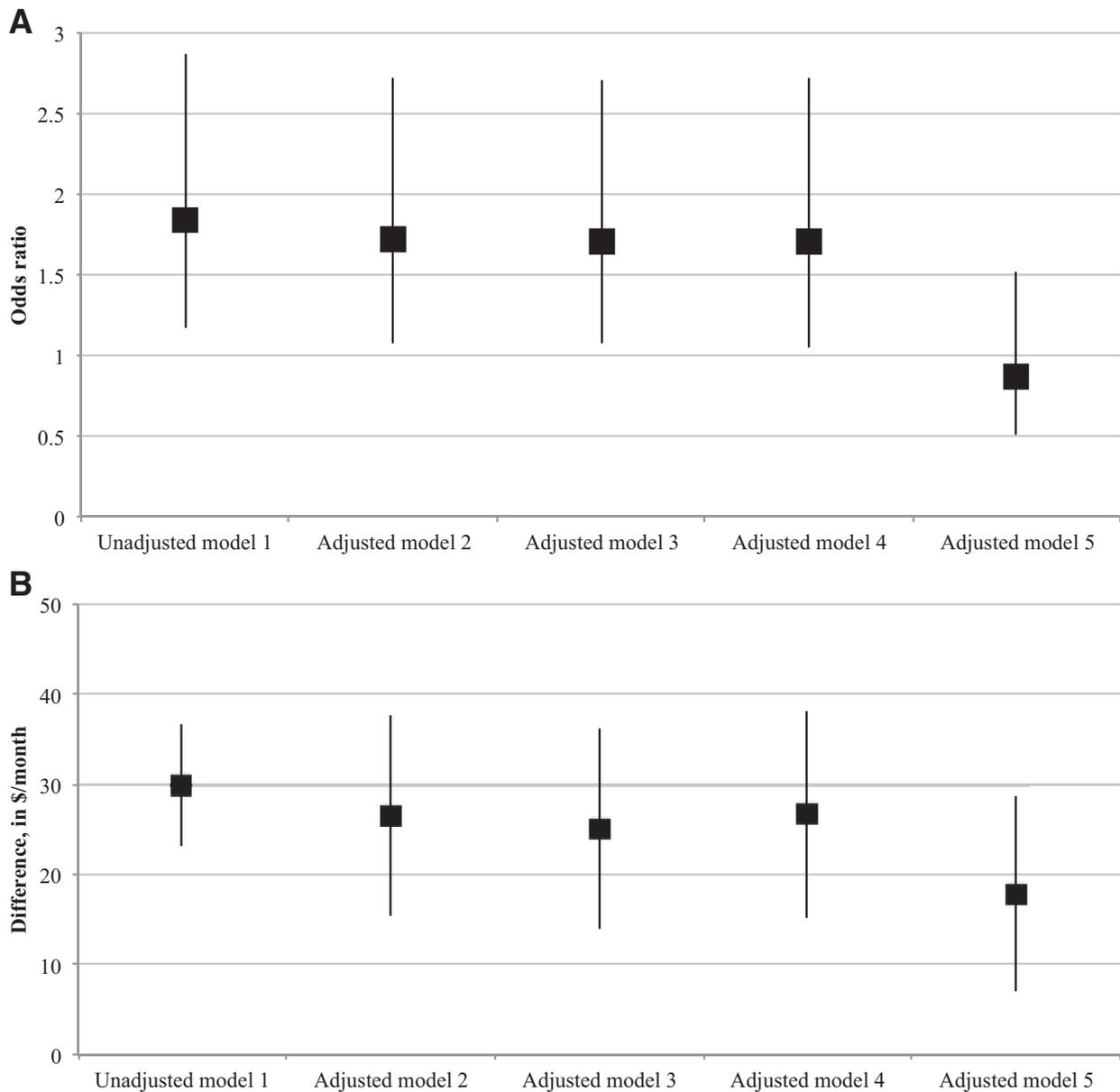


Figure 1. Difference in (A) interest to continue and (B) perceived worth of the program for participants in the EPC+C arm versus EPC arm. Model 1: intervention arm (REF = EPC). Model 2: Model 1 + child age, sex, race/ethnicity, and household income category. Model 3: Model 2 + baseline BMI category. Model 4: Model 3 + BMI category change. Model 5: Model 4 + satisfaction with the program. Error bars represent the 95% confidence interval. EPC indicates enhanced primary care; EPC+C, enhanced primary care plus coaching; and BMI, body mass index.

difference driven mainly by higher satisfaction with the program. Parents in the individualized coaching arm also reported higher perceived worth of the program and were more likely to endorse WTP out of pocket for the program. These findings were robust to adjustment for both predictors and mediators that could influence WTP, such as amount of BMI change, as well as socioeconomic factors. However, the amount parents were willing to pay in the individualized coaching arm was not significantly greater than in the enhanced primary care arm.

To our knowledge, this study is the first to report parental WTP to continue a weight management program for their child with overweight or obesity. Our study is concordant with, but also builds on, other reports. For example, 61.4% of parents whose children were taking part in a

study on health promotion and physical activity in schools reported being willing to pay for a hypothetical weight loss program that would cut the incidence of childhood obesity and overweight by half, with a mean amount of 23 euros/month.⁶ In this study, higher WTP was associated with having a child with obesity, being an immigrant, and higher household income.⁶ An adult study with a design similar to ours (evaluating WTP at the end of a clinical trial in which participants took part) found a median WTP of \$45/month, and that neither the amount of weight loss nor household income was associated with WTP.⁸

There is growing interest in the use of individualized support to help patients achieve their health goals. For example, patient navigators are increasingly being

Table 2. Effect of Different Factors Influencing Parental Interest to Continue, Perceived Worth, Willingness to Pay, and Amount Parents Were Willing to Pay, in Multivariate Models

Factor	Interest to Continue* (n = 586) Being Somewhat/Very Interested vs Not Interested aOR (95% CI)	Perceived Worth of the Program† (n = 535) Difference in Median \$/mo (95% CI)	Willingness to Pay‡ (n = 535) Being Somewhat/Very Interested vs Not Interested aOR (95% CI)	Willingness to Pay§ (n = 217) Difference in Median \$/mo (95% CI)
<i>Intervention Arm</i>				
EPC+C (vs EPC)	0.87 (0.51, 1.51)	17.90 (7.03, 28.77)	1.53 (1.05, 2.22)	5.77 (−1.50, 13.04)
<i>Child's Characteristics</i>				
Age, 6–12 y (vs 2–6 y)	0.62 (0.33, 1.16)	11.30 (2.40, 20.20)	0.99 (0.66, 1.50)	3.46 (−4.26, 11.18)
Gender, female (vs male)	1.02 (0.62, 1.69)	1.10 (−6.90, 9.10)	0.82 (0.57, 1.18)	−2.88 (−9.66, 3.89)
<i>Race/ethnicity</i>				
Non-Hispanic white	REF	REF	REF	REF
Non-Hispanic black	1.74 (0.91, 3.30)	18.90 (1.48, 36.32)	1.12 (0.70, 1.81)	3.65 (−6.57, 13.88)
Hispanic/Latino	2.85 (1.33, 6.09)	16.80 (0.29, 33.31)	1.93 (1.14, 3.27)	1.15 (−10.11, 12.41)
Other	2.28 (0.81, 6.40)	10.50 (−2.14, 23.14)	1.11 (0.56, 2.19)	5.38 (−5.69, 16.46)
<i>BMI category at baseline</i>				
85th to <95th percentile	REF	REF	REF	REF
95th to 120% of 95th percentile	0.78 (0.45, 1.37)	1.80 (−5.97, 9.57)	0.98 (0.64, 1.49)	4.42 (−3.15, 12.00)
>120% of the 95th percentile	1.68 (0.75, 3.75)	0.00 (−16.06, 16.06)	0.90 (0.53, 1.53)	4.04 (−7.99, 16.07)
<i>BMI category change after 1 year</i>				
Decreased (vs stayed same or increased)	0.57 (0.32, 1.02)	−0.80 (−9.00, 7.40)	0.84 (0.53, 1.34)	6.73 (−2.22, 15.68)
<i>Parent and Household's Characteristics</i>				
Income, <\$50,000/y (vs >\$50,000/y)	1.26 (0.72, 2.20)	−0.50 (−12.81, 11.81)	0.86 (0.58, 1.28)	2.12 (−5.88, 10.11)
<i>Satisfaction with the program</i>				
Somewhat or very satisfied (vs dissatisfied)	12.77 (6.57, 24.84)	22.70 (14.67, 30.73)	8.65 (3.00, 24.92)	6.81 (−32.68, 46.29)
<i>Perceived Worth of the Program</i>				
By \$20/mo increments	—	—	1.01 (1.00, 1.03)	0.77 (0.14, 1.40)

CI indicates confidence interval; EPC, enhanced primary care; EPC+C, enhanced primary care plus coaching; BMI, body mass index; and aOR, adjusted odds ratio.

*See Model 5, Figure 1A.

†See Model 5, Figure 1B.

‡See Model 6, Figure 2A.

§See Model 7, Figure 2B.

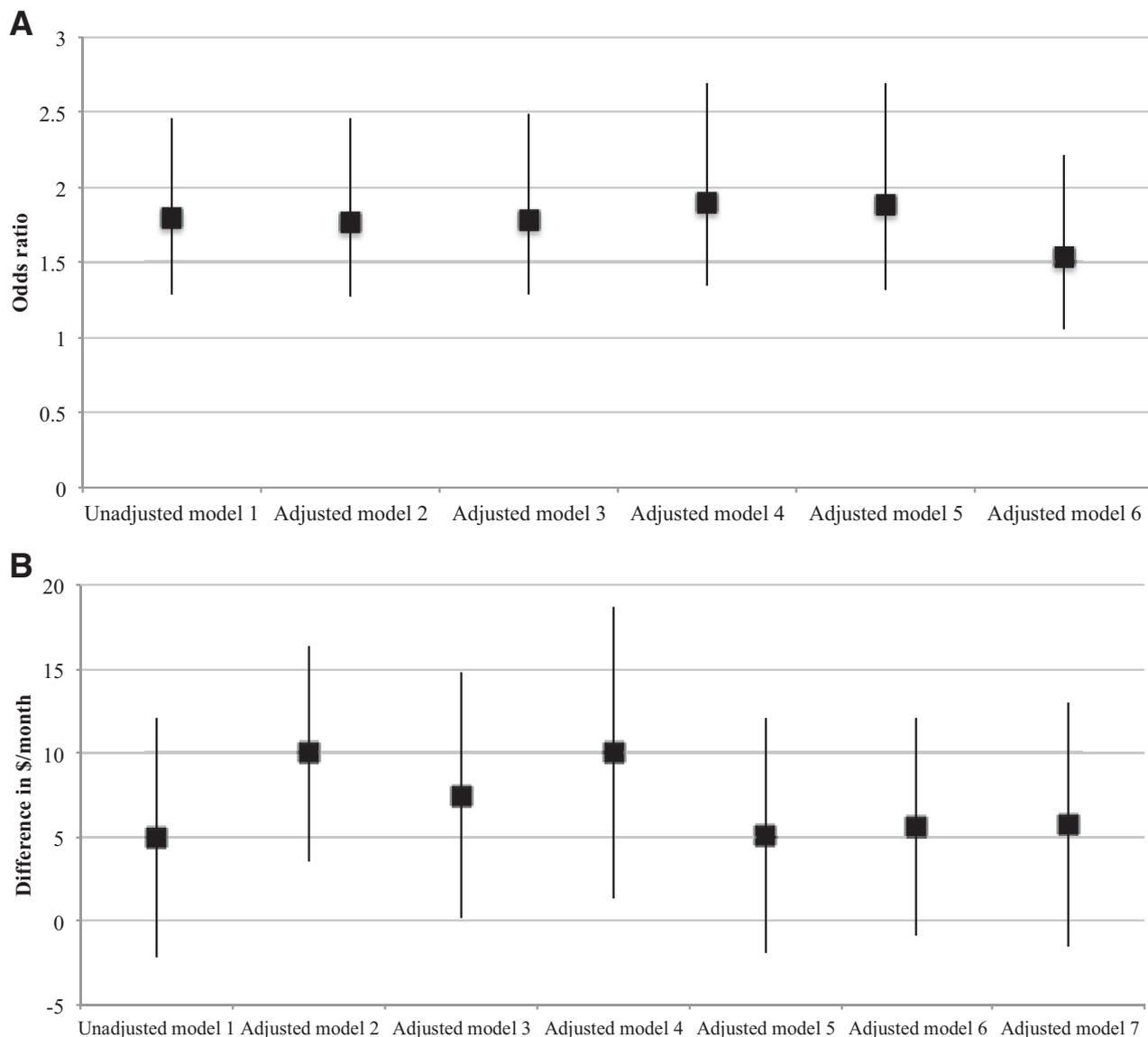


Figure 2. Difference in (A) willingness to pay and (B) amount (\$/month) parents were willing to pay for participants in the EPC+C arm versus EPC arm. Model 1: Intervention arm (REF = EPC). Model 2: Model 1 + child age, sex, race/ethnicity, and household income category. Model 3: Model 2 + baseline BMI category. Model 4: Model 3 + BMI category change. Model 5: Model 4 + perceived worth of the program. Model 6: Model 5 + satisfaction with the program. Model 7: Model 6 + order of presentation of WTP by iteration. Error bars represent the 95% confidence interval. EPC indicates enhanced primary care; EPC+C, enhanced primary care plus coaching; and BMI, body mass index.

incorporated into patient-centered medical home teams by employers or insurers to support medically complex patients.¹⁸ However, there is also interest in using individualized support for a broader population of patients to help them achieve health goals, including weight management.^{19,20} In our study, parents were more interested in continuing the program if they were randomized to the individualized coaching intervention arm, a result mainly driven by a higher satisfaction. Parents in the individualized coaching intervention were also more likely to be willing to pay out of pocket for the program. This result is of particular importance given that, currently, this type of support is not typically covered by insurance plans.

We also found a difference in WTP among racial/ethnic groups, similar to other studies,⁸ with parents of children of Hispanic/Latino ethnicity being more likely to report

WTP for the program. Although our analysis does not allow us to determine the exact reason for this difference, previous research has documented that many weight management programs are poorly adapted to minority groups, including Hispanics/Latinos.²¹ As such, Connect for Health, which used family- and patient-centered approaches, could have also created a program that was more responsive to the needs and preferences of the Hispanic/Latino population compared to traditional weight management programs, leading to a higher satisfaction from this segment of the population.

Our use of a sequence of models also allowed us to identify satisfaction as a major determinant of parental interest in continuing the program, and adjusting for satisfaction attenuated most of the difference between the two intervention arms. Interestingly, although satisfaction was

also an important predictor of WTP, a statistically significant difference in WTP remained between the two intervention arms, even after adjusting for satisfaction. It is possible that participants in the health coach intervention understood that their program was more intensive and costly and as such were more likely to be willing to pay out of pocket for this extra service that was different from their usual primary care. This cannot be the only contributor, however, given that controlling for perceived worth did not change the association between intervention arm and WTP. Interestingly, perceived worth did not emerge as a significant predictor of the amount parents were willing to pay out of pocket for the program.

Taken together, in evaluating interest to continue participating in and WTP for weight management programs, these findings show the importance of programs that are family centered and focus on patient experience. Although hypothetical treatment regimens such as those used in other studies^{6,7} have found income and the perceived importance of weight loss as important determinants of WTP, our study shows that in real-life interventions personal factors, such as satisfaction with the program, might be more important.

Our study has important strengths. First, unlike other studies in pediatrics, our study did not use hypothetical scenarios but rather a program that parents knew would impact their child directly. We also obtained data from a very diverse sample with regard to both income and race/ethnicity, increasing the external validity of the results. Second, we were able to adjust for the order in which the WTP questions were presented. This is a strength, given that previous studies have shown that the sequencing of questions can significantly influence WTP, a phenomenon known as anchoring or starting-point bias.^{8,14,15} Some participants might see the starting point as a proxy, or a suggestion, for the value of the program.¹⁵ In our case, it is not possible to determine which estimate—the one provided by those randomized to low versus high starting point—is closer to what people are “truly” willing to pay. At the very least, our study suggests the importance of continuing to randomize participants to different starting point conditions, especially if WTP is determined by the iteration method.

Our study does present some limitations. First, we only obtained data after people had completed the trial, not before they experienced it, as would be the case in a program offered to the public. It is unclear how different the results would be if parents were asked similar questions about a program their child was about to enter. To partially circumvent this concern, we did create sequential multivariable models, including models using only baseline predictors available at the beginning of the trial, such as sociodemographic characteristics and baseline weight, and those results did not differ significantly compared to models that also adjusted for mediators obtained at the end of the trial, such as weight category change and satisfaction with the program. Second, like any study on WTP, there may be a difference between the amount parents declared they would be willing to pay and what they would actually pay in real life. Similarly, there is a risk of

social desirability bias in participants’ response to measures of interest to continue, WTP, and satisfaction. These are inherent to the method used, but we believe that our study is nevertheless an important first step that will assist those who are considering offering a childhood obesity management program in which parents would pay some or all of the cost of ongoing services.

CONCLUSIONS

Most parents of children participating in a weight management trial were interested in continuing the program after 1 year, but many were hesitant to pay out of pocket for it. Participants who received individualized coaching were more likely to endorse willingness to pay out of pocket for continuing the program than were parents of children in an enhanced primary care intervention. Cost sharing may be a barrier to families interested in participating in a pediatric weight management program.

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