N.Y. City Starts Cash Incentives So Poor Get Care

BY JOHN R. BELL
Associate Editor

NEW YORK — A new program in New York City that pays low-income families for obtaining preventive medical care and for maintaining health insurance is garnering its share of praise and skepticism among physicians who practice there.

Under the pilot program, Opportunity NYC, which began in September, families will receive $20 per parent or guardian per month via wire transfer for maintaining public health insurance or $50 for maintaining private health insurance, and the same amount for maintaining insurance for all children in the family. Funding is being provided through corporations as well as from Mayor Michael Bloomberg, who conceived the idea.

The program also pays enrolled parents when their children attend school regularly, get a library card, or do well on tests. Other payments reward preventive dental care and continued parental employment.

Although the payment amount is relatively low, the hope is that it will serve as an incentive for families who already have public health insurance to actively maintain that coverage by making sure it is not disrupted when the time comes to recertify their eligibility, Linda I. Gibbs, New York's deputy mayor for health and human services, said in an interview. For the small number of participants who don't qualify for public health insurance because they are employed, the idea will help them offset the higher cost of private insurance.

The encouragement of preventive care is another component. Participants are paid $200 for each annual preventive visit to any physician in their plan. Physicians are required to provide age-appropriate preventive care. "We know that many families, even with public health insurance, are not going to those annual preventive visits." And even when they do go, "doctors are not always providing all of the [preventive care] that the child or the adult should be getting during that visit." So the program is building in an attempt to achieve quality standards.

Childhood vaccinations would fall under required preventive care services, she said. When the preventive visit indicates a follow-up visit or treatment is necessary for any family member, the family receives a $100 payment for that visit as well.

Dr. Mark Krotowski, who practices family medicine in the Canarsie area of Brooklyn, near the target neighborhood of Brownsville, was sanguine about the program's potential. "It's a good thing. … With the cash incentives, it'll certainly encourage the parents to bring in the kids," said Dr. Krotowski, who is chairman of family medicine at the borough's Brookdale Hospital.

Dr. Krotowski noted that the incentives may help primary care physicians combat childhood obesity, which he says is "probably the biggest medical challenge in New York City. If we can get the kids early, we can refer them to specialists who deal with obesity and try to take care of them."

The state of New York already has a fairly efficient system for providing medical care to its low-income residents via the HMO Medicaid or HMO Child Health Plus programs, added Dr. Krotowski, who is also vice chair of the New York state chapter of the American Academy of Family Physicians.

Dr. Linda Prine, a family physician at Sidney Hillman Health Center in New York, said that she is underwhelmed by the program's ability to have any real impact. "This program is a drop in the bucket and does not begin to address the problem of lack of affordable health care for the uninsured. People at this level of poverty cannot afford the monthly premiums to buy health insurance, even with a rebate of $20-$50," said Dr. Prine, chair of the Public Health Commission of the New York State Academy of Family Physicians.

The cost of the program, which so far is operating solely from private funding, makes its long-term viability uncertain, according to Dr. Andrew D. Racine, vice president of the American Academy of Pediatrics chapter that covers the Bronx, Manhattan, and Staten Island.

"Obviously, the American Academy of Pediatrics is delighted with any sort of rethinking of how we can improve the health status of children," but the opportunity costs have to be addressed, he said in an interview.

"If you decide you're going to spend X amount of money to induce people to maintain health insurance, there are a lot of ways to skin that cat."

Direct cash for medicine is one option; another is to extend Medicaid enrollment to automatically last for 2 years instead of 1. "We know that there are things that we could be doing to maintain health insurance in children that we're not already doing," said Dr. Racine, who also is director of general pediatrics at the Children's Hospital at Montefiore, in New York.

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DR. RACINE

That said, Dr. Racine expressed full support for the aspects of the program that encourage preventive care. "The principle of actually using cash incentives to get people to do things is great. It's sort of the opposite of taxing. You tax things that you don't want people to do, and this is sort of an inverse tax," he said.

Currently, 5,100 families are being recruited via the schools' free-lunch program in six city neighborhoods in which the poverty rates exceed 40%. Candidates must have children in the 4th, 7th, or 9th grades and must be documented legal residents or U.S. citizens.

An equal number of families (2,550 per group) will be randomly assigned to a study group and to a control group in order to study the program's efficacy, Ms. Gibbs explained.

Because many low-income families do not have bank accounts, the mayor's office recruited four banks and four credit unions to provide free checking accounts for program participants. ■

Ketogenic Diet for Seizure Control Effective but Underused

BY GREG MUIRHEAD
Contributing Writer

MAUI, HAWAII — Although a high-fat ketogenic diet is effective in helping epilepsy patients control their seizures, it is underutilized because it is misunderstood, said Dr. Eileen P.G. Vining.

The diet is not difficult. It can be palatable, adaptable, and inexpensive, she explained at a meeting sponsored by the University Children's Medical Group and the American Academy of Pediatrics.

It is estimated that the diet is initiated in only 2,500 patients per year based on a rough calculation of published data, while about 100 million people worldwide have epilepsy, according to the World Health Organization, she said.

The ketogenic diet is a high-fat, low-carbohydrate diet that provides adequate protein (1 g/kg per day), but greatly restricts carbohydrate intake, Dr. Vining said at the meeting, also sponsored by California Chapter 2 of the AAP. The effect of the diet is to mimic ketosis. The ketogenic diet's fat-to-carbohydrate and protein ratio may range from 2:1 (less strict) to 4:1 (very strict), with an average of 3:1. At a 3:1 ratio, fat intake accounts for 80%-90% of calories.

"We know the diet is effective for a wide variety of seizures," said Dr. Vining, director of the John M. Freeman Pediatric Epilepsy Center at the Johns Hopkins Hospital in Baltimore. She acknowledged, however, that "we don't understand the biology of the ketogenic diet."

About 46% of patients on the diet have greater than 90% control of seizures at 12 months, she said. For those using the diet, medications often can be decreased, although for patients helped by just two or three medications, it may make sense to continue them. She noted that a study on more "aggressive" discontinuation of medications found good results even within 1 month (Epilepsy Behav. 2004;5:499-502). "There are some 'superresponders' who become seizure free within the first 2 weeks," added Dr. Vining, who is also professor of neurology and pediatrics at Johns Hopkins University.

The diet emerged in the 1920s, when it was discovered that a person who is fasting becomes ketotic, she explained. Researchers at The Mayo Clinic developed the idea that changing the nutrient structure of a diet would mimic fasting. By using the ketogenic diet, a person is put in a constant state of ketosis. The diet was popular until phenytoin came on the market and was seen as easier to use than maintaining the diet, she said. But the diet has had a resurgence since the mid-1990s. It is comparable to the popular Atkins diet for weight loss (Epilepsia 2006;47:421-4).

Prior to beginning the diet at Johns Hopkins' clinic, children fast for 24 hours and are seen in the clinic Monday morning. They are then admitted to the clinic for 4 days (Monday-Thursday), where they are given eggnog to increase the fat in their diet from one-third to two-thirds of the full calories, and finally to a full percentage of calories using regular food. Individual adjustments are made to maintain 80-160 mmol urinary ketosis and to avoid significant weight gain or loss.

Dr. Vining cited several studies in support of the effectiveness of the diet.

A large prospective study conducted at Johns Hopkins enrolled 150 children with a mean age of 5.3 years and a mean monthly seizure rate of 410. The children used a mean of 6.2 antiepileptic drugs prior to initiating the diet. At 3 months, 83% remained on the diet, and 34% experienced greater than 90% reduction in seizures. At 12 months, 55% remained on the diet, and 27% had greater than 90% reduction in seizures. The diet appeared to work across a wide spectrum of ages and seizure types.

Another study found that after 1 year of being on the diet, 74% of pediatric patients were able to reduce their medications, with the number on two medications was reduced from 79% to 23%. No medications were needed by 48%. There was a 67% reduction in medication costs, resulting in an average savings of about $1,000 per child per year (J. Child Neurol. 1999;14:469-71).

A downside to the diet is impaired growth. A study conducted by Dr. Vining of 237 children ranging in age from 2 months to 9 years and 10 months found at 1 year that weight had not substantially increased and linear growth had also been reduced (Dev. Med. Child Neurol. 2002; 44:796-802).

Another study by Dr. Vining and her associates found that use of the diet for as long as 2 years resulted in elevated triglycerides, total cholesterol, and LDL cholesterol levels but no rise in HDL cholesterol levels (JAMA 2003;290:912-20). Also, acidosis is seen routinely.

A 2004 study found that the ketogenic diet is used at 80 U.S. centers and at 70 centers in 41 countries. Continued use in patients has ranged from 1 to 45 years, with a median of 8 years. The average number of people per country using the diet was 71.6, with 5.4 started per year, in a range of 0 to 40 (Epilepsia 2004;45:1163). ■

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