herein are previously reported findings from 2 prospective cohorts, the Singapore Chinese Health Study (SCHS)2 and the US Atherosclerosis Risk in Communities (ARIC) study,3 that support a beneficial effect of higher fiber intake in the development of respiratory morbidity. In the SCHS, among 49,140 older adults, dietary fiber intake was inversely associated with incident cough with phlegm in a dose-dependent manner (adjusted odds ratio, 0.61 [95% confidence interval, 0.47-0.78], comparing highest to lowest quartile of intake; P value for trend, .001).2 In the ARIC study, higher fiber intake was significantly associated with better lung function (higher FEV1 [forced expiratory volume in 1 second], FVC [forced vital capacity], and FEV1/FVC).3 For example, FEV1 was 49 mL higher in the highest compared with the lowest quintile of cereal fiber intake (P value for trend, <.001). Higher cereal fiber intake was also related to lower prevalence of chronic obstructive pulmonary disease defined by spirometry (adjusted odds ratio, 0.79 [95% confidence interval, 0.64-0.98], comparing highest to lowest quintile of intake; P value for trend, .017).

In summary, previous prospective data from the SCHS and the ARIC study along with recent findings from the NIH-AARP study collectively support a beneficial effect of a diet high in fiber in preventing both morbidity and mortality from respiratory disease.
Health Care Reform

More Health Care Is Not Necessarily Better Health Care

Kullgren et al1 show that low-income families with high-deductible health plans report cost-related delayed or foregone care. However, the authors fail to show that the additional care consumed by the higher-income group was essential or that outcomes were superior in that group.

In the well-known RAND study of free medical care vs cost sharing,2 the cost sharing group had one-third fewer ambulatory visits and one-third fewer hospitalizations than the free-care group, and yet there was no difference in health measures between either group for the average patient except for a trivial difference in corrected vision of 20/22 vs 20/22.5. In the subgroup of low-income high-risk patients, there was a significant 3.3 mm Hg difference in diastolic blood pressure, but there was no difference in smoking, weight, cholesterol level, or any of 5 self-assessed measures of health.

In 1984, the Stanford health care economist Victor Fuchs estimated that 20% of all medical care was either harmful or low yield.3 Without evidence that the deferred care in the Kullgren study resulted in poorer outcomes, it is reasonable to posit that much excess care is either harmful or low yield and that the deferral of care was rational from a personal cost-benefit point of view.

The value of any particular episode of care is situational and personal, and so decisions on what medical care to buy are best made at the level of patient and physician. If, however, Kullgren et al are correct in their observation of income-based health care utilization disparity, then leveling of the playing field between lower- and higher-income families could be accomplished with income-based progressive copayments, so that all patients may consider cost to benefit in their choices. Innovations of this type are a first and essential step toward rationalizing care, without the kind of one-size-fits-all, top-down rationing that is on the minds of many.

Jay Erlebacher, MD

Author Affiliation: Division of Cardiology, Englewood Hospital and Medical Center, Englewood, New Jersey.

Correspondence: Dr Erlebacher, Division of Cardiology, Englewood Hospital and Medical Center, 177 N Dean St, Englewood, NJ 07631 (drerle@mac.com).

Financial Disclosure: None reported.