

made as part of a general discussion about why reference-based pricing policies may not substantially slow the growth of pharmaceutical expenditures in the long term and did not refer to the BC program specifically.

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Reference

1. Narine L, Senathirajah M, Smith T. Evaluating reference-based pricing: initial findings and prospects. *CMAJ* 1999;161(3):286-8.

Bob Nakagawa and Rick Hudson suggest that captopril was the ACE inhibitor of choice in hypertension at the time of our study and that patients in hospitals might have been preferentially prescribed captopril. Our data, however, show that among first-time users of ACE inhibitors, the use of captopril was considerably lower than that of the other 2 agents; this does not indicate preferential use of captopril initially. Moreover, our study included only prescriptions dispensed on an outpatient basis, and availability of the drug on the hospital formularies should not have direct relevance to our study. Thus, we disagree with the claim that we present “little evidence” of the presence of therapeutic differences among ACE inhibitors on that basis.

Maurice McGregor contends that our conclusions are premature. He refers to a study by Caro and colleagues¹ that showed very low rates of persistence with ACE inhibitors in a similar cohort. We agree entirely that one should take such changes in drug use into account when trying to infer causality between drug use and subsequent use of health services, which our study did not. Our intent-to-treat analysis was a first step in using population-level data to assess whether agents belonging to the same therapeutic class differ in respects other than simply their chemical structures, such as the way they are prescribed to different patients and their impact on health ser-

vices utilization. Additional studies accounting for complex patterns of drug use would be welcome.

Reference-based pricing policies aim to ensure that the more cost-effective medication is used. Although we are advocates of this approach, we believe that such policies should be carefully evaluated, not only in terms of health-related spending but also in terms of population health. McGregor’s statement that “this is a provocative study that merits clarification” is certainly true. Indeed, our study had several methodological limitations, as Paul Grootendorst and Anne Holbrook correctly pointed out in an accompanying editorial,² and there may be other plausible explanations for the observed differences. However, population-based studies are essential in evaluating whether policies aimed at reducing costs may not in fact increase long-term costs and, more important, negatively affect public health.

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References

1. Caro J, Speckman JL, Salas M, Raggio G, Jackson JD. Effect of initial drug choice on persistence with antihypertensive therapy: the importance of actual practice data. *CMAJ* 1999; 160(1):41-6.
2. Grootendorst P, Holbrook A. Evaluating the impact of reference-based pricing [editorial]. *CMAJ* 1999;161(3):273-4.

Much ado about Furbies

The research letter by Kok-Swang Tan and Irwin Hinberg regarding the Furby toy¹ raises questions. Was more than 1 Furby tested? There may be variance among Furbies. How did they obtain the Furby? When I tried to get one at Christmas time in 1998, they were virtually impossible to obtain. Did they use expensive AAA batteries, or cheaper ones that might reduce the electric and magnetic fields generated by the Furby? Finally, they state that

the electric and magnetic field strengths generated by the Furby were about “70 times weaker” than those from a digital telephone. One time weaker would obviously mean no electromagnetic waves whatsoever, but it is hard to picture something that is 70 times weaker. Does this mean 1/70th, or 70% less? Or do the Furbies actually absorb electromagnetic waves, being in a negative mode?

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Reference

1. Tan K-S, Hinberg I. Furby does not interfere with medical devices. *CMAJ* 1999;161(8):971.

[One of the authors responds:]

We tested 2 Furbies. Neither caused any effect on medical devices. We had no difficulties in obtaining the Furbies. We obtained one from the Canadian distributor in Montreal and the other from a friend. Many colleagues had offered to lend us their Furbies for testing. We used 4 Energizer alkaline batteries. The voltage of each battery was checked after each test to ensure that it had not fallen below 1.50 V DC (about 94% of the initial voltage). As we pointed out in our paper the electric and magnetic field strengths generated by the Furby were weak — not zero. The term “70 times weaker” means 1/70th the strength.

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Old ways of treating TB may hold new appeal

As a physician who was involved in treating tuberculosis before the introduction of chemotherapeutic drugs, I found the article by Earl Hershfield