creased risk of not breast-feeding associated with cesarean delivery to be more important than the absolute risks of 44% for flatal incontinence and 9% for fecal incontinence associated with forceps delivery? In a survey of British obstetricians, up to 31% opted for ceserean delivery when faced with a normal full-term pregnancy.[5] Their reason for choosing cesarean delivery was fear of pelvic injury associated with vaginal delivery. Like these obstetricians, I suspect most women who were properly informed about the risks they face with forceps delivery would prefer cesarean delivery, despite the slight chance that it might influence their chances of breast-feeding.

Leung and colleagues cite the WHO's recommendation that accoucheurs should aim for an upper limit of 15% for cesarean delivery rates as an appropriate benchmark against which we should measure our own rates. The WHO rate, unfortunately, was chosen arbitrarily and was not based on science. Over the last 2 centuries, cesarean section has evolved from an operation performed after the mother died in an effort to save the infant, to an operation that often offers the best option to protect both the mother and the fetus. In many African countries, prolonged obstructed labour results in high rates of maternal mortality. For those women who survive, many experience the particularly morbid complication of vesicovaginal fistula. Access to good obstetric care and timely cesarean delivery could significantly reduce maternal mortality and morbidity in these countries. At a time when maternal and fetal mortality rates are the lowest in recorded history in the developed world (where cesarean delivery rates are higher), one should be cautious about equating cesarean section with the term epidemic, a term that carries significant negative connotations.

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La reconstruction de l'Afghanistan

Dans votre éditorial du 5 février[1], vous avancez que le moment semble venu de se lancer dans la reconstruction de l'Afghanistan et de son système de santé. Il est effectivement temps, car qui se souciait de ce pays? N'oublions pas que l'aide totale apportée à l'Afghanistan a été en chute constante entre 1996 et 2000, passant de 7,9 dollars US à 5,5 dollars US par habitant[2]. Le Canada a adopté une politique moins draconnienne, puisque par rapport à 1994, année où les pays de l'Organisation de coopération et de développement économiques (OCDE) ont consenti le plus d'argent, il a conservé un niveau d'aide relativement stable jusqu'en 1999 (7,5 millions de dollars US par an)[3]. Cependant, si le Canada, comme vous le rappelez, reste un piètre pays au niveau mondial pour l'aide au développement (17e sur 22 pays de l'OCDE[4]), il nous semble qu'il doit non seulement déployer plus d'argent, mais surtout exporter les valeurs sur lesquelles repose (encore) son système de santé. La reconstruction de l'Afghanistan requiert, selon certains[5], l'organisation d'un fonds commun alimenté par tous les bailleurs. Or, à la lumière de notre propre expérience en Afghanistan ou au Timor oriental, nous avançons que cette solution comporte le risque que la nature du système de santé proposé tende plus vers l'idéologie actuellement dominante de la privatisation et du paiement direct de la part des usagers que vers l'accès universel aux soins, et nous en connaissons les écueils. Cela revient plus cher à la société et les plus pauvres sont exclus de l'accès aux soins. Le Canada, par l'intermédiaire de son aide internationale, doit promouvoir et appuyer des solutions en lien avec ses propres valeurs. Dans ce cas, il doit soutenir la réorganisation du système de santé fondé sur un financement public qui demeure encore le seul moyen efficace et efficient pour offrir un accès universel et équitable aux soins de santé.

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Reference drug pricing

In his commentary, Aslam Anis correctly points out that there is a greater need for randomized trials to assess the therapeutic equivalence of prescription drugs within a class.[1] However, he misinterpreted our results[2] when he stated that the reference drug pricing policy led to a "10% decline in the use of antihypertensives." Due to a temporary reduction in the length of supply of pharmacy dispensings during a 5-month transition period, the non-significant (p = 0.15) dip in dispensings per month is likely to be inconsistent with an underutilization of antihypertensives.[3] In Figure 2 of our article it becomes even more obvious that there is no change after the transition period (p = 0.40).[2] Furthermore, we found no increase in the rate of discontinuing antihyperten-

sive drug therapy.[4] We also found that overall costs, including emergency room and hospital utilization, did not change after the policy.[4] The net savings of $6 million in the first year in the elderly alone,[4] which amounted to 6% of expenditures for all cardiovascular drugs,[5] were much higher than most drug cost-containment policies.[6] Overall, this is one of the only drug cost-containment policies (of which we are aware) that saved substantial costs without unintended outcomes on patient health status or use of expensive services.

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[The author responds:]

In my recent commentary,[1] I was remiss in not noting that the "10% decline in the use of antihypertensives" was not statistically significant (p = 0.15). Nonetheless, regardless of statistical significance, the decline was *real*. This specific statistic reported the difference in utilization of antihypertensives between the Jan. 1997 *predicted* utilization (as extrapolated from the November 1996 *observed* utilization, Figure 2) and *observed* utilization.[2]

Instead, if one were to make the comparison using the Oct. 1996 utilization relative to the March 1997 utilization, the decline in antihypertensive utilization appears to be approximately 15%, a decline that is perhaps now also statistically significant. Moreover, the estimated trend in overall antihypertensive utilization does not catch up with the predicted utilization until the very last data point presented: April 1998 (Figure 2). In fact, during the entire 16-month post-reference-pricing period studied, the estimated trend is below the predicted line. This represents a real decline in antihypertensive utilization, in which health consequences remain unmeasured.

In the same paper, the authors estimated the cost savings to the BC drug plan from the application of reference pricing of ACE inhibitors to be $6 700 000 in the first year alone. This estimate is substantially larger than those found by Grootendorst and colleagues, who found savings of an average of $1 200 000 per year over the first 2 years after the policy was introduced.[3] Given that both studies were based on the same administrative source data, could it be that one or both of the studies are methodologically incorrect? An indepth exploration of the causes of the divergence in cost savings is beyond the scope of this rebuttal.

Finally, recognizing that the source data for both of the above studies were collected to process prescription claims and not to perform outcomes research, and that underlying these claims are a complex array of business and personal incentives, exact estimates and an assessment of statistical versus clinical significance should be of secondary importance. What is important is deciding whether, on balance, reference pricing