Reviewer's report

Title: Health economics: the start of clinical freedom

Version: 2 Date: 9 November 2009

Reviewer: Salvador S Peiró

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While in their “response to reviews”, the authors claim the new manuscript “takes into consideration all the referees' concerns”, the current version of the text does not present substantial changes with respect to the previous one. The reviewers' opinions, in fact, did not require changes to the text. In two instances the reviewers expressed their (negative) views of the article's contribution and, in the case of our comments, they posed discretionary questions that the authors could choose to ignore (in fact, none of the changes ultimately made are related to these questions).

My opinion of the current version of the article has not changed with respect to what I expressed after reading the previous version: The manuscript presents a relatively novel point of view about the possibility of using economic evaluations to make individual decisions affecting patients and, although I do not agree, this point of view is sufficiently well developed for the article to be published with the intention of opening debate.

Below I expressed some of my discrepancies with this work. These discrepancies do not constitute my opposition to the article’s publication but should be considered, instead, as participation in a discussion on the topic.

The authors jump from the social perspective to the patient’s, although the examples of economic analyses they cited only address the societal perspective. Any economic evaluation relates to making a specific decision from a specific point of view. We usually work from the perspective of society as a whole, because other, more limited perspectives, including the patient’s, may be opposed to those of society as a whole (In other words, a decision that is not efficient for society as a whole may be beneficial to a patient or a subgroup of patients).

Some of the examples advanced in this article clearly show this change in perspective. Hence, in public health care systems, treating high risk cardiovascular patients with statins (where the cost/QALY is low), and not treating low risk patients (where the cost/QALY used in the example is $1,400,000) is not, nor it should it be, an individual clinical decision. It is a collective decision because it involves public financing of the drug in one or more risk groups, and it should be taken with transparency by public decision-makers.

In the space conceived for public decisions, there is also space for individual
decisions. A low risk patient may decide to spend $1,400,000 to achieve one more QALY. If there is no other cost-effective alternative to achieve this QALY, this would be a rational decision, and it would be irrational for the clinic to advise against it arguing the social perspective. A high risk patient may also decide against taking treatment that is efficient for society as a whole for various reasons. In these cases, the regulator tends to put the “sovereignty” of the patient ahead of social efficiency (unless this involves a risk to a third party -- such as tuberculosis -- or unless the risk is minimum -- such as adding fluoride to water).

In all events, collective decisions should be based on an analysis made from the social perspective, while private decision should be based on an analysis made from the patient’s individual perspective. The latter, obviously, cannot ignore the framework imposed by public decisions. Using the wrong perspective when making a decision can be inappropriate in many cases.

**Level of interest:** An article of limited interest

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests