

Are drug rebates good for oncology?

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When oncologists accept rebates, they're in danger of compromising their medical judgment, says one reformer. He challenges clinicians to set things right.

The day after *The New York Times* ran its exposé on oncology drug rebates, “Doctors Reap Millions For Anemia Drugs,” I was at a national roundtable meeting with 20 physicians (no oncologists), hospital administrators, health plan executives, disease managers, and stop-loss brokers. The topics were the state of healthcare and innovative programs that hold promise for the future.

Someone mentioned the article. By that time, it had circulated, everyone had read it, and all agreed: Rebates encourage doctors to write more prescriptions. They also were of a mind on the broader issues: Financial conflicts have no place in a care process that should be detached and in patients’ interests. When rebate incentives drive prescribing behavior, the result is excess costs in every part of the continuum, deepening the healthcare crisis. We won’t re-establish systemic stability and sustainability until we eliminate profiteering from medical practice and other areas of healthcare as well.

Tale of the numbers

According to the *Times* report, documentation showed a six-oncologist practice made \$1.8 million in profits from Amgen on prescriptions for Aranesp and Epogen. That’s a 20% return—or \$300,000 per oncologist—on just two drugs in a practice that, presumably, receives rebates on many other drugs, as well as revenues for physician services.

The article was anecdotal. But there was no reason to doubt that it reflects a

widespread practice. Oncologists I’ve been in contact with since that piece was published both strongly favor and oppose rebates. Not one of them suggested this was an isolated case.

Undoubtedly, many physicians are sincere when they protest that their clinical judgment is not for sale. But in any other arena, these rebates would be understood as kickbacks, specifically aimed at swaying decision-making. There is every appearance of impropriety. Would you have confidence in the objectivity of a financial advisor who recommends a \$100,000 investment that stands to make him \$20,000?

The argument that oncologists “deserve” the rebates for delivering complex care that includes treatment planning, counseling, and drug administration doesn’t wash either. Seek compensation for what you do, not for general deficiencies. When you objectively document how your patients demand more complicated, time-consuming care, then you can take your case to Medicare and commercial payers. In a time of cost crisis, you should expect strong resistance, so craft the solutions. Argue, for instance, that the health plans could easily obtain the funds you rightly deserve by cutting reimbursements for the drugs, since the drugs are the sources of rebates.

It may be too much to ask oncologists to willingly give up sources of money, like rebates, that, in an increasingly tough reimbursement environment keep practices afloat and incomes healthy. But rebates demean physicians’ important work and raise questions about clinical objectivity.

And the practice separates oncologists from most other physicians who also care for very sick patients.

What’s best for patients

Doctors should be paid for providing care, with additional incentives tied to patient volumes and outcomes. Physicians should not benefit from moving more product or conducting more procedures that are independent of quality or safety. The deeper issue here is that medical profiteering favors what’s best for the doctor rather than the patient. This arrangement compromises quality, increases cost, and erodes the patient-physician relationship.

An issue as complex and entrenched as this deserves an exercise that seeks clarity. Community oncologists might do well to convene as a group and explore the roles and impacts of rebates in their practices and on oncology. To inform your discussions and avoid myopia, you might seek the external counsel of physicians from other specialties and of nonmedical professionals. You should undertake a process that affirms the correctness of your present course or acknowledges that a new direction is warranted.

Whatever you do, you should acknowledge the gravity of the allegations and respond appropriately. The details of the *Times* article undermine your mission, appalling healthcare professionals and lay readers alike. Do whatever is necessary to publicly set things right.

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