



LETTER TO THE EDITOR

Can distortions in coding and remuneration in the SUS table interfere with medical practices?

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"Have you ever asked what is the root of money? Money is a tool of exchange...". This is how Francisco D'Anconia's speech on money begins in Ayn Rand's "Atlas Shrugged"¹. My intention is not to make moral or professional-ethical judgments, but rather to take a more pragmatic approach. Money has been one of the most effective means created by man to assign value to an individual's work. About 10 years ago, the high complexity oncology table underwent its last update in values. At that time, several new codes were introduced, and old codes were revised, both in concepts and remuneration. However, there are many flaws and inefficiencies in the oncological table. Modifications or improvements to the table are usually discussed in the meetings of CONSINCA, a permanent collegial body whose purpose is to "advise the Ministry of Health on proposals for the formulation, regulation, and supervision of the national policy for cancer prevention and control". Since the end of 2012, 38 CONSINCA minutes have been released for consultation².

In 2015, the official publication of the American Thyroid Association (ATA) was released, bringing guidelines for the management of thyroid nodules and cancer in adults worldwide, which are still the current guidelines. One of the most debated topics was the introduction of lobectomy as an indicated treatment for early low-risk carcinomas, something that accumulated evidence over the previous years justified as one of the most appropriate approaches for this type of disease. However, the high complexity Unified Health System (SUS) Table only includes the code 04.16.03.027-0 - TOTAL THYROIDECTOMY IN ONCOLOGY, which does not adapt to partial thyroid surgeries. This code remunerates as a total hospital value BRL 2.836,30. For eventual cases of partial thyroidectomy with oncological confirmation, the recommendation of SUS audit services is to charge the code 04.02.01.003-5 - PARTIAL THYROIDECTOMY, a medium complexity table code, with a total hospital value of BRL 425,63. After 38 CONSINCA meetings, this issue has never been put on the agenda. The change in criteria for lobectomy from the

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ATA guidelines of 2015 led to a significant reduction in total thyroidectomies in favor of lobectomies in other parts of the world³. These data are not yet available in Brazil. Unpublished data suggest that we are following the same trend⁴, but this may be influenced by biases generated by data from teaching hospitals, where SUS procedure remuneration is usually linked to the Consolidation of Labor Laws (CLT). Half of medium complexity and 70% of high complexity public procedures in the country are accounted for philanthropic hospitals and Santas Casas⁵. Our impression as service providers without an employment relationship with a philanthropic hospital in the interior of the state is that, for various reasons, this trend follows modestly, below the benefits it could generate for the assisted population.

SUS suffers from a structural deficit, where, in addition to a general lack of funding, resources are poorly allocated, without a logic of investment vs. result. Naturally, as a consequence of a philosophy not oriented towards the market, the System has difficulty in keeping up with the natural evolution of science and the development of medicine. The SUS Table should be continuously revised, not only in terms of its remuneration but also in the introduction of new codifications, review of compatibilities, and distortions of codes, encouraging attitudes according to the most updated recommendations in each topic. I would not be surprised to see financial savings by the government if such measures were implemented.

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