Comments on the article by Girardi et al: Costs in Cardiac Surgery

Paulo R. Benchimol-Barbosa

Hospital Universitário Pedro Ernesto - Universidade do Estado do Rio de Janeiro; Hospital Central Aristarcho Pessoa; Corpo de Bombeiros Militar do Estado do Rio de Janeiro, Rio de Janeiro, RJ - Brazil

To the Editor,

I read with interest the article by Girardi et al, in which the authors analyze the impact of two surgical techniques on the hospital costs related to the procedures[1]. I would like to congratulate the authors for their boldness in addressing such a controversial subject as well as for their transparency and objectiveness.

The funding of myocardial revascularization surgeries in hospitals accredited by the Brazilian Public Health System (SUS), either with or without extracorporeal circulation, seems to have a negative impact on the number of elective surgeries performed, as is the case in our institution. Apparently, the funding offered by the public health insurance system (SUS) does not cover the entire cost of the procedure, which eventually results in lack of payment to suppliers and contractors. The immediate consequence is the limitation of the number of performed cardiac surgeries with the ensuing long waiting for the procedure, which within short and mid-term periods, possibly affect the outcome of patients waiting to undergo the procedure.

In this context, de Oliveira et al[2], in an a excellent article published in the Brazilian Archives of Cardiology, verified the high social cost related to invasive cardiac procedures (surgical or interventionist ones), performed at institutions accredited by SUS in the state of Rio de Janeiro between 1999 and 2003, in which they demonstrated high intra-hospital morbidity and mortality, much higher than the accepted quality standards. When looking at the two sides of the situation, it seems that the apparent paradox completes itself: the inadequate funding of hospital expenses supplied by the health insurance company reflects directly on the quality of the procedures and, consequently, on the hospitalization outcomes. What should one do? Efficient surgical procedures, with low intra-hospital costs and adequate therapeutic efficacy are noteworthy and must be considered in health care management. However, the improvement in health quality indicators, such as intra-hospital morbimortality rates, must be preceded by the adequate management of health care services and the appropriate funding of the performed procedures.

Peace and blessings.

Key Words

Fees and Charges; Health Care Costs; Thoracic Surgery.

Mailing address: Paulo R. Benchimol-Barbosa •
Rua Pompeu Loureiro, 36/702 - 22061-000, Rio de Janeiro, RJ - Brazil
E-mail: pbarbosa@cardiol.br
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Answer to Letter to the Editor

I was granted the right to respond by the Editor related to the article "Comparative Costs between Myocardial Revascularization Surgery With and Without Extracorporeal Circulation[1]. I would like to thank you for the comments; I entirely agree with you.

In fact, our health system has become a state monopoly, where the great majority of the patients depend on the Brazilian Public Health System (SUS), with no qualitative option to choose and no economical condition to have access to treatment through supplementary or private health services. Therefore, SUS pretends to remunerate for the health care service and the health care suppliers pretend to be reimbursed. The latter, however, gives the best quality healthcare services, considering the conditions imposed by SUS. The discussions on the reimbursement of medical healthcare services deserve deep and dispassionate considerations on who this monopoly belongs to and whether society itself must regulate this activity. What cannot be accepted is this state of arbitration between the government and the healthcare service suppliers. Otherwise, let us analyze this: our research, which aimed at evaluating the hospital costs of a high-complexity procedure, only addressed concrete situations dealing with the price of ortheses and prosthesis, without taking into account the prices that were effectively paid by the hospital. As it is well-known, the prices do not always pay for the costs.

Because of this monopoly, SUS practices an arbitrary and different remuneration for the same procedure and for each hospital. In our hospital, we work with a fixed maximum monthly payment concerning all medical-assistential activity, regardless of the quantity and type of assistance practiced. Thus, when we perform a higher number of diagnostic investigation and also sequential therapeutic procedures that the monetary limit allows, we will inflict upon the institution additional loss on top of the already deficient payment program. This characterizes a "risk contract", where the risk lies only on one side.

Considering all that, it is worth mentioning that surgical complications that require high-complexity resources such as Intra-aortic Balloon or Hemodialysis Circuit, among others, are not covered by SUS.

Another arbitrary form of reimbursement used by SUS refers to the payment by procedure quotas. It is known that SUS reimburses a limited number of examinations or procedures for each hospital, according to its capacity of providing assistance. Patients treated above this quota, or in the presence of procedure complications, will not be reimbursed. Additionally, there are technological developments that are not accepted by SUS and, therefore, are not reimbursed. This practice has stimulated the complementary healthcare insurance providers to not remunerate the procedures that are not paid for by SUS, either. That occurs, for instance, with the implant of pharmacological stents.

Hence, as the letter writer classified our study of costs as a "bold" one, I consider this study as a symbolic way to quantify how much a certain procedure costs for SUS. Therefore, we are not allowed to know what cost is, what price is, what value is. Not for the society, not for the patient and not for the hospital.

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References

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