Hrvatski psihijatar u emigraciji – dojmovi
/ *Croatian Psychiatrist in Emigration – Impressions*

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UVOD

U ovom se članku opisuje tek mali dio njemačkog zdravstvenog sustava koji financijskim pritiskom utječe na kliničku svakodnevicu u jednoj njemačkoj klinici za psihijatriju i psihoterapiju. Opisujem i osobni dojam pri susretu s takvim sustavom koji se upravo po toj sveprisutnosti financijskog pritiska razlikuje od hrvatskog sustava.

INTRODUCTION

This article describes a small part of the German health care system that influences clinical daily life in German psychiatric and psychotherapy clinics due to financial pressure. The article also describes a personal impression when encountering such a system, which differs from the Croatian system precisely in the presence of this ubiquitous financial pressure.

PRIKAZ

Nije lako napustiti svoj dom. No, u nekim slučajevima, kao što je to bilo u mome, bilo je neizbježno. Neizbježno zbog dva razloga: prvi je bio velika financijska potreba, a drugi želja za upoznavanjem stranog, drugačijeg, novog i naizgled naprednijeg. Koliko god je tada, 2013.

REVIEW

It is not easy to leave one's home. However, in some cases, as it happened in my case, it was inevitable for two reasons. The first one was related to a financial need and the second to a desire to learn something new by encountering a foreign system. As attractive as the salary

godine kada sam bio pred napuštanjem Hrvatske, plaća koja me čekala u Njemačkoj i s tim povezano konačno financijsko olakšanje bilo atraktivno, ipak sam suznim očima saopćio pokojnom profesoru Jukiću da odlazim.

Kažu da je Njemačka obećana zemlja. Njemačka, naime, obećaje onome koji dođe raditi, stvarati i doprinositi, siguran život. Siguran u financijskom, socijalnom, gospodarskom i zdravstvenom smislu. Ja sam osobno tu sigurnost iskusio. Mislim da toj sigurnosti doprinosi činjenica da su Nijemci razvili sustave po kojima se živi i radi. U daljnjem tekstu opisujem dijelove sustava psihijatrijske i psihoterapijske skrbi s kojim sam se susreo u gradu Stuttgartu.

Radio sam u Klinici za psihijatriju i psihoterapiju „Furtbachkrankenhaus“ (1), na poziciji šefa odjela *(Oberarzt)* akutne psihijatrije, psihoterapijske dnevne bolnice i konzilijarne službe. Akutni odjel je imao 25 kreveta plus 5 mjesta za dnevnu bolnicu koja je integrirana u taj akutni odjel. U idealnim okolnostima smo imali po tri specijalizanta na odjelu (10 pacijenata po specijalizantu), no zbog enormnog nedostatka liječnika najčešće smo imali jednog, najviše dva specijalizanta. To su pak mahom bili budući neurolozi koji u sklopu specijalizacije moraju proći godinu dana psihijatrije. Interes za psihijatriju je općenito bio mali, pa je bila prava rijetkost dobiti specijalizanta psihijatrije. U dnevnoj bolnici su za 20 pacijenata bile odgovorne dvije psihologinje; liječnike je bilo gotovo nemoguće „namamiti“ u dnevnu bolnicu. Nedostajalo je i specijalista psihijatrije pa sam ja najčešće bio odgovoran za još jedan odjel od 25+5 pacijenata. Bolnica se sastojala od četiri gotovo jednaka odjela te je sveukupno bilo mjesta za oko 100 bolničkih i 34 dnevnobolnička pacijenta čime je skrbila za područje od oko 200 000 stanovnika grada Stuttgarta. Ostatak od oko 400 000 stanovnika je gravitirao većoj psihijatrijskoj klinici u gradu („Klinikum Stuttgart“) (2).

Nakon nekoliko godina rada u Njemačkoj ostaje dojam da je jedan od najvažnijih razloga zašto

waiting for me in Germany and the consequent financial relief were at the time, in 2013, when I was about to leave Croatia, I still informed the late Professor Jukić about my decision with tears in my eyes.

Some say that Germany is a promised land. To people coming to work, create and contribute there, Germany promises a safe life and financial, social, economic and health welfare. I have personally experienced that security. I think that the fact that the Germans have developed systems for living and working contributes to that security. Hereby, I would like to describe certain parts of the psychiatric and psychotherapeutic care system I encountered in the city of Stuttgart.

I worked in the *Furtbachkrankenhaus* clinic for psychiatry and psychotherapy (1) as the head of the department (Oberarzt) of acute psychiatry, psychotherapy day hospital and counselling service. The acute ward had 25 beds plus 5 integrated day-hospital beds. Ideally, we had three trainees in the ward (10 patients per trainee), but due to the enormous lack of doctors, we usually had one or two trainees at the most. These were mostly future neurologists who had to undergo a year of psychiatry as part of their specialization. Interest in psychiatry was generally low, so it was really rare to get a psychiatry trainee. In the day hospital, two psychologists were responsible for 20 patients, and it was almost impossible to “lure” doctors to work at the day hospital. There was also a lack of psychiatry specialists, so I was usually responsible for another ward of 25 + 5 patients. The hospital consisted of four almost equal wards, and in total there were places for about 100 hospital and 34 day-hospital patients, taking care of about 200,000 inhabitants of the city of Stuttgart. The remaining 400,000 inhabitants gravitated to the city’s larger psychiatric clinic (*Klinikum Stuttgart*) (2).

After several years of working in Germany, the impression remains that one of the most important reasons why their systems are functional due to an extremely strict control mechanism.

su njihovi sustavi funkcionalni taj što postoji iznimno striktna kontrola tih sustava. Tako je bilo i u psihijatrijsko-psihoterapijskoj skrbi. U mojoj klinici je to izgledalo ovako: Svake godine je financijski direktor bolnice (po struci ekonomist) pregovarao sa zdravstvenim osiguranjima o paušalnoj svoti novaca koje je bolnica dobivala za svoj rad. Jedan od važnijih argumenata u pregovorima bila je popunjenost bolnice (uglavnom oko 105 %), a od drugih argumenata je bio udio akutnih pacijenata. Što je veća popunjenost i veća akutnost, tim je i paušalna svota novaca bila veća. To je jedan od razloga zašto u Njemačkoj općenito psihoterapijska skrb ide u smjeru privatnih ordinacija - bolnice se sve više okreću akutnim pacijentima. Moja uloga šefa odjela bila je voditi računa o stručnim kriterijima u liječenju, ali sam morao voditi računa i o financijskoj strani liječenja (ta je stavka jasno stajala u ugovoru o radu). Stoga je postojao jedan neizrečeni imperativ primati i zadržavati pacijente na odjelu kako bi popunjenost bila barem 100 %, a s druge strane je trebalo dobro argumentirati što je to toliko akutno da pacijent uopće mora biti na odjelu. Ove dvije težnje su često bile u suprotnosti, pogotovo ako se radilo o socijalnim indikacijama za prijam, npr. prijam beskućnika. Naime, Njemačka ima dobro razvijen sustav socijalne skrbi pa nitko ne bi trebao biti na ulici, stoga je postojao golemi financijski pritisak da beskućnici ne završavaju u bolnici, osim kada je to nužno.

Sve što se tijekom radnog vremena radi sa pacijentima mora biti dokumentirano, pregled, intervencija ili pak kratki razgovor. To je vrijedilo za sve radne skupine, liječnike, medicinske sestre, socijalne radnike i druge. Upravo je ta dokumentacija bila osnova za pregovore koje je provodio financijski šef. Zdravstvenim osiguranjima je bilo u interesu dati što manju, a bolnici dobiti što veću svotu novaca. Kako bi zdravstveno osiguranje osiguralo kontrolu troškova liječenja, oformljena je jedna agencija pod nazivom MDK – "*Medizinische Dienst*

This was also the case in psychiatric and psychotherapeutic care. In my clinic, the hospital's financial director (an economist by profession) negotiated every year with the health insurance on a lump sum of money for the hospital's work. One of the most important arguments in the negotiations was the occupancy of the hospital (mostly around 105%), and among other arguments was the share of acute patients. The higher the occupancy and the greater the acuteness, the higher the lump sum of money. This is one of the reasons why in Germany in general the psychotherapeutic care is moving in the direction of private practices, and hospitals are increasingly turning to acute patients. As head of the department, my role was to take care of the professional criteria in the treatment, but I also had to take into account the financial aspects of the treatment (this item was clearly stated in the employment contract). Therefore, on the one hand there was one unspoken imperative to receive and keep patients on the ward so that occupancy was at least 100%, and on the other, it had to be well argued why the patient had to be on the ward at all. These two aspirations were often at odds with each other, especially when it came to social indications for admission, e.g., by the homeless. Namely, Germany has a well-developed social welfare system so no one should be left on the street. There has been a huge financial pressure to keep the homeless from ending up in a hospital unless necessary.

Everything that is done with patients during working hours must be documented, i.e., an examination, an intervention or even a short conversation. This was the case for all working groups, doctors, nurses, social workers and others. It was this documentation that was the basis for the negotiations conducted by the finance chief. It was in the interest of health insurance to give as little as possible, and the hospital to get as much money as possible. In order to ensure the control of health care costs, a health insurance agency has been set up under the auspices

der Krankenversicherung" (3), u prijevodu *Medicinska služba zdravstvenog osiguranja*.To je služba u kojoj rade kolege liječnici svih specijalnosti, pa tako i psihijatrije, koji u svakom trenutku imaju pravo zatražiti cjelokupnu dokumentaciju o liječenju pojedinog pacijenta. S obzirom da te kolege financira zdravstveno osiguranje jasno je da im je cilj bio naći što više propusta u toj dokumentaciji, kako bi se pojedina hospitalizacija proglasila ili predugom ili pak uopće nepotrebnom. U tom slučaju zdravstveno osiguranje traži povrat dijela ili pak cijelog iznosa predviđenog za tu pojedinu hospitalizaciju. Bolnici je u interesu da taj novac zadrži, i upravo tu imaju ključnu ulogu šefovi odjela koji pismeno korespondiraju sa zdravstenim osiguranjima. Takva tenzija vas praktički prisiljava da u svakom trenutku znate što se događa s vašim pacijentom, tjera vas na to da se svakodnevno odmjerava učinak liječenja ne bi li zadržavanje u bolnici bilo što kraće. Osim toga, sve povezano s dijagnostikom i liječenjem mora biti tako dokumentirano da sadržajno odgovara smjernicama za psihijatriju S2 odnosno S3, jer se upravo na to pozivaju kolege iz prije navedene agencije MDK. Stoga vas takav pritisak neminovno tjera na stalno aktualiziranje svog znanja o trenutnim smjernicama za dijagnostiku i liječenje. Takva konstelacija često je znala dovoditi do takvog raspoloženja u bolnici gdje se najviše brinulo o dobroj dokumentaciji, no bez fokusa na pacijenta kao osobe, nema ni dobre dokumentacije. Unatoč velikoj pažnji koja se morala poklanjati dokumentaciji, nebrojeno je primjera kada zdravstveno osiguranje nije htjelo platiti određenu hospitalizaciju unatoč svim stručnim psihijatrijskim argumentima. Tada spor ide na sud, tzv. *Sozialgericht* (socijalni sud), te sve skupa preuzimaju odvjetnici obiju strana. U nekim se slučajevim pokazalo da ta procedura dolaska do suda bude više poput igre pokera ne bi li bolnica odustala pred strahom od suda. No, ako je iz dokumentacije vidljivo da ste se u dijagnostici i liječenju vodi-

of the MDK (*Medizinische Dienst der Krankenversicherung*) (3), or the Medical Health Insurance Service. It is a service staffed by fellow doctors of all specialties, including psychiatry, who may at any time request complete documentation on the treatment of an individual patient. Given that these colleagues are financed by health insurance, it is clear that their goal was to find as many omissions in the documentation as possible in order to declare each hospitalization either too long or unnecessary at all. In that case, the health insurance requires a refund of a part or all of the amount provided for a particular hospitalization. It is in the hospital's interest to keep that money, and that is where department heads, who correspond in writing with the health insurance, play a key role. Such tension practically forces one to know at all times what is happening to the patient and to measure the effect of treatment on a daily basis in order to keep the patient in the hospital as short as possible. In addition, everything related to diagnosis and treatment must be documented in a way that corresponds in content to the S2 and S3 guidelines for psychiatry, as this is what colleagues from the aforementioned MDK agency are referring to. Therefore, such pressure inevitably forces one to constantly update knowledge of the current guidelines for diagnosis and treatment. Such a constellation often led to a mood in the hospital where good documentation was most important. However, without a focus on the patient as a person, good documentation is not possible. Despite the great attention given to the documentation, there are countless examples when the health insurance refused to pay for a certain hospitalization despite all the expert psychiatric arguments. In that case, the dispute goes to the so-called *Sozialgericht* (Social Court), and the whole case is taken over by lawyers representing both parties. In some cases, the court procedure has been shown to be more like a game of poker in order for the hospital to give up in fear of going to the court. However, if it is evident from the documentation that one was guided exclusively by professional criteria in the

li isključivo stručnim kriterijima, onda nema straha ni od suda. Osobno sam svjedočio tomu kako je jedno zdravstveno osiguranje odustalo pred sam čin sudskog sučeljavanja i platilo cjelokupni traženi iznos za spornu hospitalizaciju. No, veliki problem nastaje kada se iz zdravstvenih osiguranja odluče otvoriti "stare slučajeve", dakle hospitalizacije od prije nekoliko godina. Naime, kako je velika fluktuacija liječnika, događa se da "na stol" dobijete dokumentaciju od pacijenta kojeg nikad niste liječili. Dokumentacija je tada jedino čime se raspolaže pa takvi slučajevi često završe nepovoljno za bolnicu. Sve to skupa doprinosi tomu da je komunikacija i suradnja sa zdravstenim osiguranjima vrlo živa, praktički svakodnevna, a u osnovi se sastoji u podastiranju dokaza o nužnosti pojedine hospitalizacije. To s jedne strane stvara veliki pritisak, i općenito se na zdravstveno osiguranje gleda gotovo kao na "neprijatelja", no upravo takva konstelacija traži od liječnika da se aktivno bave sa svojim pacijentima i stalno preispituju stručne kriterije liječenja. Moj osobni dojam je bio da takav sistem, u konačnici, poboljšava akutnu psihijatrijsku skrb. No, s druge strane, takav restriktivan pristup ima svoje mane u dnevnobolničkom liječenju. Tako je u dnevnoj bolnici u prijašnjim vremenima bilo odobreno 6-9 mjeseci liječenja, a danas je to spalo na 2-3 mjeseca (1). Kako je moja bolnica pokušavala njegovati psihoanalitičku tradiciju, to je bio snažan udarac na uspostavu i održavanje terapijskog odnosa. Naime, postajalo je sve teže, a na kraju i nemoguće argumentirati što je to toliko akutno u jednom psihoterapijskom odnosu da bi se opravdalo dnevnobolničko, a ne ambulanto liječenje. Mnoge su kolegice i kolege zbog toga napustili bolnički sistem te su osnovali privatne ordinacije što je pak samo produbilo enorman nedostatak liječnika i drugog osoblja (4).

Treba napomenuti kako su sporni slučajevi ipak u manjini, dakle većina hospitalizacija

diagnosis and treatment, then there is no fear of the court either. I have personally witnessed how one health insurance company gave up before confronting the court and the insurance paid the whole amount requested for the disputed hospitalization. However, a big problem arises when health insurance companies decide to open "old cases", i.e., hospitalizations from a few years ago. Namely, as there is a large turnover of doctors, it happens that one gets the documentation about a patient one has never treated. That documentation then becomes the only thing available and such cases often end unfavourably for the hospital. All this combined contributes to the fact that communication and cooperation with the health insurance is very lively, practically on everyday basis, and basically consists of presenting evidence of the necessity of a particular hospitalization. On the one hand, this creates a lot of pressure, and the health insurance is generally seen almost as an "enemy", but on the other such a constellation requires doctors to actively deal with their patients and constantly review professional treatment criteria. My personal impression was that such a system ultimately improves acute psychiatric care. However, such a restrictive approach has its drawbacks in day hospital treatment. Thus, in the past 6-9 months of treatment were approved for a day hospital, and today the number of months has dropped to 2-3 (1). As my hospital tried to nurture the psychoanalytic tradition, this was a powerful blow to establishing and maintaining a therapeutic relationship. Namely, it became more and more difficult, and in the end impossible, to argue what was so acute in a psychotherapeutic relationship that it would justify day hospital and not outpatient treatment. Many colleagues left the hospital system for this reason and founded private practices, which in turn only deepened the enormous shortage of doctors and other staff (4).

However, it should be noted that the disputed cases are still a minority, so most hospitalizations and day hospital treatments are easily

i dnevnobolničkih liječenja prolazi bez problema, priznato od zadravstvenih osiguranja te sveukupno ostaje dojam dobre međusobne suradnje, a ne "neprijateljstva." U biti se radi o restriktivnosti kojoj je cilj štednja. A štednja je, po mom mišljenju, jedan od glavih razloga uspješnosti njemačkog zdravstvenog sustava, jer se upravo iz te uštede generiraju golema i ciljana povratna ulaganja u to isto zdravstvo.

Zaključujem da sam se u ovom osvrtu samo dotaknuo jednog segmenta zdravstvenog sustava s kojim sam se susreo u Njemačkoj. Moram priznati da taj susret izaziva određeno strahopoštovanje koje tjera na aktivno bavljenje svojim pacijentima, ali i potiče da se zauzimate za interese svoje bolnice u kojoj radite. Kako sam i prikazao, taj sustav ima i svojih mana. Moj je dojam kako to sve skupa oplemenjuje psihijatrijsko-psihoterapijske vještine unatoč stalnoj prisutnosti financijskog pritiska. Dakle, ostaje dojam obogaćivanja znanja i iskustva koje se nadam prenijeti u svoju domovinu. Njemačka nudi sigurnost, znanje i iskustvo, nudi čak i priliku stvoriti si dom. No, osjećaj doma nije nešto što se može dobiti po nekoj ponudi, već je to pitanje našeg unutrašnjeg, apstraktnog, fantazmatskog svijeta, a taj moj svijet ipak je u Hrvatskoj.

recognized by the health insurance, and overall, there is an impression of mutual cooperation rather than "hostility." In essence, it is about restrictiveness that aims to save money. And savings are, in my opinion, one of the main reasons for the success of the German health care system, because it is from these savings that huge and targeted return on investment in the health care system is generated.

In this article, I only touched on one of the segments of the health care system that I encountered in Germany. I have to admit that this encounter evokes a certain awe that drives one to actively deal with patients but also encourages to stand up for the interests of the hospital where one works. As I have shown, this system also has its drawbacks. My impression is that all these elements combined really improve psychiatric and psychotherapeutic skills despite the constant presence of financial pressure. So, what remains is the impression of enriching the knowledge and experience that I hope to transfer back to my homeland. Germany offers security, knowledge and experience; it even offers the opportunity to create a home. However, the feeling of home is not something that can be obtained from an offer. Rather, it is a question of our inner, abstract, fantasy world, and for me, that world still remains in Croatia.

LITERATURA / *REFERENCES*

1. www.fbkh.org
2. www.klinikum-stuttgart.de
3. www.medizinischerdienst.de/leistungserbringer/krankenhaus
4. www.aerzteblatt.de/aerztemangel