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Ambulatory geriatrics in the Czech Republic: A survey of geriatricians' opinions

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INFORMACE O ČLÁNKU

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ABSTRACT

According to the latest published data, the total of 33 outpatient geriatric facilities were registered in the Czech Republic at the end of 2011 employing (mostly on a part-time basis) 63 physicians. The aim of this paper was to analyze the reasons of this situation. An extensive survey of the opinions of Czech geriatricians performed in spring 2013 addressing all the 230 geriatricians registered in the Czech Medical Association of J. E. Purkyně was focused on the situation in ambulatory geriatric care, the experience with the demand for it, the approach of health insurance companies, and the cooperation with other physicians. The survey has identified that the major obstacle to the development of geriatrics is the persisting artificial separation of medical and social care. Its negative consequence is a breach of the complexity and consistency of care and the cooperation among specialists. A real threat to the development of ambulatory geriatric care is particularly the existing financing system of ambulatory geriatric services and the unofficial "stop state" of health insurance companies that prevent new contractual relationships. Another obstacle is the lack of readily available relevant information, so that the demand for specialist care remains on a low level. The phenomenon of the ageing population is still not perceived as a major challenge by the Czech society, and this situation is also reflected by the level of awareness and interest in these issues.

Introduction

According to 2011 census results [1], 10.44 million inhabitants live in the Czech Republic, of them over 1.64 million (15.7%) persons older than 65 years, over 697 thousand (6.7%) persons older than 75 years, and nearly 155 thousand (1.5%) persons older than 85 years (42.9 thousand men and 111.8 thousand women). According to the medium variant of the 2013 Population Projection of the Czech Republic elaborated by the Czech Statistical Office (ČSÚ) [1], the life expectancy at birth will have grown to 91 years for women and nearly 87 years for men by the end of the century. Fig. 1 displays the projected

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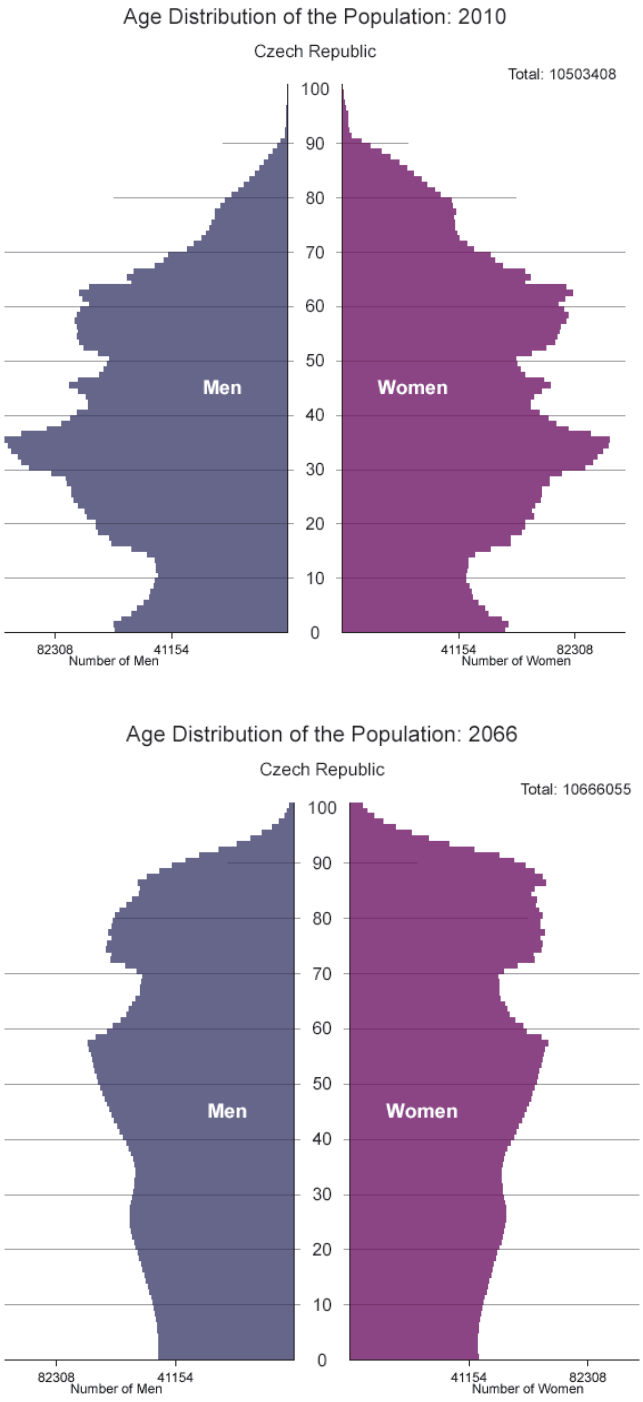

Fig. 1 – The age distribution of the population in the Czech Republic in 2010 and 2066.
Source: [1]

change in the age distribution of the Czech population. These demographic data clearly manifest the growing need for medical and social care for senior citizens. In February 2013, the Czech Republic adopted the National Action Plan Supporting Positive Aging for the period of 2013–2017 [2] (as a follow-up to a similar programme covering the period of 2008–2012 [3]). Its emphasis is on creating conditions for independent life of senior citizens in their natural environment, and on a system of support and assistance implemented primarily through the interconnection of medical and social services. The main objective is the preservation of senior citizens' quality of life, prevention, social integration and participation. The starting point of the plan is the motto that "the responsibility for one's own health rests above all with every individual; the government, however, is obliged to ensure accessible and high-quality medical care corresponding to the needs of the population" [2].

The offer of geriatric outpatient care seems to be insufficient in the Czech Republic and, moreover, it is not harmonized with social services [2, 4, 5]. The objective of the recent survey was to map, how the situation is perceived by the geriatricians themselves, and what they consider to be the main obstacles to a successful geriatric outpatient practice. In this paper, we present the results of the survey and confront them with statistical data [1, 6, 7].

To allow comparison, we briefly describe the situation in geriatric ambulatory care in Switzerland, Austria, Germany and Sweden. Germany and Austria were chosen for their geographic proximity, Switzerland and Sweden for differences in health care systems and its funding. In Switzerland, geriatrics is a certified medical specialty since 2000. About 125 geriatricians work mostly in municipal geriatric centres. It is possible to study geriatrics at 4 of 5 medical faculties. Special attention is paid to clinical research in the field of the care of senior citizens. The model of preventive visits of senior patients at home was tested, and the country supports research of senior health risks [8]. In Austria, geriatrics is taught through isolated lectures within individual clinical fields. Gerontology and geriatrics do not have their position in academic sphere yet, which implies difficulties in the area of quality standards in the care of seniors. Thanks to recent activities of the Austrian Society for Geriatrics and Gerontology, the structure of geriatric care has improved (both its acute and ambulatory part and long-term care) [9]. In Germany there are about 1800 geriatricians having office hours. The system of education differs slightly in individual federal states. The geriatric care is reimbursed in all insurance types, quality standards have been established [10]. A complete overview and expectations of the geriatric care in Germany can be found in the White Book of Geriatrics [11] presented by Bundesver-band Geriatrie (Federal Geriatrics Association) in 2010. In Sweden there is a well-developed system. Kalvach [12] states that is has been formed for about 30 years. It consists in offering long-term care comprising both health care and social security of needy citizens. If a patient does not need hospitalization, by law he must be provided with the care at home; a hospitalization is only for patients that need continuous care. The provision of the care is not conditioned by age nor by financial circumstances, the fees are low. The access to the long-term care is provided on the community level, the communities are obliged to take care of senior citizens by law. The community decides whom it will provide with the necessary services [13].

When speaking about the professional care of senior patients, multimorbidity and polypragmasia are most often mentioned. They present two fundamental problems that are intensely investigated. Kuhlmey [14] concentrates

above all on interconnected diseases in German citizens aged 65+. Above one half of these people showed 3 or more interconnected chronic diseases. Multimorbidity affects significantly the quality of life, morbidity and peace of mind, which implicates not only great demands on health care, but also social and economic problems. According to Anderson and Horvath [15], nearly two thirds of Americans aged 65+ have two or more serious health problems. A significant economic consequence of multimorbidity are frequent hospitalizations of geriatric patients. The study carried out at University of Pittsburgh in 2002 [16] investigated the effectiveness of care dependent on whether the patients were in the care of geriatricians or physicians of other specialties. Multimorbid patients in the care of geriatricians showed significantly shorter hospitalization times and there treatment was more cost-effective without any negative effect on the treatment outcomes.

Ambulatory geriatric care

Summary information on the development of ambulatory geriatrics in the Czech Republic in 2001–2011 was published by the Institute of Health Information and Statistics of the Czech Republic [7]. In 2011, the total of 33 departments or workplaces providing outpatient geriatric care were registered in the Czech Republic employing, mostly on a part-time basis, 63 physicians (after recalculation into full-time positions, how-ever, the number was only 18.4 physicians). In three regions out of fourteen (Plzeň, Karlovy Vary and Vysočina regions), no health care facility providing ambulatory geriatric care was registered at all. During 10 years, from 2001 to 2011, the total number of physicians in geriatric outpatient facilities grew by one third, when the very growth in the number of physicians occurred in 2001–2004, while since 2005 the number of geriatricians has stabilized (see Table 1). In 2011, 21 534 patients were treated in outpatient departments (the number of first treatment contacts), which is by 53% more than in 2001. There were on average 1 182 patients per physician. The number of treated patients per one hundred thousand inhabitants grew by nearly 50% from 137.9 to 205.2, and per one thousand inhabitants aged over 65 years by 29% from 10.0 to 12.9 patients. The percentage of women in all treated patients (monitored since 2006) is relatively stable ranging around 60%.

Table 1 – Numbers of physicians in ambulatory geriatric care between 2001 and 2011 (recalculated into full-time job positions as of 31 December)

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Physicians	13.8	15.2	19.3	21.1	18.7	18.1	18.4	17.6	16.9	19.0	18.4

Source: [7]

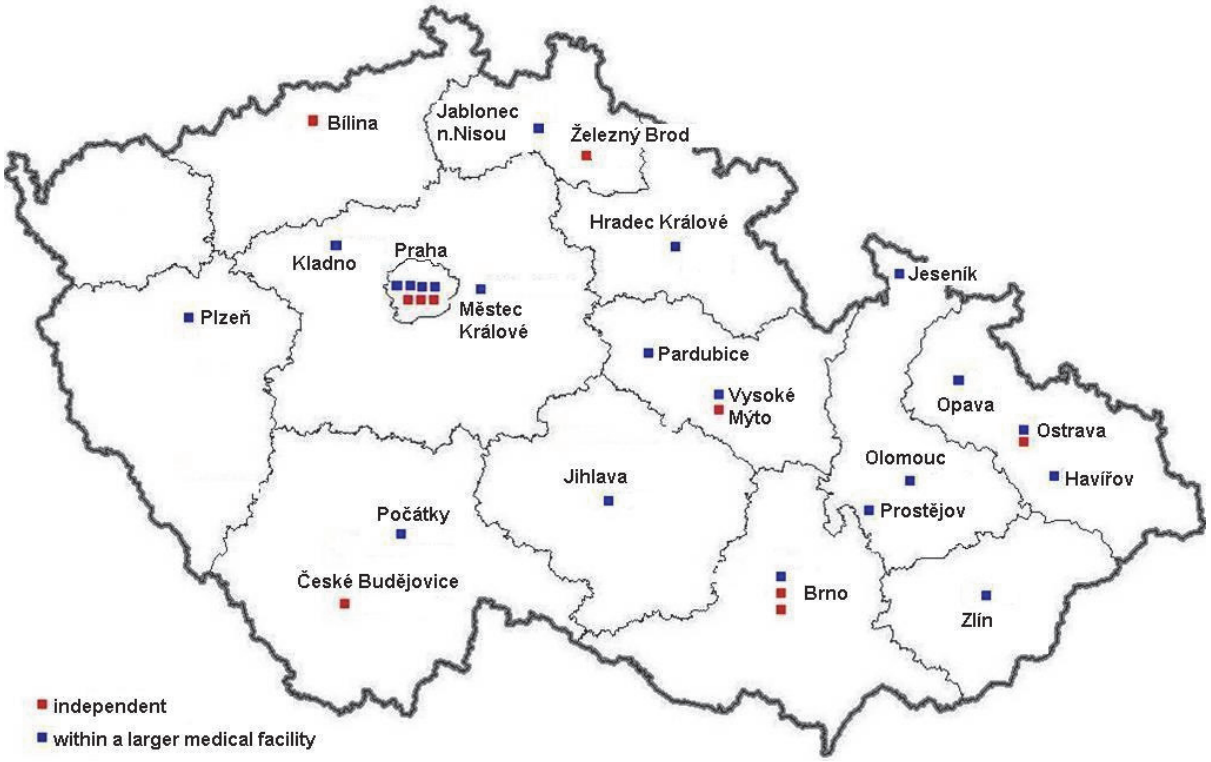

Fig. 2 – Geriatric outpatient departments in the Czech Republic, situation as of April 2013.
Source: own map based on [6]

According to the data published by the Czech Medical Chamber [6], 30 geriatric outpatient facilities were registered on the territory of the Czech Republic in April 2013, i.e. at the time of the survey below (see Fig. 2), which was by 3 departments less than in 2011. Among these thirty outpatient facilities, ten were run independently and twenty within larger medical facilities – geriatric clinics (5), geriatric centres (3), or departments of aftercare in hospitals or long term care hospitals (14). The densest network of outpatient facilities is in Prague, while, on the contrary, there is none in the Karlovy Vary region. There are, on average, 56 715 people aged 65+ per one geriatric outpatient department, most of them in the Ústí nad Labem region (122 843), and least of them in the Karlovy Vary (0) and Pardubice (28 237) regions. The register of the Czech Medical Chamber[1] lists 230 geriatricians (situation as of February 2013). This number includes both physicians working in the outpatient as well as bedcare sphere, and many of them do not work in geriatrics at all (see below).

Materials and methods

In April 2013, we conducted a questionnaire survey among Czech geriatricians focusing on their experience in the demand on the part of patients, the approach of health insurance companies to geriatrics, and the cooperation with other fields of medicine. Besides, geriatricians expressed their degree of satisfaction with the current form of geriatric care, assessed its accessibility, quality and links to other services, the preparedness of the Czech Republic for the demographic ageing process, and also the contribution of programmes supporting health and active ageing. The questionnaire was distributed in (native) Czech language; its English translation is shown in Appendix I.

All physicians working in the Czech Republic are mandatorily registered in the Czech Medical Chamber. In February 2013, the register included 230 names of geriatricians, and all of them were addressed in the first phase of the survey with a question about their willingness to answer the questions; 48 physicians refused the cooperation, when the main reason was in 39 cases the fact that the physician had not been working in the field of geriatrics for a long time and could not, or did not want to, give his/her opinion on the essential issues. The questionnaire was successively sent to 182 geriatricians that had agreed to cooperate; of them, 129 actually got involved in the survey, i.e. the questionnaire response rate was 70.9%. The combination of the fact that all currently active geriatricians were involved and the high response rate guarantee the representativeness of the survey results.

Results

In this section we present the results of the principal questions in the survey, where the respondents indicated main problems of the current situation in the Czech Republic.

Answers to questions 21 and 22 indicated that the majority of the registered geriatricians (81 respondents, i.e. 63%) are not working in a geriatric outpatient department; 48 respon-dents (37%) were involved in ambulatory practice, but in their greater part only on a part-time basis. However, over 80% of geriatricians that presently do not work in a geriatric outpatient department responded that they would be interested to do under changed conditions (question 24). The principal condition for a successful functioning of a geriatric outpatient department (question 14), as articulated by the geriatricians in 92% of cases (119 respondents), is signing a contract with health insurance companies (see Fig. 3). While doctors mentioned unwillingness on the part of health insurance companies to conclude contracts (questions 15 and 16), health insurance companies stated in their response that they do not intend to extend the network of contract geriatric outpatients departments, unofficially justifying this approach by low demand for geriatric services. The area of compensations from health insurance companies and their willingness to conclude contracts with geriatric care providers belongs, according to the respondents, to the worst graded parameters: 74% of the geriatricians think that the concluded contracts are unfavourable for the providers, pointing out the effort of health insurance companies to shift the focus of care into the social area. According to answers to question 12, over one half of the respondents (53%) believe that the system of financing should deserve greater support by the government, when emphasis should also be placed on efficiency assessment, so that the allocated resources brought the expected outcome.

The demographic ageing of European population seems to be the main challenge for health care systems for the near future. Table 2 describes the opinion of Czech geriatricians on the preparedness of the system for demographic ageing (graded on the scale from 1 = best to 5 = worst) (question 2). This is closely related to the current situation.

In questions 1, the geriatricians assessed the accessibility and quality of care and its links to other services (Figs. 4 and 5). The accessibility is graded worst in geriatric outpatient departments and acute geriatric care, while as for the quality, the grade "rather satisfied with care" prevails. Here, it should be noted that the assessment of geriatric care quality is the expression of a personal opinion and experience of individual geriatricians. Accessibility is best graded in aftercare (96% of the respondents are satisfied or rather satisfied with it), the network of medical facilities of this type is developed and the capacities of these facilities need not be extended in the future. Links to other services are also graded worst in geriatric outpatient departments and acute geriatric care (78% or 71% of the respondents respectively are dissatisfied).

The respondents compared practical time accessibility of the outpatient departments with their opinion. Theoretically they insist on the limit of 60 min for accessibility of the geriatric outpatient department (question 3), when 90.8% indicated this or lower limit time (and 36.1% even the utmost limit of 30 min). However, the realty appeared to be quite different, when we asked about

[1] The membership in the Chamber is mandatory for all practicing physicians in the Czech Republic.

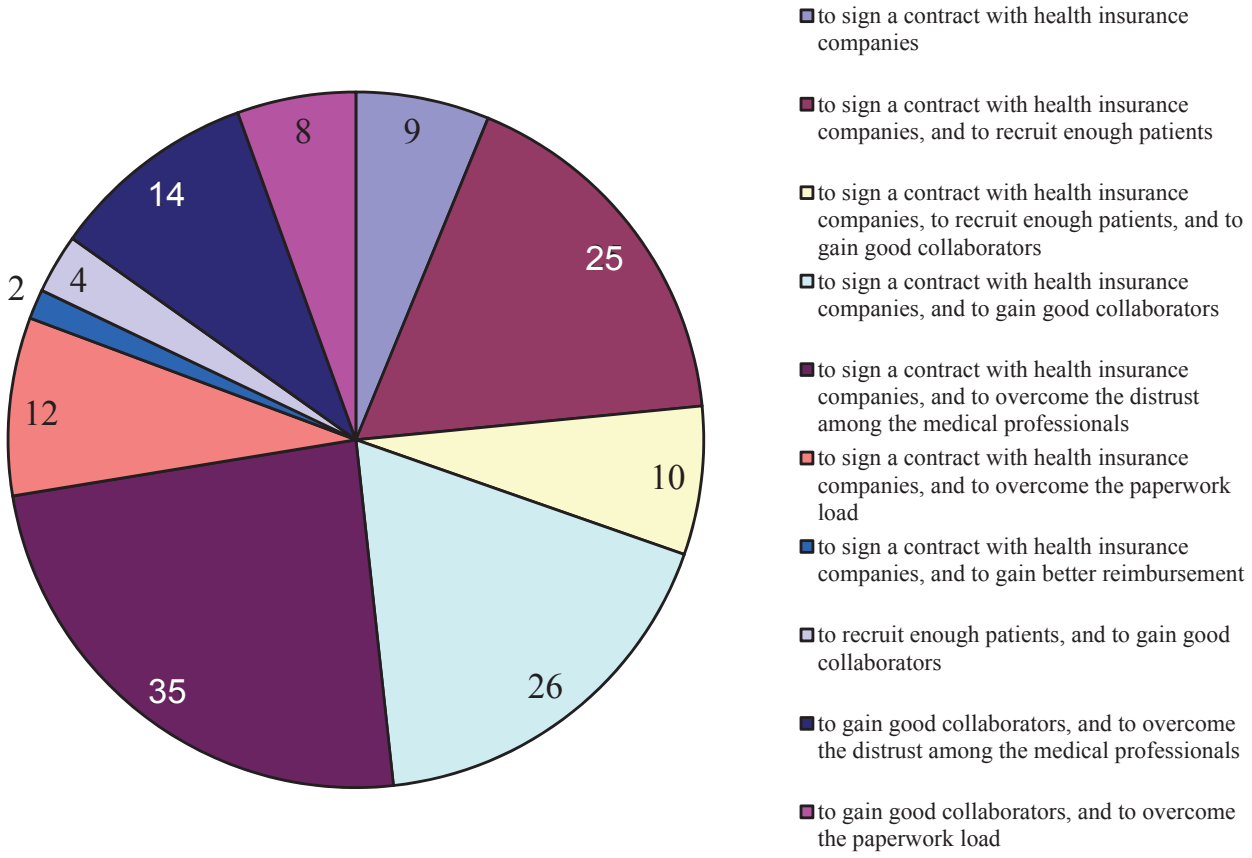

Fig. 3 – Conditions for a successful operation of an outpatient geriatric practice

the actual distance from patients' home to the outpatient department (question 4). Only 46 respondents answered this question (the other stated they did not work in an outpatient department) indicating distances up to 100 km (and in one case even 300 km, although this might be an exception). Question 5 asked who initiates the geriatric examination. The answers are summarized in Table 3. We can see that in 76.6% these are physicians (equally GPs and physicians of another specialty). This corresponds with answers to the question 6, where geriatricians indicated the main reasons for the little interest from the part of patients: patients do not know about the possibility of specialized geriatric departments (77%), and they are even not able to find the information due to their poor health state and social reasons (49.2%). Geriatricians were also asked about their cooperation. Question 8 was focused on consultations for other physi- cians. Only 23.4% geriatricians hold a consultation more than once a month, while 68% hold it never. About half of them (51.2%) are involved in collaboration with non-profit organizations or with state authorities.

Table 2 – Results of the survey (in absolute numbers of respondents); 1 = best grade, 5 = worst grade

Grade (evaluation)	1	2	3	4	5	No answer	Average grade
Economy	3	0	13	55	58	0	4.3
Contracting policy of health insurance companies	2	2	24	52	49	0	4.1
Utilisation of gerontechnologies	0	4	23	58	42	2	4.1
State health care policy	1	0	33	63	32	0	4.0
General public	0	4	42	47	36	0	3.9
Structure of geriatric services	0	6	65	44	14	0	3.5
System of social services	0	21	57	43	8	0	3.3
System of medical services	2	28	60	32	7	0	3.1
Specialists – non-doctors	13	45	39	26	6	0	2.7
Specialists – doctors	13	42	46	21	7	0	2.7

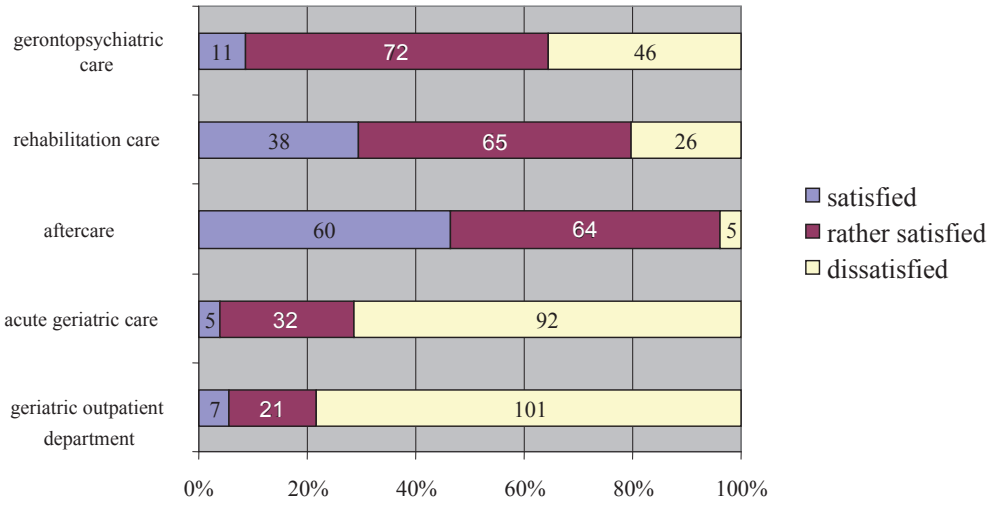

Fig. 4 – Satisfaction with accessibility of geriatric care

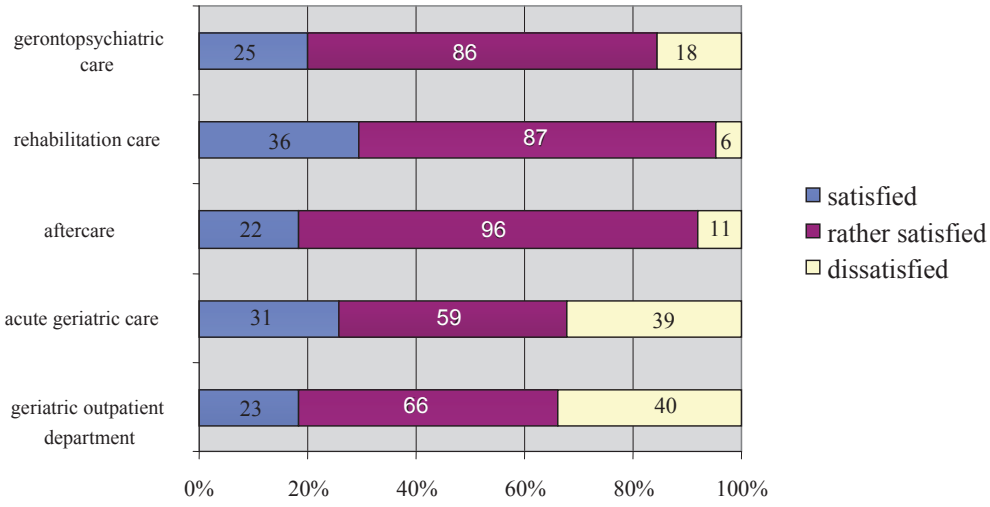

Fig. 5 – Satisfaction with quality of geriatric care

Table 3 – Who asks for the geriatric examination	
The patient	7
Patient's family	7
GP	25
Physician of another specialty	24
Medical worker – non-physician	4
Social worker	18

Questions 19 asked about the opinion on strict separation of health care and social services for senior citizens. The respondents chose from pre-formulated options, when they might tick more options. The results are shown in Fig. 6. The last question 25 was an open one; the geriatricians were asked to formulate which changes would bring them back to outpatient geriatrics. The question was answered by 81 out of total of 129 respondents; they named most frequently the following conditions (other answers were stated 6 times and less):

- change in the policy of health insurance companies, in their contractual policy, in the reimbursement level (stated 76 times);
- development of health care for seniors in home setting (56 times);
- interconnection of the systems of health care and social services (53 times);
- change in national health care policy for senior citizens (50 times);
- better collaboration with other physicians, GPs and ambulatory specialists (41 times);
- simpler legislation, less paperwork (36 times);
- better compensation for the work – both financial and social (20 times).

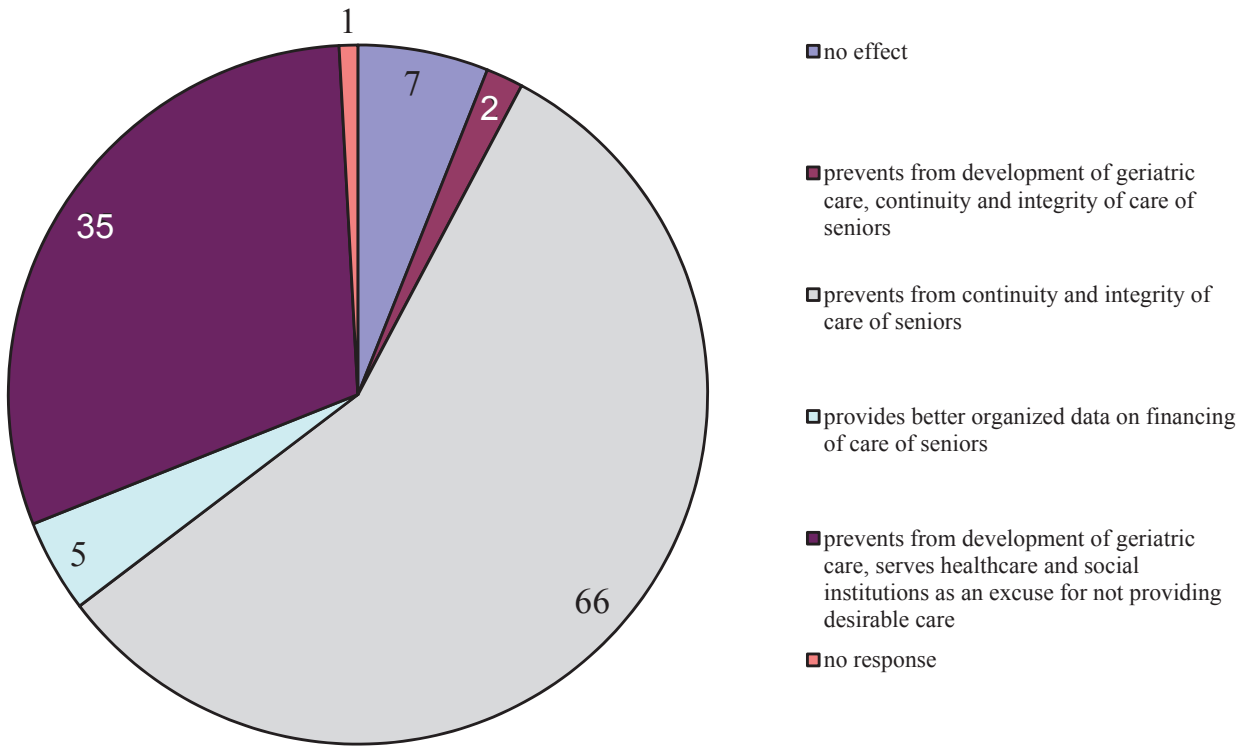

Fig. 6 – Effect of strict separation of health care and social services to the development of geriatrics

Discussion

The creation of a full scope of high-quality services for senior citizens is a great challenge for Europe's health care systems. The majority of currently offered services frequently show little respect for the latest achievements in modern clinical gerontology, and it very much depends on which country the person lives in [17]. The Czech Republic has developed a health care system and a social care system; these systems, however, are not effectively interconnected, which brings significant problems in providing medical and social services. This is also reflected by the offer of services and by the system of their financing. Senior citizens are receiving services that do not correspond to their specific needs that cannot be strictly subdivided into medical and social services in real life. The creation of a functional, mutually interconnected system of care for seniors is one of the objectives of the above mentioned National Action Plan [2]. It is also due to the minimum practical impact of this programme on the accessibility and the level of existing services that the assessment of this Plan's daring objectives fulfilment is relatively brief: one quarter of the geriatricians are basically not familiar with the programme, and the majority (55%) consider it merely declarative (question 20). The Plan puts a relatively strong emphasis on frail senior citizens, setting out objectives with a presumed implementation in 2013 and 2014, which is the time that has already come. The strategic objective is to offer the widest scale of services possible, including specialized geriatric care. This objective, however, was already proclaimed in the previous programme [3], so that the prevailing opinion on the part of the geriatricians that the respective programmes have no impact on the improvement of the situation in the accessibility of geriatric care is based on their evident negative experience. Neither senior citizens themselves, however, have information about either the governmental programme or even the potential outpatient geriatric services to be offered; therefore, they do not demand them.

The concept of modern gerontology and geriatrics places emphasis on quality of life and the greatest possible independence and autonomy of elderly people perceiving the population in the context of longevity – life prolongation and consequential demographic changes in society. It respects old age as a natural process and a phase in life. Old age brings changes that are physiological, but also particular diseases occurring more frequently in older age. The goal is an enforcement of a model of healthy and active ageing, and preservation of the highest quality of life possible. The priority area in the care for seniors should be community care. A significant position in this area is that of geriatric outpatient departments and home care, whose establishment and activity should receive maximum support [18]. An incorrect perception of geriatrics as a field concentrated exclusively on the aftercare frequently persists in the minds of Czech professional community, impacting on the relationships of other physicians to geriatricians. It is of interest that the other physicians ask for geriatric consultations only scarcely – only less than one third of the surveyed geriatricians (32%) are regularly asked for consultations. It is likely that a good level of

geriatric knowledge in physicians of other specialties would enhance the quality of care for patients aged 65+.

A specific role in the area of geriatricians' collaboration with other specialists is that of general practitioners. GPs need not hold professional competences in geriatrics [5], still, they devote more than 60% of their working time to patients aged 65+ [19]. Eight of the surveyed geriatricians simultaneously worked as GPs; in general, however, a sceptical attitude to GPs' skills in the area of complex geriatric assessment prevails (in question 10, only 20.2% respondents agreed that GPs are prepared to do complex geriatric examination). Apart from diagnostics and treatment, also supervision and special care for high risk patients and prevention of geriatric fragility and disability must be ensured.

According to Kalvach et al. [20] there are more and more so called frail people that require short accurate diagnostic and therapeutic interventions, and even able-bodied people requiring prevention of geriatric frailty, geriatric decrepitude with sarcopenia, including recondition counselling. There is an increasing number of older people medically misunderstood and, to make matters worse, often "excommunicated" by medicine, as health problems of older age, including disability, get loose from a tight relation to particular ICD-10 diseases, break through the so-called disease model of medical thinking, and become multi-causal, without leaving the territory of medicine: multi-causal problems including the geriatric frailty can also be diagnosed, intervened, rehabilitated, prevented. Taking into account the bio-psycho-socio- spiritual integrity (the existential will to live and the meaningfulness of the life in its senior form), the multi-causal problems always have a significant biomedical part, and they can even be worsened by the geriatrically untrained medicine, inducing iatrogenic damage together with frequent unnecessary utilization of hospitalizations in aftercare institutions, i.e. adverse effects of incorrectly applied pharmacotherapy, immobilization syndromes, malnutrition, delays caused by incorrect interpreting the "typically atypical" manifestations of diseases in old age, and other manifestations of the geriatric hospitalism.

At present, a frail old senior is in a danger of misunderstanding and inappropriateness in a medical establishment; some performances including semi-invasive ones are performed unnecessarily, due to embarrassment, misunderstanding the patient and his/her multi-causal geriatric syndromes, due to an obstinate concentration on "hunting" or eliminating diseases instead of diagnosing and intervening the whole person. This situation moves the collaboration of geriatricians with general practitioners, who play the leading role in the initial contact with frail seniors in the medical services system, to a completely different level.

Conclusion

The main well known obstacle to the development of the ambulatory geriatric care in the Czech Republic is the persisting separation of medical and social care [5]. According to our survey, further development should be primarily encouraged by a new financing system and dismantling the unofficial "stop state" (that presently means signing no new contracts in this field) imposed by health insurance companies that, despite the existing interest on the part of geriatricians, prevent new contractual relationships. Another obstacle is a lack of readily available relevant information, as well as the identified ambiguous level of knowledge about geriatrics in the professional community. A long term focus on raising the issue of the society geriatrization phenomenon among both the medical community and general public, an introduction of efficient low-cost curative and preventive interventions, and a support to field ambulatory and community services are highly recommended.

Information from international projects focused on the care of senior citizens prove that this are develops extraordinary dynamically, as concerns the care planning methods, case management, assessment of needs of both care dependents and carers, innovative practice in the area of supporting care in home environment, senior activization and social integration, ICT development and applications, etc. Hence, we can probably expect changes in providing and funding the geriatric long-term health and social care also in the Czech environment. Considerations have appeared whether it were not convenient to introduce a principle of insurance into the long-term care system that would cover all expenses of this system instead of current multiple sources, which seems to be one of main barriers of better accessibility of social services [21].

Conflict of interest

The authors declare that they have no conflicts of interest concerning this article.

Appendix I. Questionnaire

(English translation from the Czech original.)

1. How are you satisfied with the form of complex geriatric care in the Czech Republic?

facility	accessibility	quality	interconnection with other services
outpatient facilities	1 2 3	1 2 3	1 2 3
acute geriatric care	1 2 3	1 2 3	1 2 3
aftercare	1 2 3	1 2 3	1 2 3
rehabilitation care	1 2 3	1 2 3	1 2 3
gerontopsychiatric care	1 2 3	1 2 3	1 2 3

please tick off: 1 = satisfied 2 = rather satisfie d 3 = unsatisfied

2. Try to "grade" the state of preparedness of the Czech Republic to demographic ageing (tick off the grade as at school: 1 is best, 5 is worst).

structure of geriatric services	1	2	3	4	5
contracting policy of health insurance companies	1	2	3	4	5
national health policy	1	2	3	4	5
social services system	1	2	3	4	5
health services system	1	2	3	4	5
specialists: physicians	1	2	3	4	5
specialists: non-medical	1	2	3	4	5
lay public	1	2	3	4	5
economy	1	2	3	4	5
gerontotechnology utilization	1	2	3	4	5

3. What time accessibility of geriatric outpatient care do you consider for the utmost limit taking into account the specificities of geriatric patients?

Give your time estimate in minutes:.....

4. If you work in a geriatric outpatient department: what is the longest distance your patient travel to your department:

☐ give approximate distance in km:.....
☐ I do not work in an outpatient department

5. Are you asked to do specialized geriatric examinations?

☐ yes
☐ no

if yes, tick off who usually asks the examination:

☐ patient ☐ patient´s family ☐ GP ☐ physician of other specialty
☐ paramedical worker ☐ social worker ☐ other (specify)

6. Do you meet with a lack of information about possibilities and benefits of geriatric care among patients?

☐ yes
☐ no, patients have quite enough information

if you answered yes, where do you see the main reason for the lack of information?

☐ ignorance of patients
☐ information of this kind is not available for the patients
☐ incompetence to find information due to bad health state or social reasons
☐ patients do not know about the possibility of geri atric health care, and thus they do not require it
☐ information is in a form inaccessible for patients

□ patients do not feel any subjective need of specialized geriatric care
□ other reason – specify:

7. What is your experience with the willingness to pay for health care services among geriatric patients and their family members?
□ patients are willing and able to pay for extraordinary care
□ patients are willing to pay, but their possibilities are limited
□ patients are not willing to pay
□ most geriatric patients are not able to pay, current regulation fees are a heavy burden for them
□ I do not have enough experience, cannot give my opinion

8. Do you provide geriatric consultations on request of physicians of other specialty?
□ yes, more than once a month
□ yes, less than once a month
□ no, in my opinion colleagues of other specialty are not interested in geriatrician´s expert opinion
□ no

9. List specialty of physicians you collaborate with most often:

10. Most of elderly (multimorbid) patients have to rely primarily on GP´s care. In your opinion, do GPs have necessary knowledge to do complex evaluation of geriatric patients?
□ mostly yes
□ mostly no
□ only those trained in the field of geriatry

11. Do you think that a professional publicity campaign would help the public to be better informed about geriatric services?
□ yes
□ no

12. Do you consider the system of financing the specialized geriatric care through health insurance for:
□ unsuitably chosen
□ insufficiently supported from the part of the government
□ at present inefficient, i.e. the financial means spent do not bring the expected benefit
□ corresponding to the needs of patients within the bounds of possibility

13. According to data of the Institute of Health Information and Statistics of the Czech Republic (Topical Information No. 59/2012), there are 33 registered geriatric outpatient facilities in the Czech Republic. In your opinion, which factors mostly affect their amount?
In each question, tick off the option corresponding mostly to your opinion (0 = I do not agree, 1 = rather improbable reason, 2 = probable reason, 3 = I fully agree), you can specify your opinion.
Little demand from the part of patients – patients do not feel the need of specialized geriatric care.
0 1 2 3
Little demand from the part of patients – patients do not have enough relevant information about possibilities and benefits of geriatric care.
0 1 2 3
Geriatry does not have an equal position among medical specialties, it has even little support from the part of the Czech Medical Chamber and colleagues of other specialties; hence, young physicians are little interested in the geriatric specialty.

0 1 2 3
Geriatry has a distorted perception in the Czech Republic – above all as a specialty engaged exclusively in aftercare.
0 1 2 3
Health insurance companies do not want to contract providers of geriatric outpatient care.
0 1 2 3
A separate operation of a geriatric outpatient facility presents a high economic risk for a physician.
0 1 2 3
The lack of acute geriatric beds goes hand in hand with the lack of geriatric outpatient facilities; hence, the specialty lacks for the necessary basis.
0 1 2 3
Other reason – please specify incl. the evaluation in grades:
……
0 1 2 3

14. For a successful operation of a geriatric outpatient facility, the most important thing is:
□ to get a contract with health insurance companies
□ to acquire patients
□ to find good co-workers – physicians and non-medical workers
□ to overcome the distrust of the professional public
□ to cope with the administrative burden
□ other, specify:

15. I evaluate the collaboration with health insurance companies as follows:
□ smooth
□ sometimes there are problems, above all of an administrative character
□ the contracts made between health insurance companies and health care facilities are unfavourable for the care providers
□ the contracts are alright within possibilities; however, there is less and less financial means
□ the health insurance companies are permanently trying to move the main emphasis of geriatric care to the social area, which leads to endless discussions about the medical or social character of the care

16. Evaluate the relation of health insurance companies to your health care facility:

interest and willingness	1	2	3
solving the problems	1	2	3
administrative burden	1	2	3
reimbursement	1	2	3
contractual policy	1	2	3

please tick off: 1 = satisfied 2 = rather satisfied 3 = unsatisfied

17. Are you, in any way, involved in collaboration with civic initiatives and/or state/local administration bodies in solving the problems concerning the securing and organization of the care of seniors in the catchment area?
□ yes
□ no

18. Do you take part in consultancy and/or teaching activities in the field of care of seniors?
□ consultancy for family members (formal or informal)
□ consultancy for nursing teams or homecare (formal or informal)
□ teaching at a secondary school or college
□ teaching at a university

□ lecturing for the professional public
□ lecturing for the lay public
□ no, I do not take part in any of these activities

19. Do you think that the strict separation of healthcare and social services for seniors affect the development of geriatric services?
□ no, no influence
□ yes, in its consequences it protects from the development of geriatric services
□ yes, it protects from the continuity and entirety of the care of seniors
□ yes, it serves many health care facilities and soc ial service institutions as an excuse allowing not providing the required care
□ it provides clearer organized data on financing the care of seniors
□ other influence:

20. Do you consider programs promoting health of seniors and their active ageing (e.g. the National Programme of Preparation for Ageing for the Period 2003–2007 or the National Action Plan Supporting Positive Aging for the Period 2013–2017) for beneficial from the point of view of building-up the complete network of geriatric services, above all outpatient?
□ yes, above all from the point of view of better information for the lay public
□ no, they are rather proclamative
□ yes, but not for an improved situation in providing geriatric outpatient services
□ I am unfamiliar with these programs

21. Your current employment
□ physician in a geriatric outpatient facility
□ physician in a hospital ward
□ outpatient specialist in another specialty…… (specify the specialty)
□ general practitioner
□ other……(please specify)

22. The work in a geriatric outpatient facility takes at present the following part of your weekly workload:
□ no, I do not work in a geriatric outpatient facility
□ less than 2 hours per week
□ 2–6 hours per week
□ 7–10 hours per week
□ 11–20 hours per week
□ more than 20 hours per week

23. If you have, next to geriatry, another specialty, please give its name:

Please, answer the last 2 questions only in the case you are currently not working in a geriatric outpatient facility.

24. If you are currently not working in a geriatric outpatient facility, would you be interested in working in one or in operating one, provided the conditions for its operation or for working in it changed?
□ yes
□ yes, but only a part of my weekly workload
□ no

25. Specify what would have to necessarily change in order it gave rise to your interest in working in a geriatric outpatient facility:

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