2017
AMA Aged Care Survey Report

Contents

AMA

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Summary

The 2017 AMA Aged Care Survey (the survey) sought feedback on AMA members' impressions and experiences of providing medical care to older people. The survey results provide insight into the perceptions and priorities of members in providing medical care in the aged care sector. As older Australians living in Residential Aged Care Facilities (RACFs) require a high level of medical care, many of the questions are focused on medical access in RACFs. In 2017, there was significant aged care system review by the Federal Government and consultation with stakeholders regarding the quality of care older Australians receive – therefore, quality of care questions were included, in order for the AMA to accurately understand members' current views.

This survey has been conducted in 2008, 2012, 2015, and now 2017.

The 2017 survey revealed that, since the 2015 survey, medical practitioner visits have increased by 1.2 visits (from 7.4 to 8.6 visits per month) while the average number of patients seen per visit has remained relatively similar, with only a slight increase of 0.1 patients per visit (from 6.5 to 6.6 patients per visit). However, the average reported non-contact time on each patient seen (13minutes 35 seconds) has decreased since 2015 (17 minutes 30 seconds), although is similar to the 2012 average (13 minutes 54 seconds).

Although non-contact time has decreased, several members remain concerned about non-contact time demands, commenting on the considerable amount of paperwork involved, responding to faxes and phone calls, and discussing issues with RACF staff or relatives of residents. This has been a common concern for respondents of all the surveys and was listed as a major influence to decrease visits, or never visit, RACFs (page 35 and 36).

All surveys indicate an increased demand for RACF-visiting medical practitioners. The average reported time spent on each patient has increased since previous years. The 2017 survey saw an average of 17 minutes 7 seconds spent on each patient, while in 2012 and 2015, the average was 16 minutes 6 seconds and 16 minutes 12 seconds, respectively. This indicates that although the number of patients seen per visit remains the same, medical practitioners are making more visits to RACFs and spending slightly more time with each patient.

Respondents aged 41-60 remain the largest age group reporting they visit RACFs (46.94 per cent) and contributing to the highest proportion of monthly visits (49.32 per cent). Respondents aged 61 and over contribute to 47.11 per cent of monthly RACF visits, and those aged 40 or under contribute to only 3.57 per cent. This raises concerns that as the older age groups move into retirement, there could be a shortage of medical practitioners willing to visit patients in RACFs.

Respondents were asked of their intentions to visit RACFs over the next two years. Over one third (35.67 per cent) of respondents who currently undertake RACF visits intend to either visit current patients but not visit new patients, decrease the number of visits, or stop visiting RACFs altogether.

Respondents were also asked why the quantity of their RACF visits had changed in the past five years. Nearly half (48.48 per cent) of respondents 'agreed' that the reason they had decreased their visits to RACFs was because unpaid non-face-to-face time is increasing, while 40.82 per cent agreed that the decrease was due to a too-busy practice. The two reasons that were rated the highest under the 'strongly agree' category include that unpaid non-face-to-face time is increasing (34.34 per cent) and that patient rebates are inadequate and do not compensate for lost time in the surgery (33.33 per cent).

Similarly, influences to never visit RACFs are mostly fee-related, with 35.29 per cent strongly agreeing that never visiting RACFs was due to an increase in unpaid non-face-to-face time, and 32.84 per cent stating that patient rebates are not adequate and do not compensate for lost time in the surgery.

In all the surveys, respondents were asked to rate the importance of measures to improve access and quality of medical care in RACFs. Respondents, similar to previous years, marked the following measures as 'urgent' and 'extremely urgent':

- improve availability of suitably trained and experienced nurses and other health professionals (65.92 per cent)
- increase funding for medical practitioners (57.55 per cent).

Other 'urgent' and 'extremely urgent' measures included:

- improve access to palliative care services (54.10 per cent)
- improve access to mental health services in RACFs (53.17 per cent)
- reduce polypharmacy to lower the risk of adverse health events in older people (51.23 per cent)
- improve access to specialist care (such as geriatrician, palliative care, psychiatric, renal, cardiac, and diabetic) (49.29 per cent).

These high ratings of urgency for the above measures indicate that respondents believe the quality of care and access to care for older Australians is sub-par and must be addressed quickly.

Method

Data size and integrity

The survey was distributed to 5,599 AMA Members who identify as general practitioners (GPs), consultant physicians, and palliative medicine and geriatrician specialists in early November 2017 via an email from Dr Michael Gannon, AMA President (2016-2018).

These members were sent a reminder email one week before the survey closed. Members were given three weeks to complete the survey.

The survey was also promoted via articles in GP Network News, *Australian Medicine* and AMA Rounds, and a notification was published on the Federal AMA home page (ama.com.au).

608 members responded to the survey. As no question was compulsory, the results of each question have different sample sizes. Sample sizes are indicated below each graph, or in each results section.

Assumptions and expectations

As many of the questions were framed in order to give expression to frustration, a greater proportion of negative responses toward providing medical care to older Australians were expected than positive ones. It is likely that respondents (correctly) expected the AMA to be interested in improving the existing arrangements for providing medical care in RACFs, and thus had an incentive to concentrate on critical responses.

Questions

The main objective of the survey was to compare results to the previous surveys and identify trends in access to medical care in aged care settings. For this reason, the majority (72.72 per cent) of questions have not changed since the 2015 survey. However, individual responses were confidential, and it could not be determined whether the same AMA members are completing the survey each year. Therefore, the survey represents trends of AMA members as whole.

As there has recently been significant media attention, government consultation with stakeholders, and policy reform in the aged care system, additional questions were created to better inform the AMA's advocacy strategy to improve medical access to older Australians. New questions are Q3, 15, 26-31, 33, and 40-43 covering issues such as Medicare Benefits Schedule (MBS) items, access to infrastructure, clinical communications, and the quality of aged care providers.

The survey was carried out through Survey Monkey[1]. In total, there were 45 questions in the survey, however, different questions were asked according to the participant's answer

[1] https://www.surveymonkey.com/

pathway. The maximum number of questions a participant could answer was 36 (see Figure 1). A list of the questions is provided in the **Appendix.**

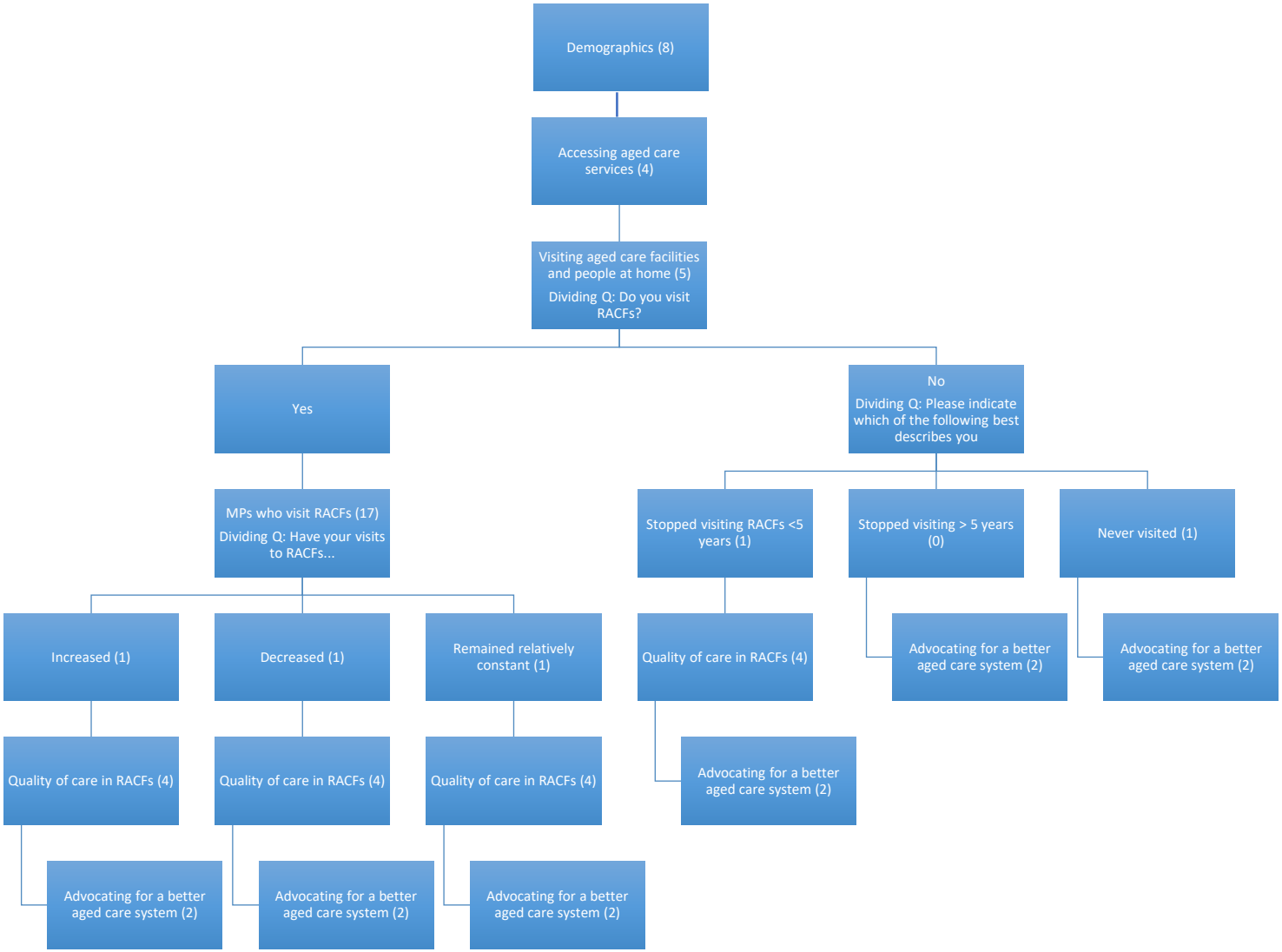

Figure 1: Flow chart of questions for the 2017 AMA Aged Care Survey. Numbers in brackets identify the number of questions in each segment.

Results

Demographics

Respondents are grouped into four categories (Figure 2):

- Medical practitioners who visit RACFs (63.75 per cent),
- Medical practitioners who stopped visiting at some point during the past five years (10.51 per cent),
- Medical practitioners who have never regularly visited a RACF (15.76 per cent), and
- Medical practitioners who stopped visiting RACFs more than five years ago (9.98 per cent).

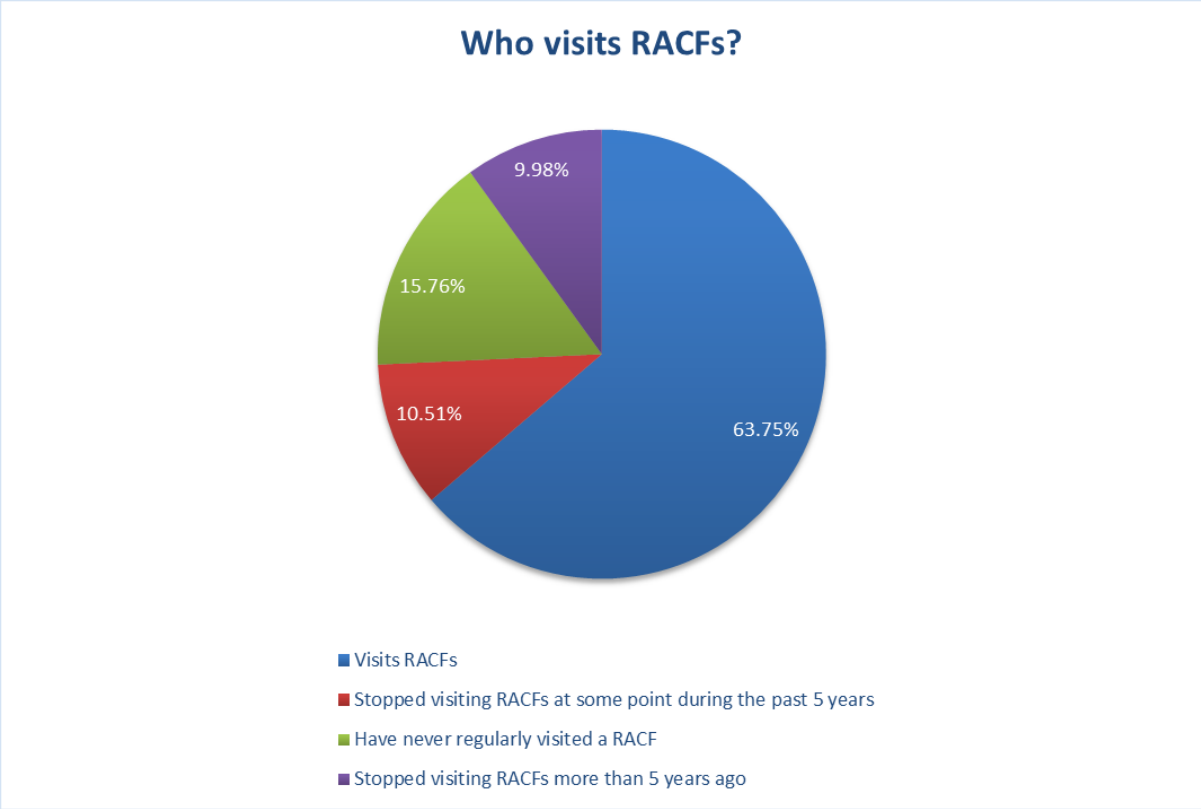

Figure 2: Which respondents visit RACFs or have in the past (n=571).

The proportion of respondents who visit RACFs has decreased by 13.55 per cent since the 2015 survey (Figure 3).

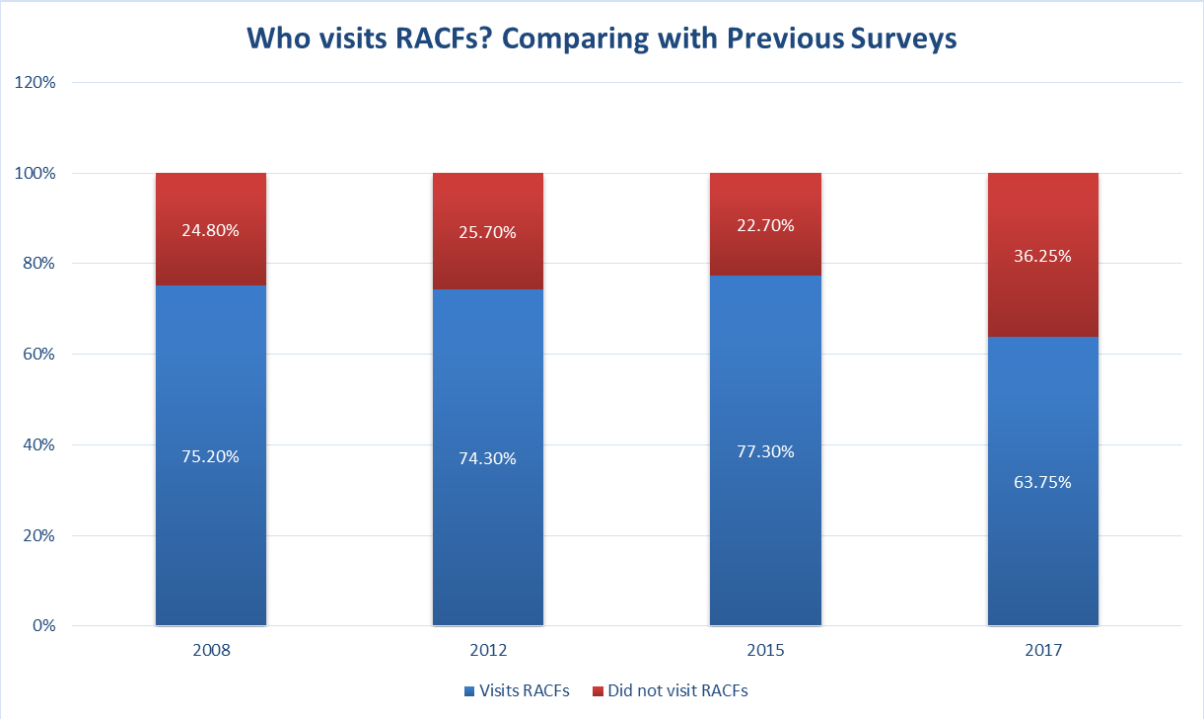

Figure 3: Proportion of respondents who visit RACFs, in comparison to previous surveys (2008, 2012, 2015).

Gender

Nearly two-thirds (60.86 per cent) of survey respondents were male; 37.50 per cent were female; two respondents (0.33 per cent) identified as a gender other than male or female; and eight respondents did not supply a gender (1.32 per cent).

The proportion of male respondents who visit RACFs was higher than the proportion of female respondents. (62.97 per cent compared to 54.39 per cent, respectively) (Figure 4). Similarly, the proportion of female respondents who have never regularly visited RACFs was higher than the proportion of men (18.86 per cent compared to 12.43 per cent, respectively).

In comparison to previous years (Figure 5), the proportion of respondents who do not visit RACFs for both genders has increased since 2012 and 2015. However, the proportion of female respondents who did not visit in 2017 is similar to that reported in 2012.

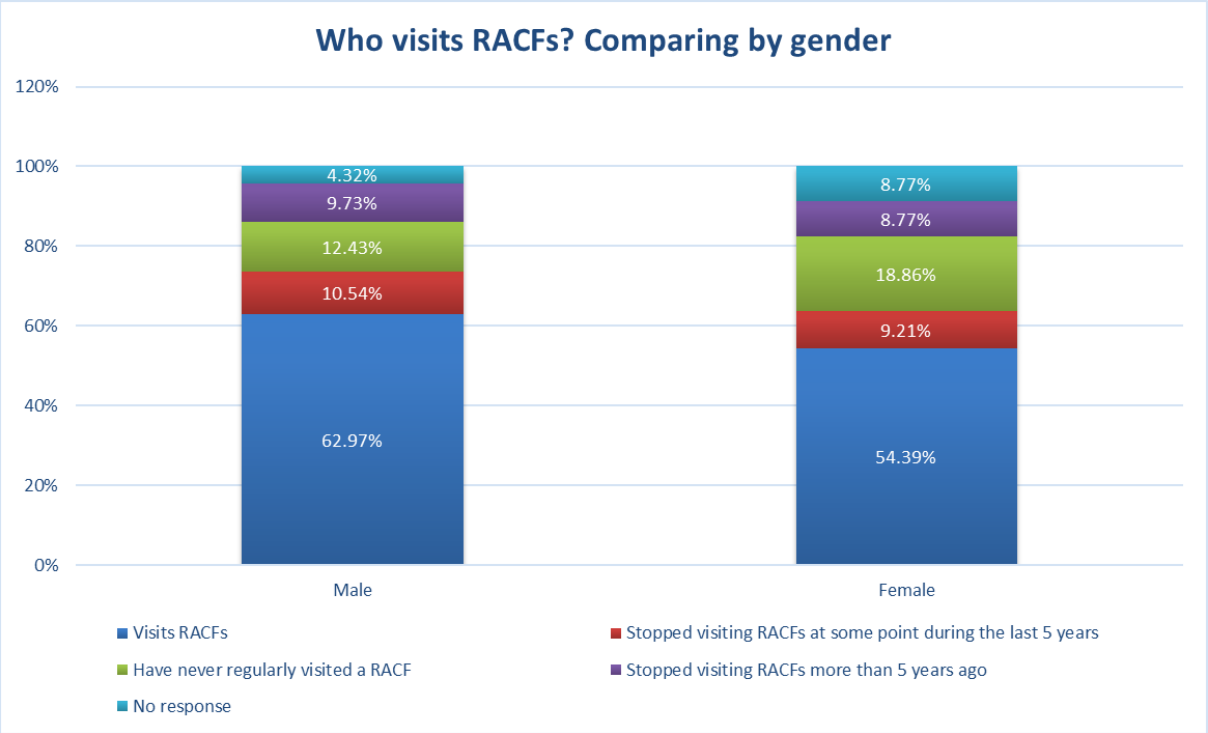

Figure 4: Proportion of males and females who visit RACFs (n=598)

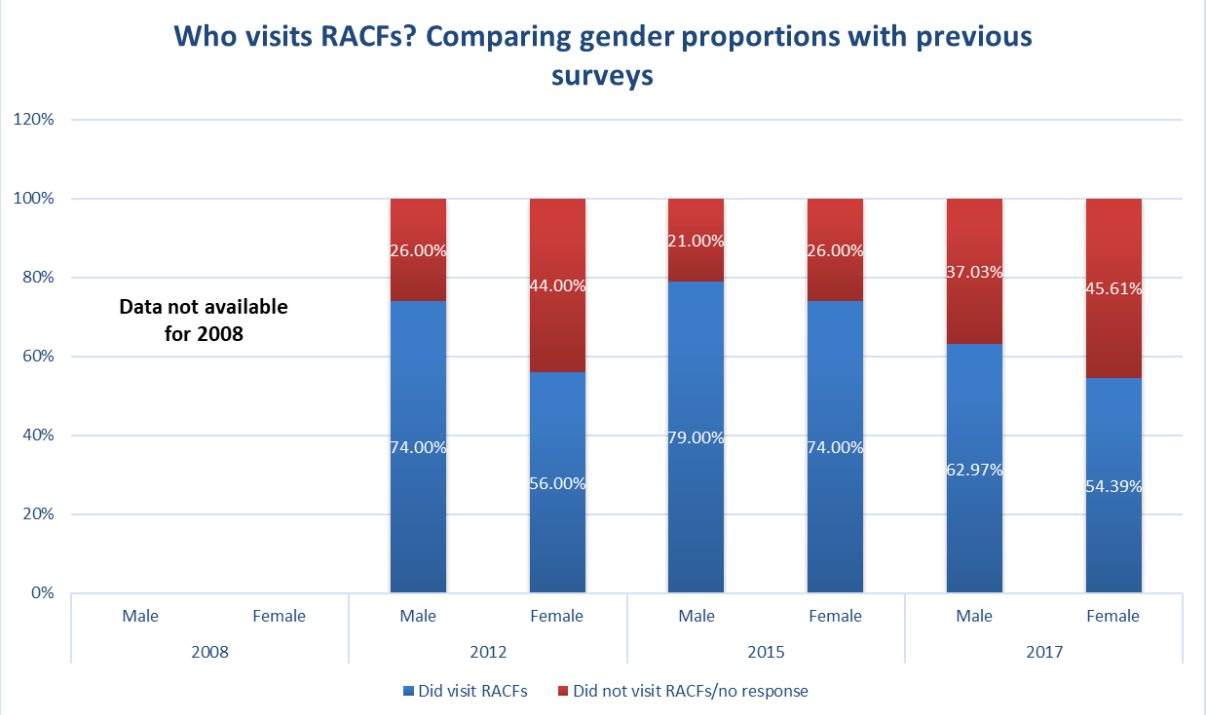

Figure 5: Comparing the proportions of genders who visit RACFs with previous surveys (this data was not collected in 2008).

Age

Responses to the survey were received across all age groups, with the largest proportion from respondents aged 41-60:

Age group	Percentage
≤40	9.21%
41-60	42.27%
61-70	31.91%
≥71	15.63%
Age not provided	0.99%

Figure 6: All survey respondents by age group (n=608).

Nearly half (46.94 per cent) of respondents who visit RACFs were aged 41-60 (Figure 7), followed by respondents aged 61-70 (32.50 per cent):

Age group	Percentage
≤40	8.61%
41-60	46.94%
61-70	32.50%
≥71	11.94%

Figure 7: Percentage of respondents who visited RACFs by age (n=360).

The trend that respondents aged 41-60 visit RACFs more than the other age groups continues in 2017 (Figure 8), however, the proportion of respondents in the same age group who visit RACFs has decreased since 2015 (from 57.80 per cent to 46.94 per cent). The proportion of respondents aged 61-70 visiting RACFs has increased since 2015 (from 28.00 per cent to 32.50 per cent). A likely explanation is that respondents who completed the 2015 survey have aged to be included in the older age group. However, for privacy reasons, individual respondents are not identified to determine whether they completed previous surveys.

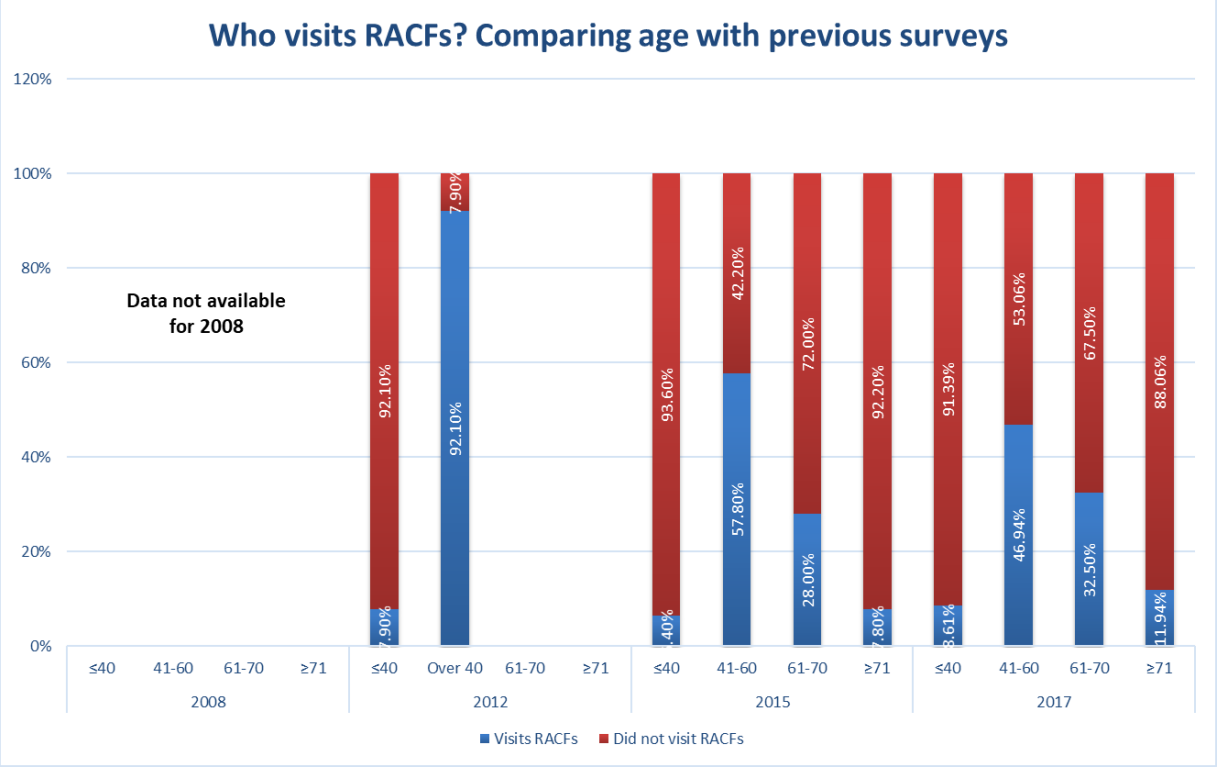

Figure 8: Comparing the proportion of respondents who visit RACFs by age, across all surveys (2012, 2015, 2017).

Practice arrangements

Just over half (52.76 per cent) of respondents who visit RACFs reported they work in a small group/small partnership practice arrangement (Figure 9), followed by large group/corporatised arrangements at 19.89 per cent. Respondents who selected 'other' mostly came from public hospitals, but also included large not-for-profits, community health services, and rural and remote locums.

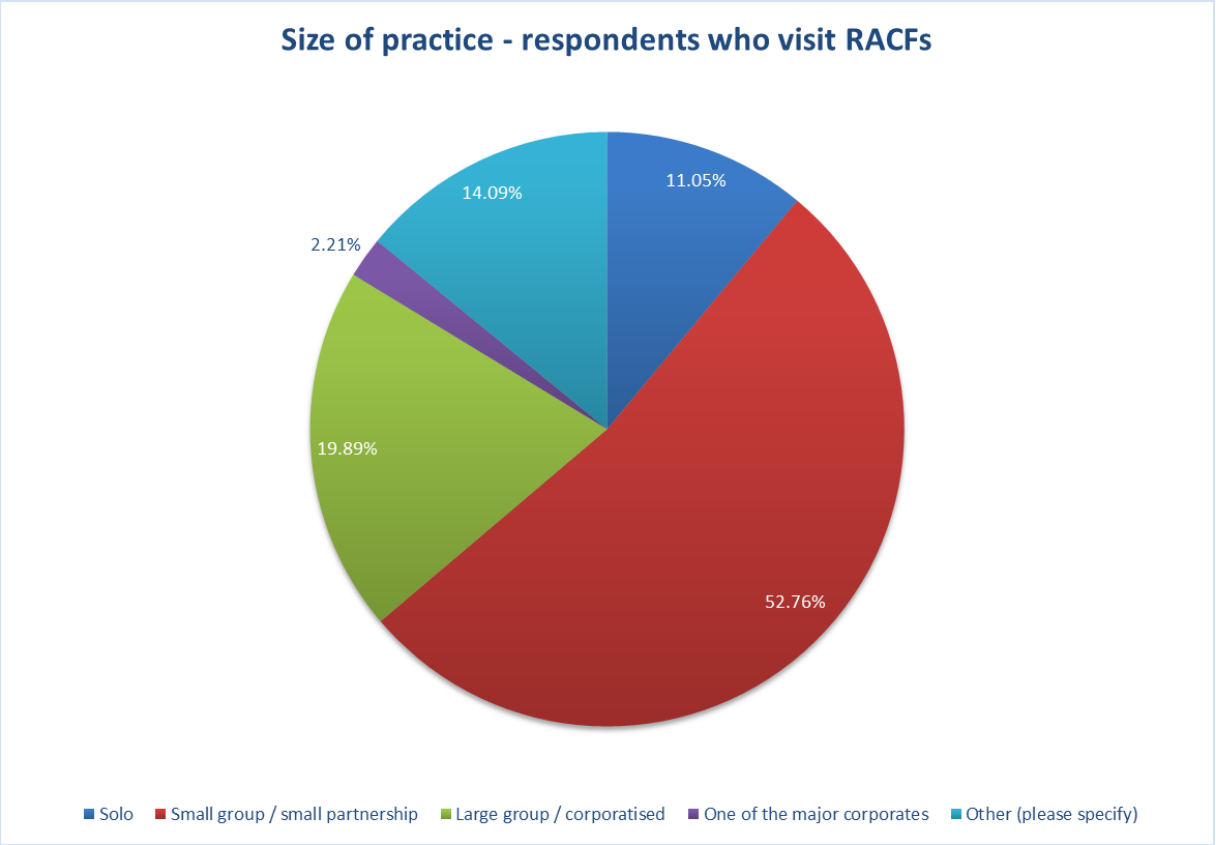

Figure 9: Size of practice for respondents who visit RACFs (n=362).

Practice arrangements by age group

Nearly half (48.39 per cent) of the 40 or under age group who visit RACFs are from small group/small partnership practices (Figure 10), followed by 22.58 per cent who categorise their arrangements as large group/corporatised.

Just over half (52.07 per cent) of the 41-60 age group are from small group/small partnership arrangements, followed by 18.34 per cent who categorise as large group/corporatised.

Nearly 60 per cent (58.97) of the 61-70 age group are from small group/small partnership arrangements, followed by 20.51 per cent who categorise as being from a large group/corporatised arrangement.

Finally, 42.86 per cent of the 71 and above age group are from small group/small partnership arrangements, followed by 23.81 per cent who categorise as being from a large group/corporatised arrangement.

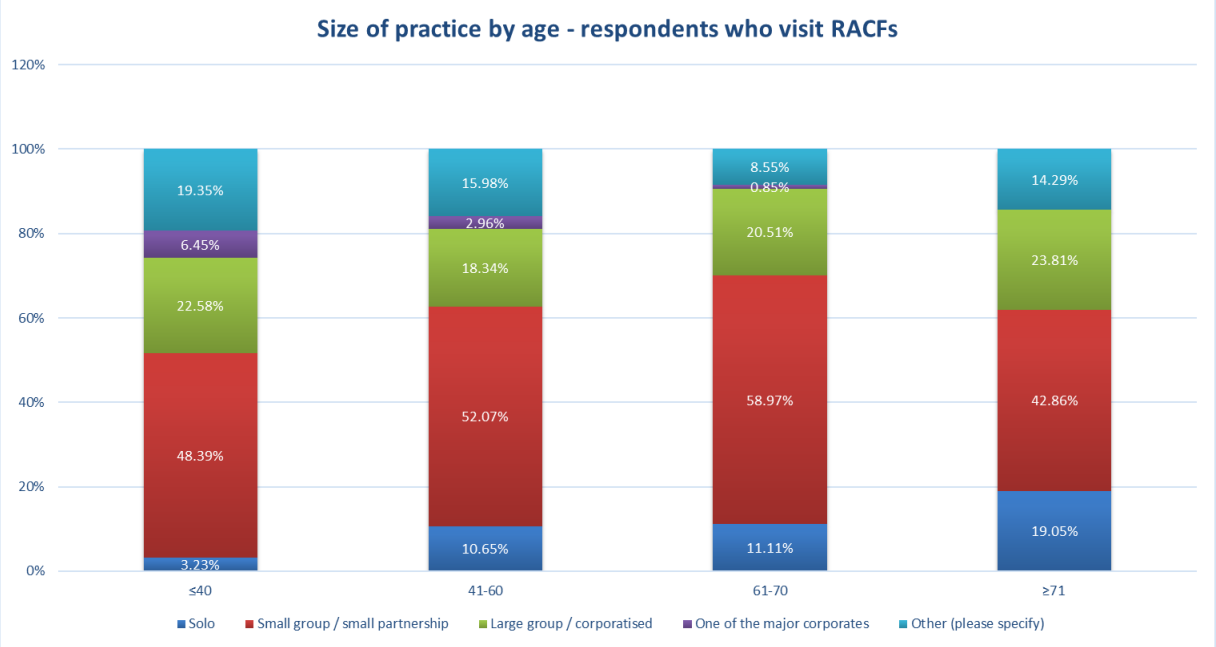

Figure 10: Practice arrangements stratified by age for respondents who visit RACFs (n=362).

Practice approach to visiting RACFs

We asked respondents who visit RACFs about their predominant practice approach. About half (50.91 per cent) visit during regular 'clinic' business hours; 31.69 per cent visit at 'other' times; while 17.40 per cent visit in the evening after a full day at their surgery (Figure 11).

Respondents who chose 'other' times usually work on an 'as needed' basis, and subsequently visit RACFs both during business hours and after hours. Others indicated they allocate a full day to visiting RACFs, or on lunch breaks, weekends or days off from working at their surgery.

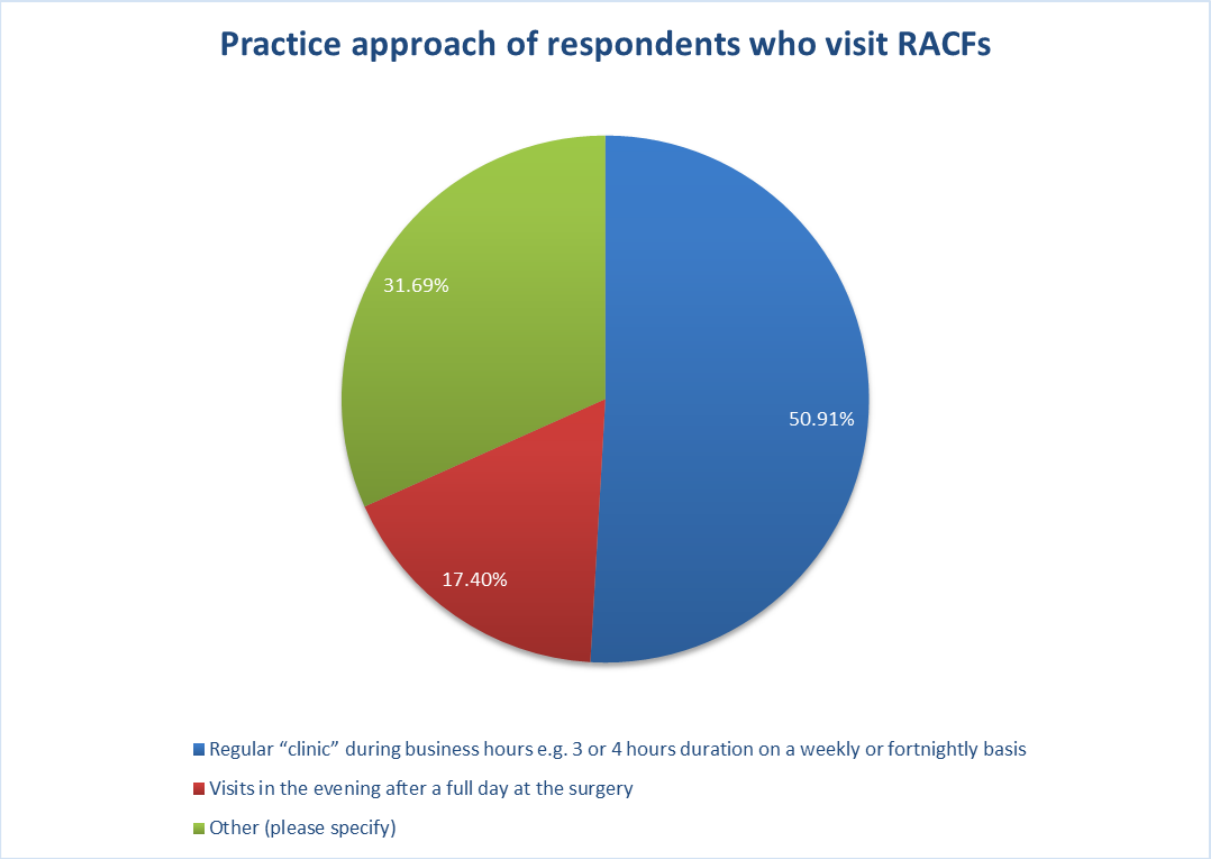

Figure 11: When do respondents visit RACFs? (n=385).

Years in practice

On average, respondents who attended RACFs had been in practice for 30.5 years, only slightly less than the average of all respondents (31.04 years, range 0-62 years). Respondents who did not attend RACFs had an average of 31.99 years in practice. All groups' years in practice has increased since the previous survey (all respondents = 29.3 years, who attend RACFs = 29.4 years, who do not attend RACFs = 27.2 years).

The majority (60.71 per cent) of respondents who attend RACFs have been in practice for 21-40 years (Figure 12).

Years in Practice	<10	10-20	21-40	>40	Average
Proportion of respondents who attended RACFs - 2017	7.97%	14.29%	60.71%	16.76%	30.5

Figure 12: Years in practice for respondents who attend RACFs (n=364).

A summary of other key demographics results is provided in Figure 13.

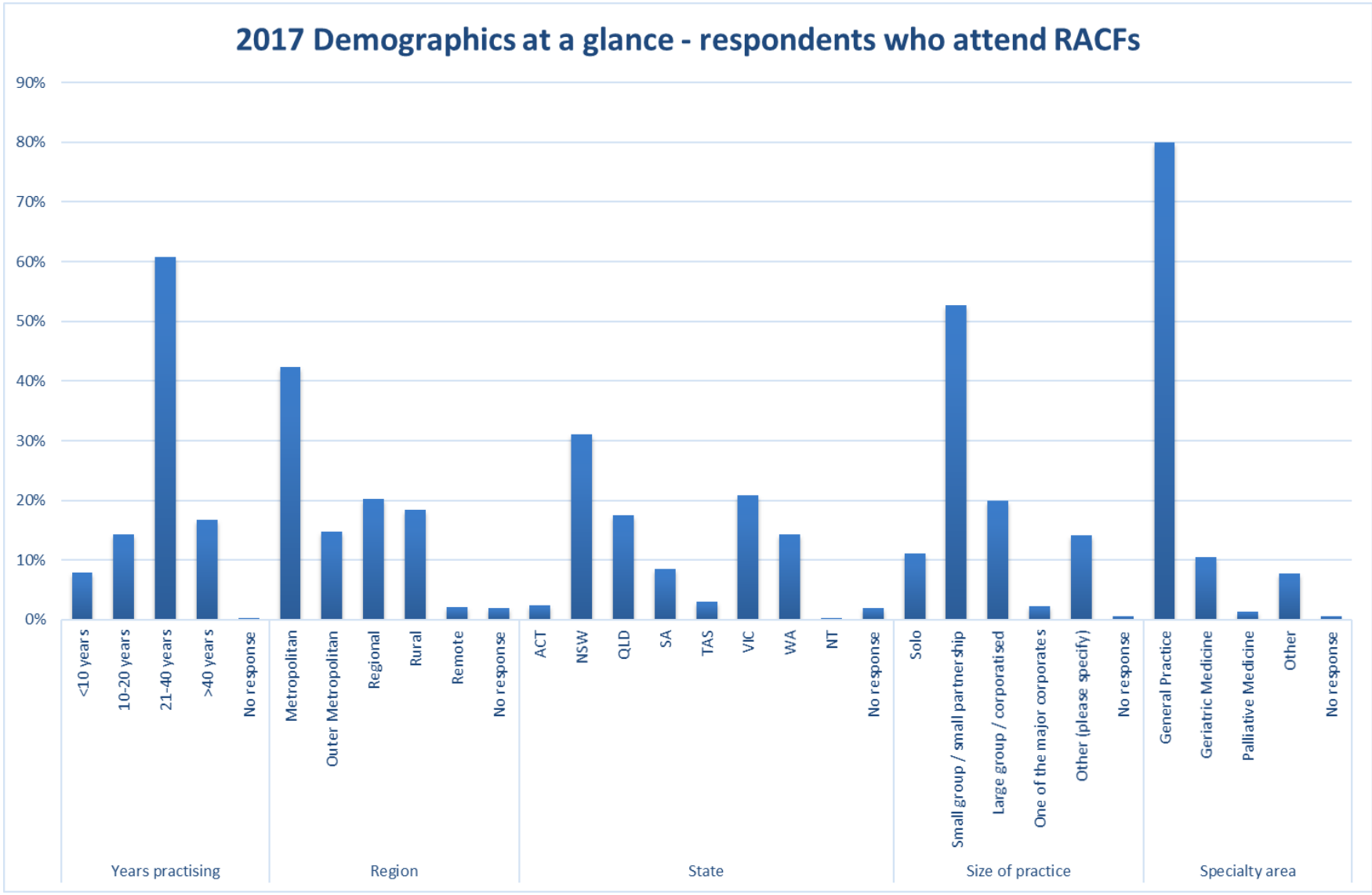

Figure 13: Snapshot of demographics of survey respondents who attend RACFs (n=364).

Medical practitioners who visit Residential Aged Care Facilities

Respondents were asked to state how many of their patients reside in RACFs, estimate the amount of time spent on each patient living in RACFs, the number of patients seen in one visit, per month, and the amount of non-contact time per patient.

Non-contact time includes:

- locating the patient at the RACF
- filling in scripts and paperwork
- talking to relatives
- renewing scripts on the telephone
- discussing issues with RACF staff on the telephone while in the surgery.

Average number of patients in RACFs

The average number of RACF patients per respondent was 29 (Figure 14). Respondents aged over 70 had the highest average number of patients, compared to the 60-70 age group having the highest in 2015. The average number of patients for respondents aged over 70 has increased (from 26 to 32). Averages have decreased in the 60-70 age group, compared to the 2015 survey (from 46 to 29). Respondents 40 or under have increased their average number of RACF patients from 16 to 27, while those aged 41-60 have decreased slightly from 32 to 28 RACF patients.

Average no. of patients in RACFs	≤40	41-60	60-70	≥71	All
2015	16	32	46	26	**n/a**
2017	27	28	29	32	**29**

Figure 14: Average number of patients seen by respondents, by age (n=320).

Time spent on RACF patients

Respondents who visited RACFs reported an average of 8.60 visits per month (range 0-65), and an average of 6.55 patients seen per visit (range 0-50). Since 2015, average visits per month has increased by 1.20 (from 7.4), while patients seen per visit has decreased insignificantly by 0.05 patients (from 6.50). There has been an increase in both factors since 2012, with visits per month at 6.9, and 5.8 patients seen per visit in this year. In 2008, respondents who visited RACFs saw 4.8 patients per visit, however, monthly averages were not recorded.

Respondents aged 71 and over had the highest average of 12.51 visits per month and visited the most patients per visit (7.81) (Figure 15).

	≤40	41-60	61-70	≥71
Average visits per month	4.17	8.86	7.50	12.51
Range	0-20	0-65	0-60	1-45
Average patients seen per visit	5.63	6.51	6.50	7.81
Range	1-25	0-50	0-40	1-30

Figure 15: Time spent on RACF patients per month (n=334) and per visit (n=332).

Respondents who visit RACFs and are 40 or under only make up 3.57 per cent of monthly RACF visits (Figure 16) and report the lowest average patients seen per visit (5.63, Figure 15). Respondents aged 41-60 make up the highest proportion of monthly visits (49.32 per cent).

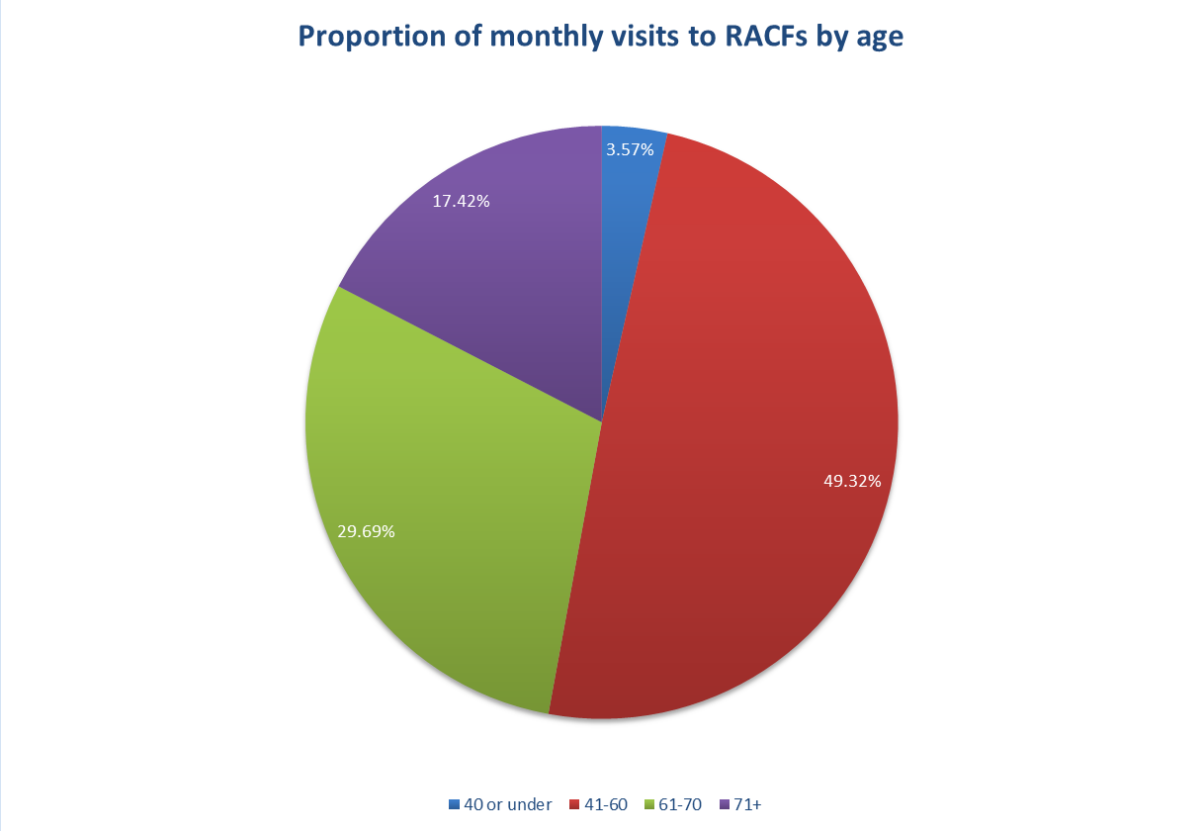

Figure 16: Proportions of age groups who make up total monthly visits (sum of all visits =2802).

The average reported time spent on each patient in 2017 has increased slightly since previous years. In 2017, respondents spent an average of 17.12 minutes per patient, while 2012 and 2015 had averaged 16.20 minutes and 16.10 minutes, respectively.

The average reported non-contact time on each patient seen in 2017 was 13.58 minutes. This has decreased since 2015 (17.5 minutes), but is similar to the 2012 average of 13.90 minutes.

Although non-contact time has decreased, several members remain concerned about non-contact time demands, commenting on the considerable amount of paperwork involved, responding to faxes and phone calls, and also discussing issues with RACF staff or relatives. This has been a common concern for respondents of all the surveys.

Increasing the MBS fee

As a result, respondents are asked each year to provide their opinion on how much the MBS fee should increase to properly compensate for non-contact time spent on a patient (Figure 17). More than one third (37.46 per cent) of respondents considered that a 50 per cent MBS fee increase would be appropriate. This compares to 39.3 per cent of respondents supporting a 50 per cent increase in 2015.

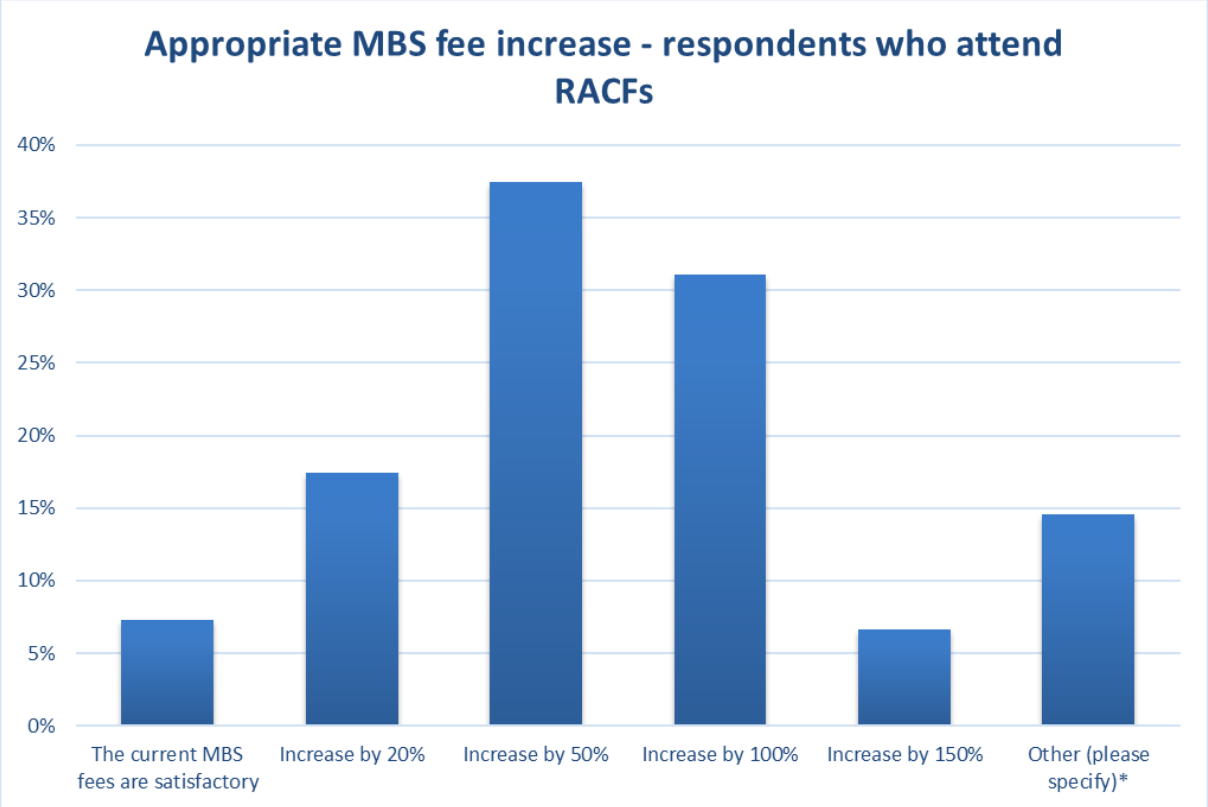

Figure 17: Respondent results on what fee increase would be appropriate to compensate for the non-contact time spent on a patient (n=315).

When asked which medical services not currently funded by the MBS should attract a specific MBS item number, typical responses included:

- case conferencing, palliative care, advanced care planning, medication reviews by a GP-led team
- family consultations
- liaising with other service providers (e.g. pharmacists, aged care staff) over the phone
- prescription writing
- home visits
- travel time.

Time spent on RACF patients by practice size

Respondents working in a solo arrangement had the highest average visits per month (10.17, Figure 18). Respondents in the large group/corporatised arrangement had the highest average patients seen per visit (8.17). Respondents in a major corporate spent on average the highest amount of time per patient (22.29 minutes) and had the highest average amount of non-contact time (15.71 minutes). Solo respondents had the highest average number of RACF patients (31.05), followed closely by large group/corporatised respondents (31.01).

	Average # visits per month	Average # patients per visit	Average time spent per patient	Average non-contact time per patient	Average no. RACF patients
Solo	10.17	5.78	20.23	14.16	31.05
Small group / small partnership	8.62	6.40	16.38	13.38	28.08
Large group / corporatised	7.49	8.17	15.97	13.54	31.01
One of the major corporates	3.29	4.00	22.29	15.71	13.86

Figure 18: Time spent of RACF patients broken down by practice size. Time is in minutes.

After-hours availability of GPs

Nearly two-thirds (62.16 per cent) of GPs who visit RACFs make themselves available to their RACF patients after-hours. Reasons for this include to provide continuity of care and to avoid hospital admissions. Other respondents make themselves available only in emergency situations or when palliative care is required.

When broken down by practice size, 62.23 per cent of GPs in a small group/small partnership arrangement make themselves available to RACF patients after-hours (Figure 19), followed by GPs in large group/corporatised arrangements (25.00 per cent), then GPs in solo arrangements (11.70 per cent). Only 1.06 per cent of GP respondents in one of the major corporates make themselves available after-hours.

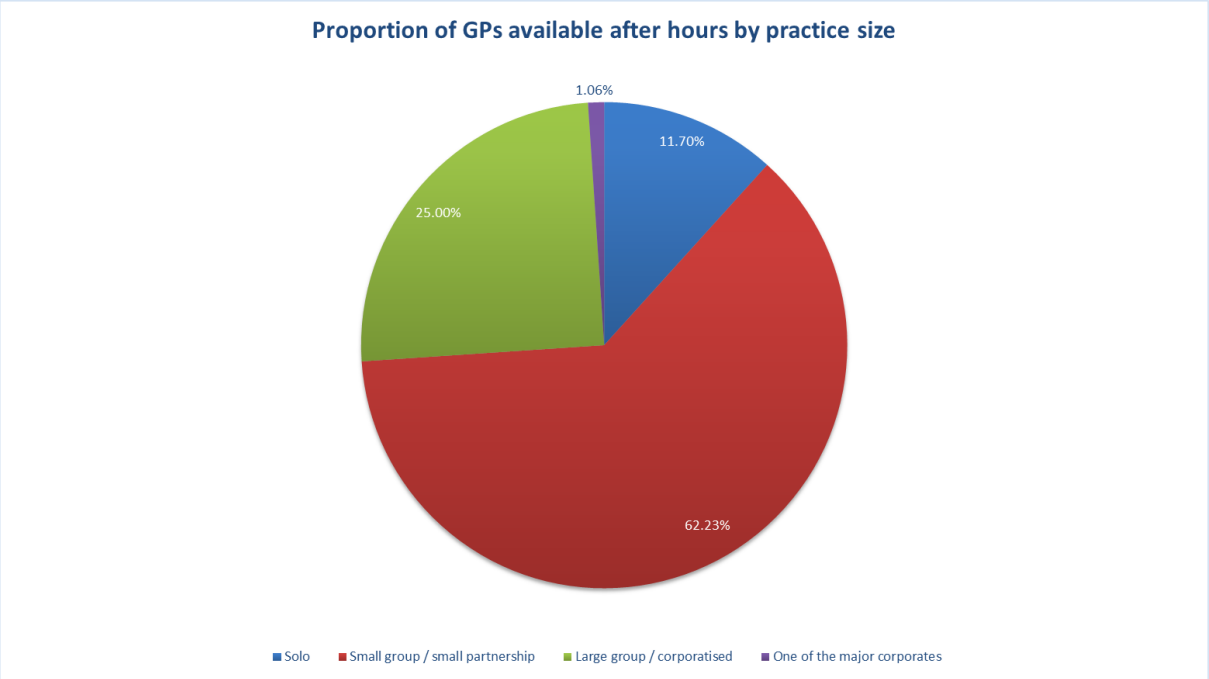

Figure 19: Proportion of GPs who make themselves available after-hours to attend to patients in RACFs (n=188).

Quality of care in aged care settings

In response to the significant volume of inquiries into the quality of care in RACFs, respondents were asked to comment on the general quality of care their patients receive from aged care providers (Figure 20). 40.21 per cent believe the quality of care was 'good', while 30.56 per cent believed the quality of care was 'fair'.

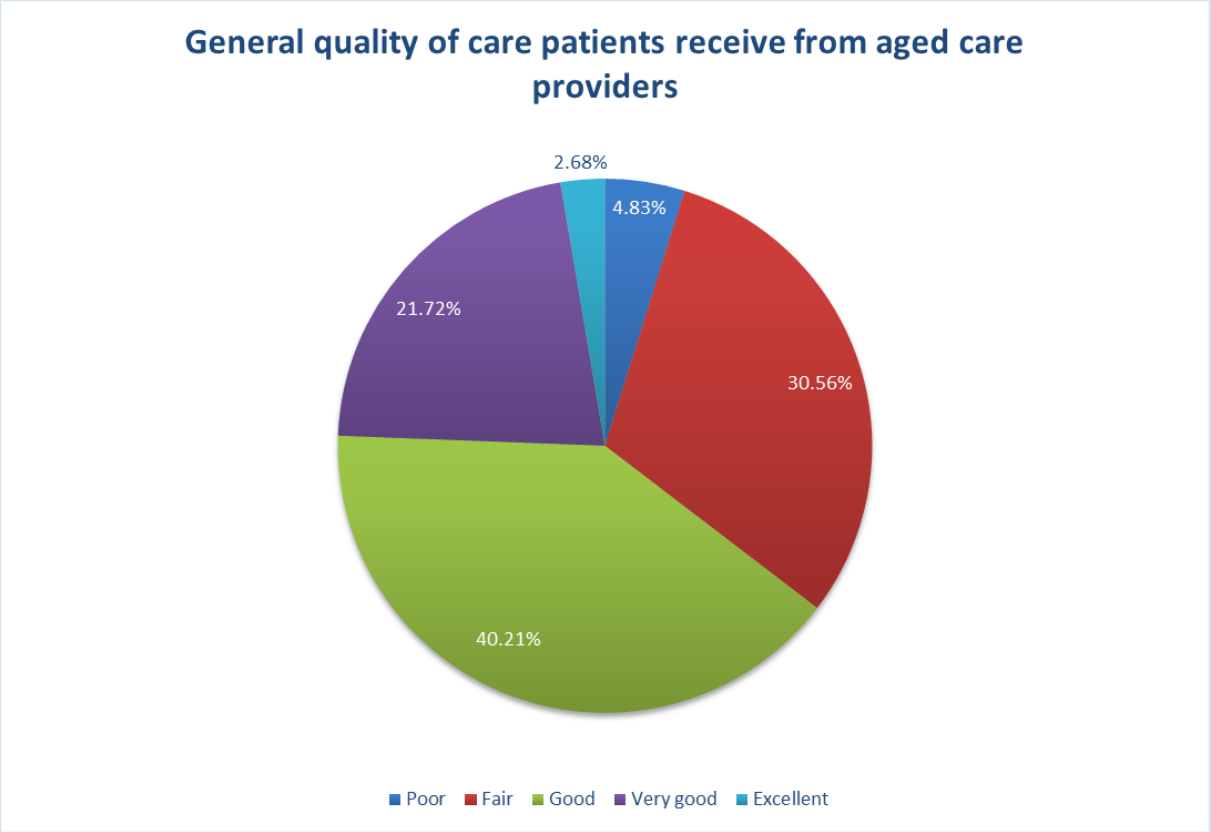

Figure 20: Respondent opinion on the general quality of care their patients receive from aged care providers (n=373).

Elder abuse

Respondents were asked whether they had ever identified issues with elder abuse[2] within aged care settings and to comment on their experiences. More than one quarter (28.66 per cent, n=335) of respondents stated that they had identified issues with elder abuse. However, respondents who did identify issues reported that it was rare or occurred a long time ago. Further, several elder abuse cases were observed as financial abuse through family members. Respondents commented that most medical abuse cases were cases of neglect through delaying care, not giving medication, or leaving a patient in bed for an extended period.

Respondents who did not report experiences with elder abuse commented that there was still neglect due to a lack of trained, appropriate staff, and that older people with complex

[2] WHO definition of elder abuse: *a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.* http://www.who.int/ageing/projects/elder_abuse/en/

medical conditions can be extremely challenging and frustrating for aged care staff, who do their best with the limited resources available.

Aged Care Accreditation Standards

Respondents were asked whether the current Aged Care Accreditation Standards[3] were appropriate (Figure 21). The majority (48.13 per cent) were unsure, highlighting that medical practitioners are not widely consulted when a RACF undergoes an accreditation review. Other respondents commented that the Accreditation Standards are just extra paperwork and "ticking boxes" and do not necessarily translate to quality care. Others mention that a focus on increasing the number of trained staff would improve quality, and that an appropriate number of trained staff should be included in the Standards.

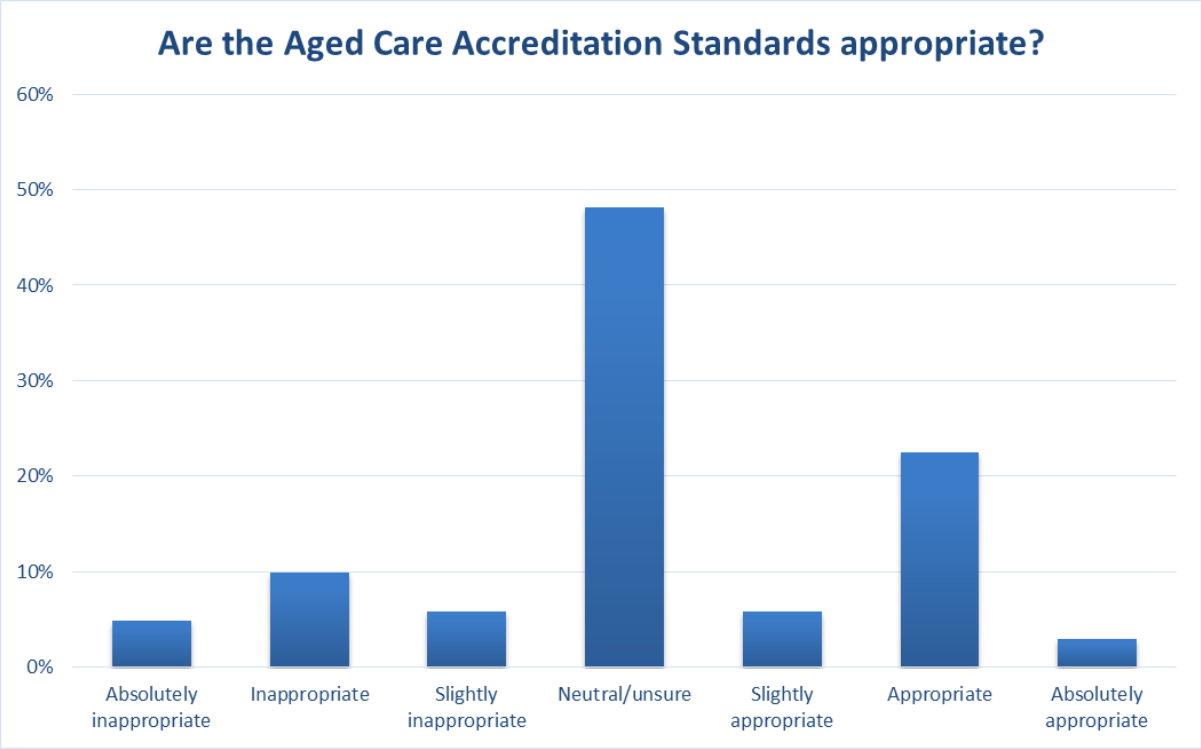

Figure 21: Respondent comments on whether current Aged Care Accreditation Standards are appropriate (n=374).

[3] https://www.aacqa.gov.au/providers/accreditation-standards

Access to aged care services

The aged care system has processes in place for individuals to access different levels of, and funding for, aged care services. My Aged Care[4] has been established by the Federal Government to act as a 'one-stop-shop' for individuals to access aged care services. Medical practitioners frequently assist their patients in accessing these services, through making referrals and applications to carry out an Aged Care Assessment Team (ACAT) or Regional Assessment Service (RAS) assessment, which determines their required level of care and allows them to access government funding.

My Aged Care

Respondents were initially asked whether they had any experience with My Aged Care. Those who replied with yes (65.65 per cent) were then asked whether it was useful for their patient. Almost half (49.39 per cent) of those respondents responded with 'yes'; 24.21 per cent said 'no'; and 26.41 per cent were 'unsure' (Figure 22).

Respondents who provided comments about the usefulness of My Aged Care provided positive comments such as 'allowed patients to access aged care services' and 'gave a lot of information on aged care services that was useful to the patient'.

Negative comments included:

- difficulties for patient access – assumes that patients are computer-literate and have internet access
- very slow, bureaucratic, process to access services
- time-consuming for medical practitioners and their staff to fill in referral forms
- does not allow for auto-populating data
- little feedback given to the treating medical practitioner on outcome.

[4] https://www.myagedcare.gov.au/

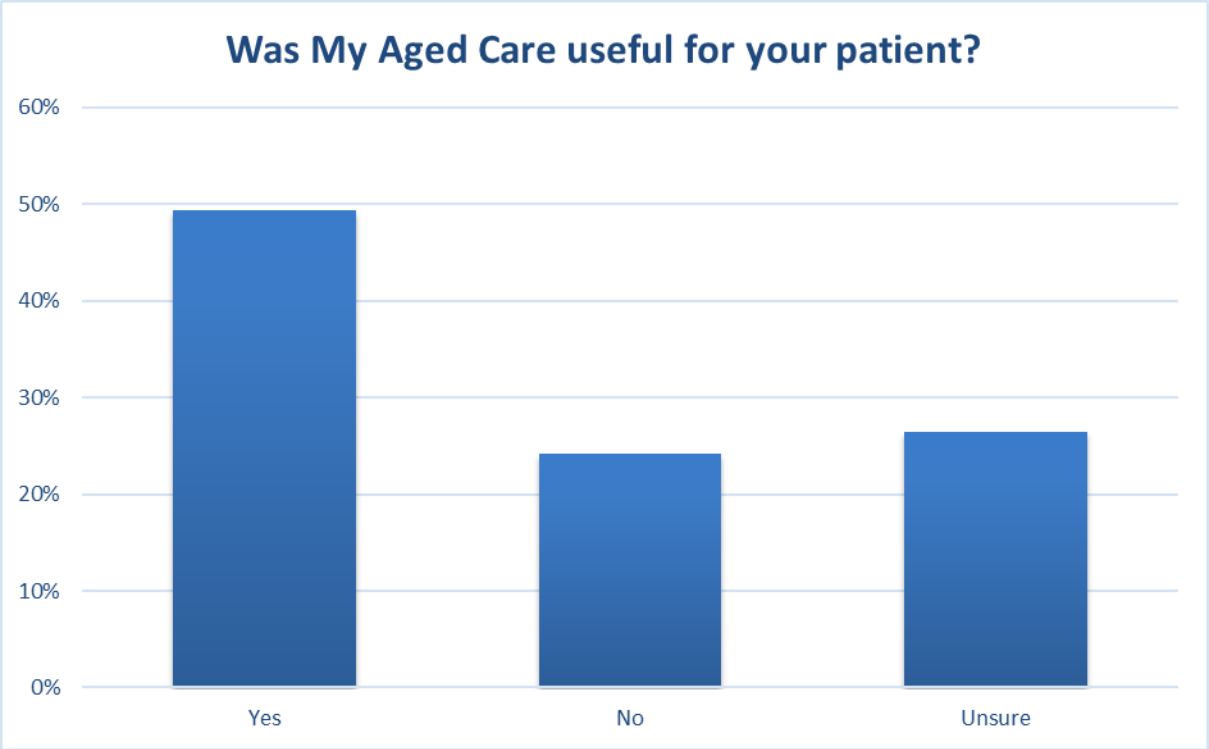

Figure 22: Determining the usefulness of My Aged Care for patients (n=409).

Aged Care Assessment Team (ACAT)

Since 2012 and 2015, the highest reported average waiting times for an initial ACAT assessment has shifted to one to three months (46.77 per cent), while in previous years the highest reported averages were less than one month (Figure 23). Forty per cent (39.33) of respondents stated that their patients had to wait less than one month.

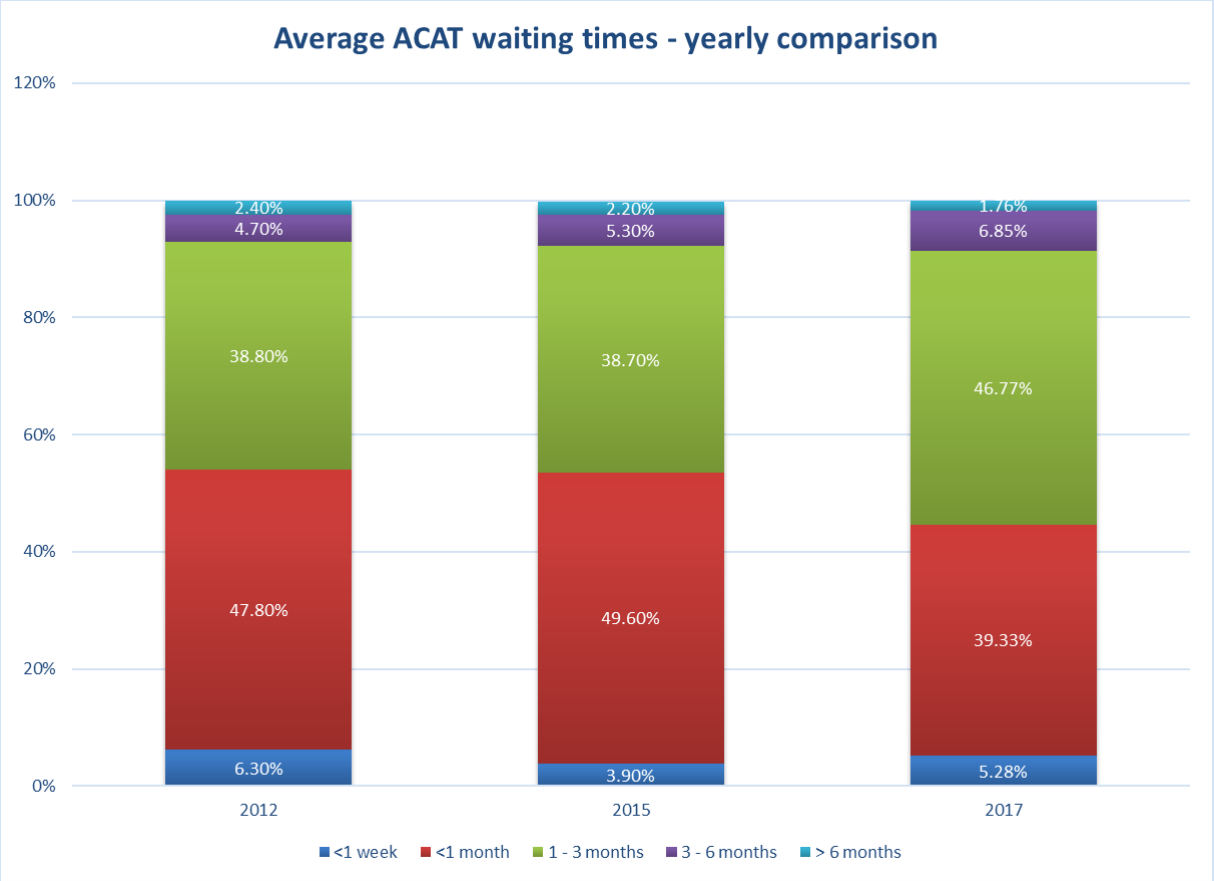

Figure 23: Average Aged Care Assessment Team (ACAT) waiting times for respondents' patients (n= 511 for 2017).

The highest proportion of reported initial ACAT waiting times for each State or Territory were:

- ACT: 1-3 months (25 per cent)
- NSW: 1-3 months (40.46 per cent)
- NT: 1-3 months (60 per cent)
- QLD: 1-3 months (49.15 per cent)
- SA: 1-3 months (41.86 per cent)
- TAS: 1-3 months (36.84 per cent)
- VIC: 1-3 months (37.74 per cent)
- WA: < 1 month (44.25 per cent)

The above follows the same trend as 2015 results, with patients living in NSW, QLD and SA more likely to wait longer for an initial ACAT assessment.

Data may not be representative in the ACT, Tasmanian and NT populations, as respondent rates were low for this question (n=12, n=19 and n=5, respectively).

Access to the facility, infrastructure, and external services

The following questions were asked of respondents because some AMA members raised concerns about access to particular facilities in RACFs, that are either deterring members from visiting RACFs, or are impacting on the quality of care their RACF patients receive.

Presence of doctor treatment/visiting rooms

More than one third (36.20 per cent) of respondents reported that RACFs never have doctor treatment/visiting rooms, and only 8.31 per cent reported that RACFs always do (Figure 24). When stratifying the data by region, rural respondents reported the highest proportion of 'always' responses (16.92 per cent). By contrast, outer metropolitan areas had the lowest proportion of 'always' responses (3.77 per cent) and the lowest proportion of 'never' responses (33.96 per cent).

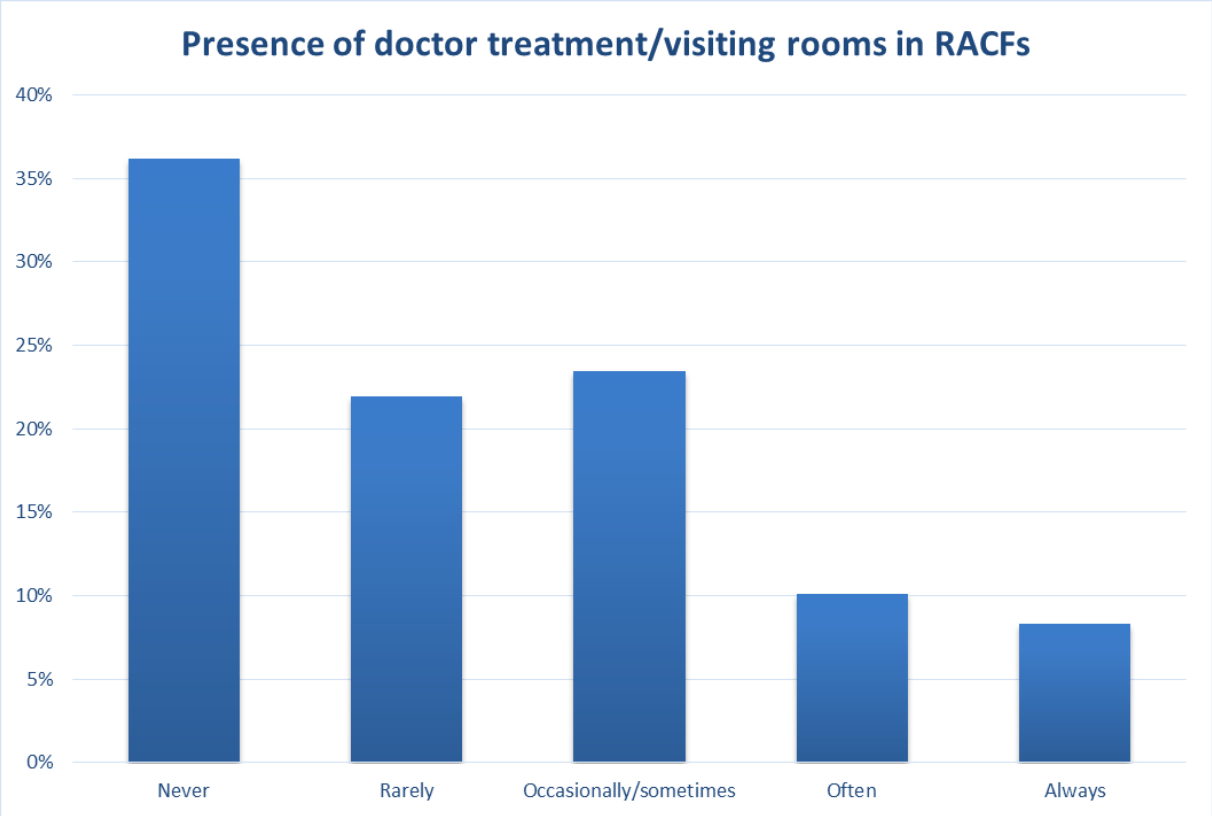

Figure 24: Availability of doctor treatment/visiting rooms in RACFs (n=337).

GP employment model

Respondents were asked whether they thought having a GP employed by the RACF was beneficial to the patient; 42.36 per cent were unsure. The high proportion of 'unsure' responses may be because this alternative model of care is currently not widely used and therefore its effectiveness in not well known.

34.85 per cent of respondents answered 'Yes'. Typical supporting comments included:

- "GP is on hand and also gets to know better what care is needed and appropriate"
- "I think it supports high quality care of [a] population who frequently has complex health needs"
- "GP would be able to manage care with reduced transfer to hospital [and] better assessment of requirements"

22.79 per cent of respondents answered 'No'. Typical comments included:

- [several comments] Lack of continuity of care, could restrict patient choice.
- "Conflict of interest. GP should [be there] for their patients and no one else."
- "They will have even less power to care for these unfortunates if their clinical decision making is governed by the same appalling system that created the mess in the first place."

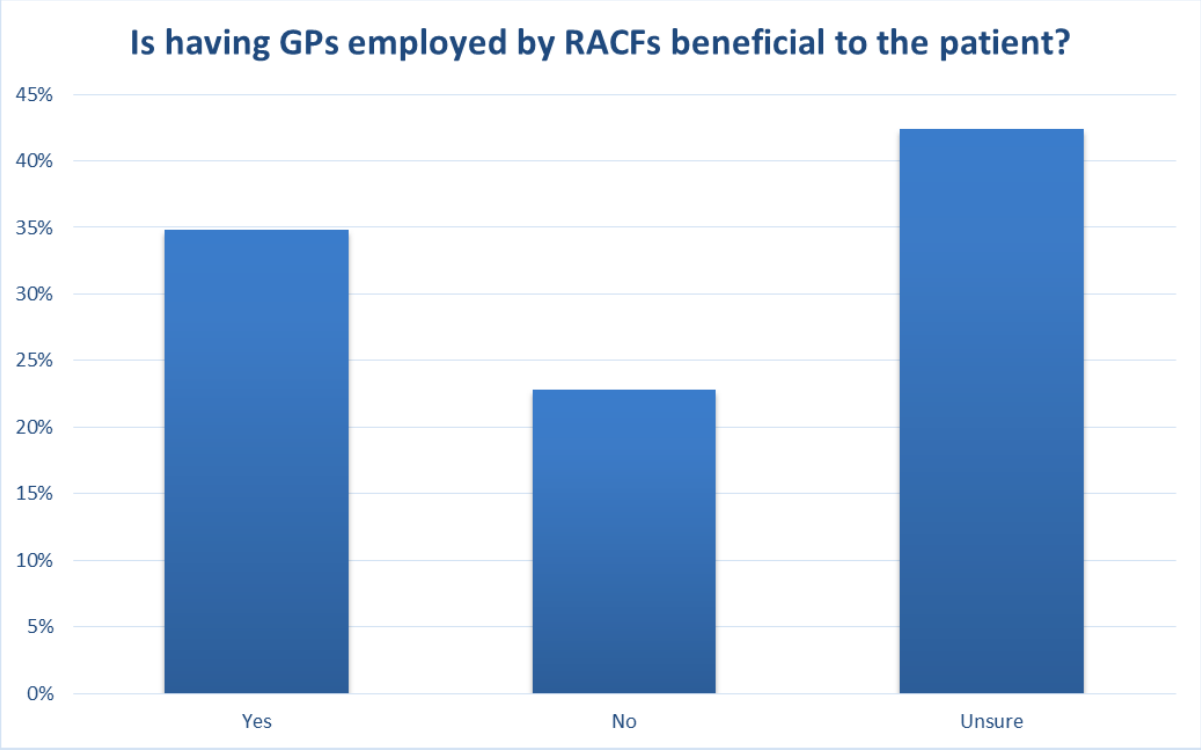

Figure 25: Whether GP employment by RACFs would be beneficial to the patient (n=373).

Reliable clinical handovers

When asked whether RACFs implemented adequate processes to ensure a reliable clinical handover (Figure 26), 40.66 per cent of respondents reported that this 'often' occurs, followed by 26.20 per cent who reported that it 'occasionally/sometimes' occurs. When asked what level of expertise was required for the respondent to conduct a professionally responsible handover for their patients' care, 84.92 per cent listed a nurse, with the majority of respondents listing a Registered Nurse.

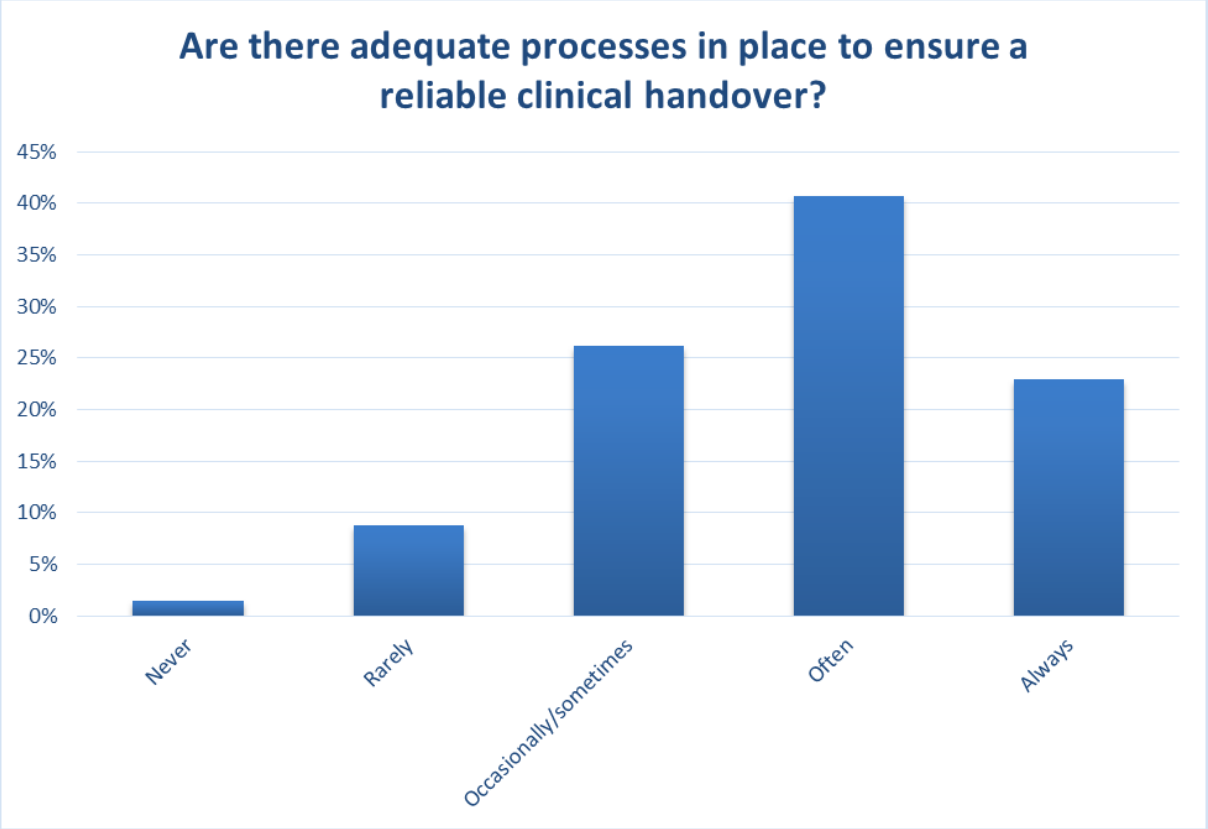

Figure 26: Processes to ensure a reliable clinical handover (n=332).

Access to RACF infrastructure

Respondents were asked to rate how important they believed access to particular infrastructure items were (Figure 27). Items with the highest proportion of 'very important' responses were 'appropriate room/lighting/privacy to examine (the patient)' (48.08 per cent), followed by 'easy and safe access to RACFs' (44.64 per cent). Items with the highest proportion of 'extremely important' responses were 'health records communication between RACFs and practice software' (43.66 per cent) and 'internet access' (33.53 per cent).

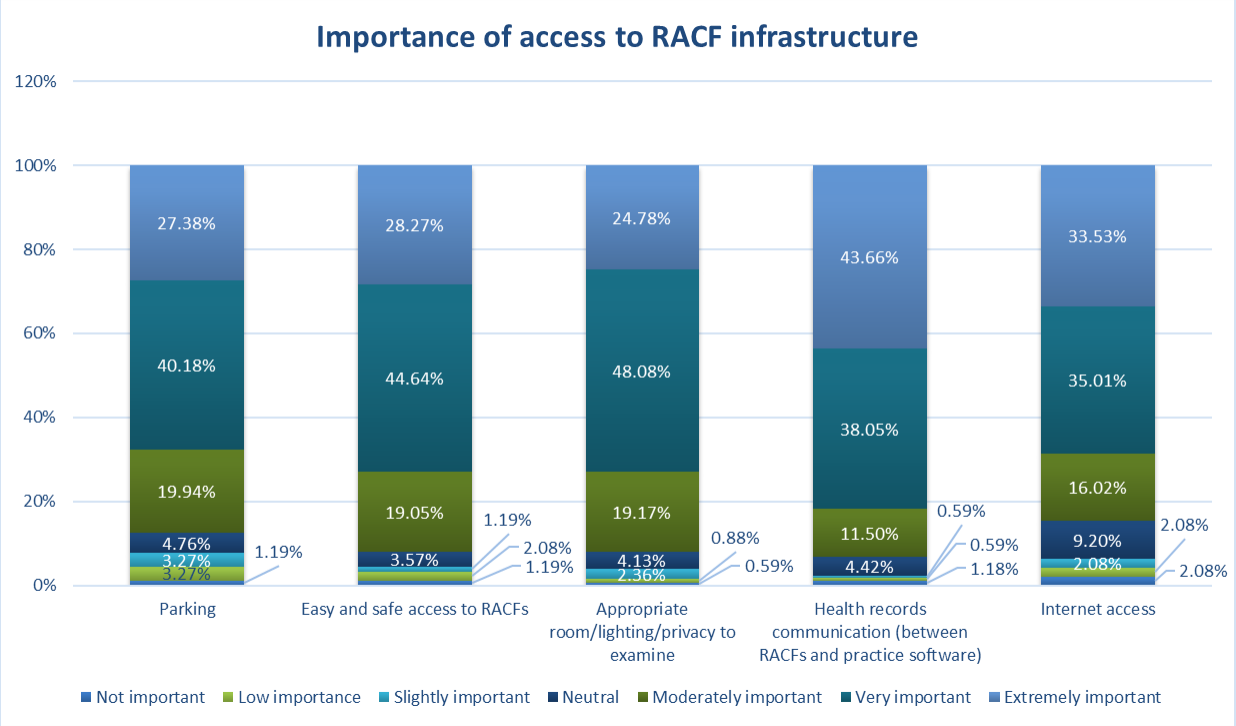

Figure 27: Results for "Please rate how important you think access to these RACF infrastructure items are" (n=339).

Access to health services

When asked how difficult it was for patients to access particular services when required, 48.96 per cent responded it was 'very difficult' to access mobile x-ray and ultrasound services, followed by 'secondary support and consultation with specialists' (27.60 per cent) (Figure 28). Most 'difficult' services to access were 'secondary support and consultation with specialists' (43.62 per cent), followed by 'allied health professionals' (31.75 per cent). Most 'neutral' services were 'allied health professionals' (38.87 per cent) and 'timely nursing care' (33.53 per cent). 54.30 per cent of respondents reported that it was 'easy' to access 'pathology services', following by 'timely nursing care' (39.76 per cent). Finally, 'pathology services' (20.18 per cent) and 'timely nursing care' (10.09 per cent) were rated the two highest services that were 'very easy' to access.

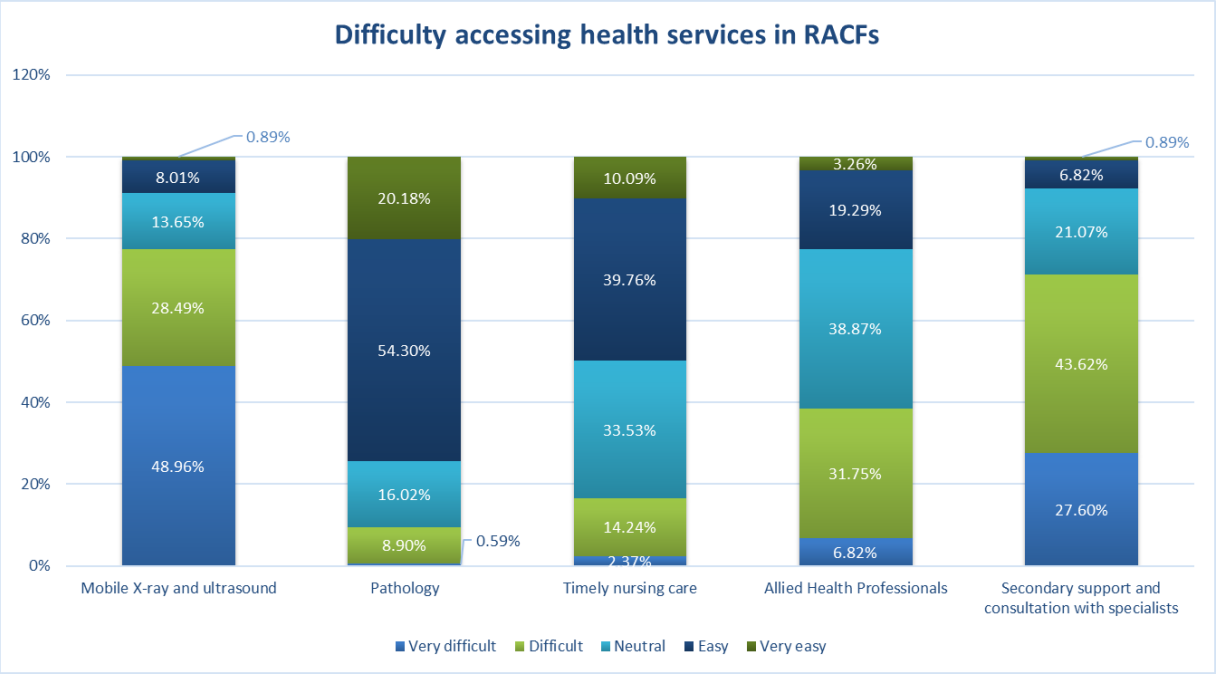

Figure 28: Results for the question "please rate how difficult it is for your patients to access the following when they need it" (n=338).

Access to Information Technology facilities

Respondents were asked to comment on what Information Technology (IT) facilities would be useful when visiting the RACF that are not currently provided. Comments included the following.

- Access to electronic records that is linked with the GP's clinical software, both off-site and when in the RACF
- Adequate internet access
- Electronic medical charts, prescriptions, and referrals
- A modern computer for medical practitioners within a dedicated room.

Respondents also expressed frustrations that each RACF used different software systems without interoperability with their own clinical software. Many respondents take their own laptop to RACFs to bypass this issue.

Intentions to visit RACFs

Respondents that currently visit RACFs intend to over the next two years (Figure 29):

- increase the number of visits to RACFs (11.63 per cent)
- maintain the number of visits to RACFs (52.71 per cent)
- decrease their visits (20.16 per cent)
- visit their current patient but not take on any new patients (6.98 per cent)
- stop visiting RACFs altogether (8.53 per cent).

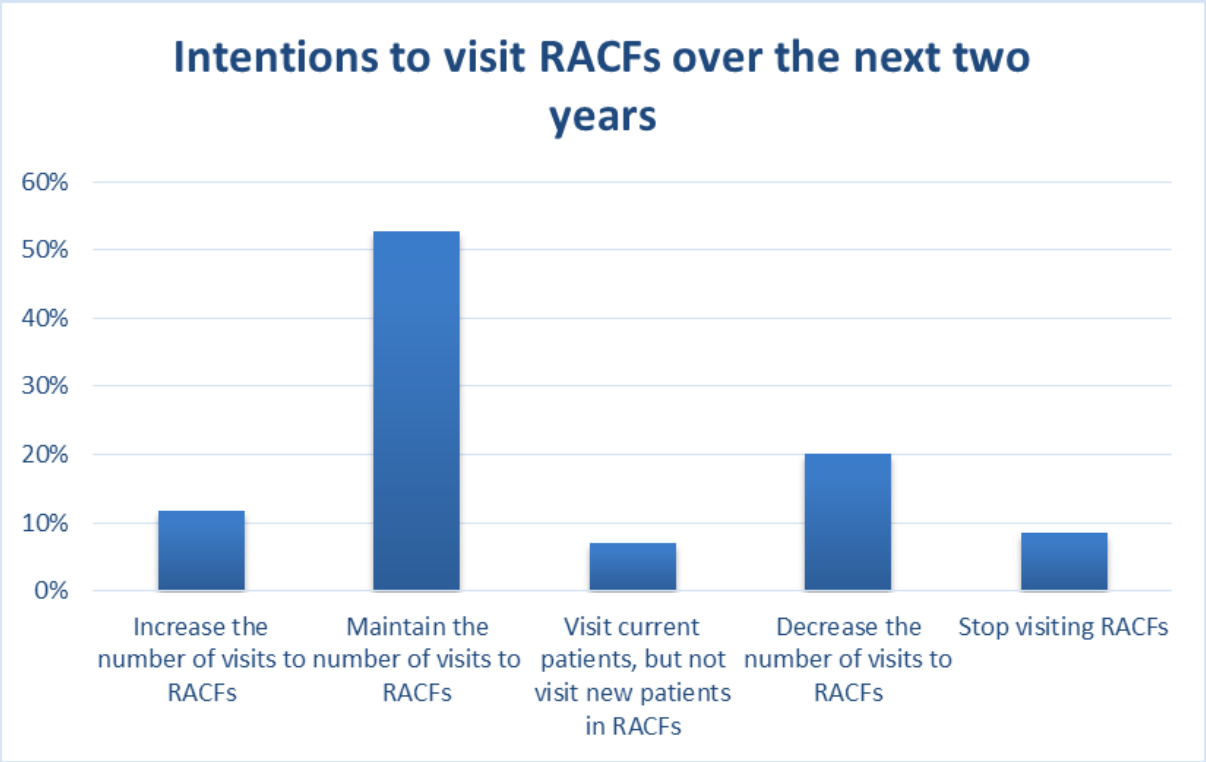

Figure 29: Intentions to visit RACFs over the next two years - respondents who currently visit RACFs (n=129).

When broken down by practice size (Figure 30), most respondents for this question came from small group/small partnership arrangements, whose proportion of responses were relatively similar across the range of intentions given. A quarter of respondents intending to visit current patients but not take on new patients were from large group/corporatised arrangements.

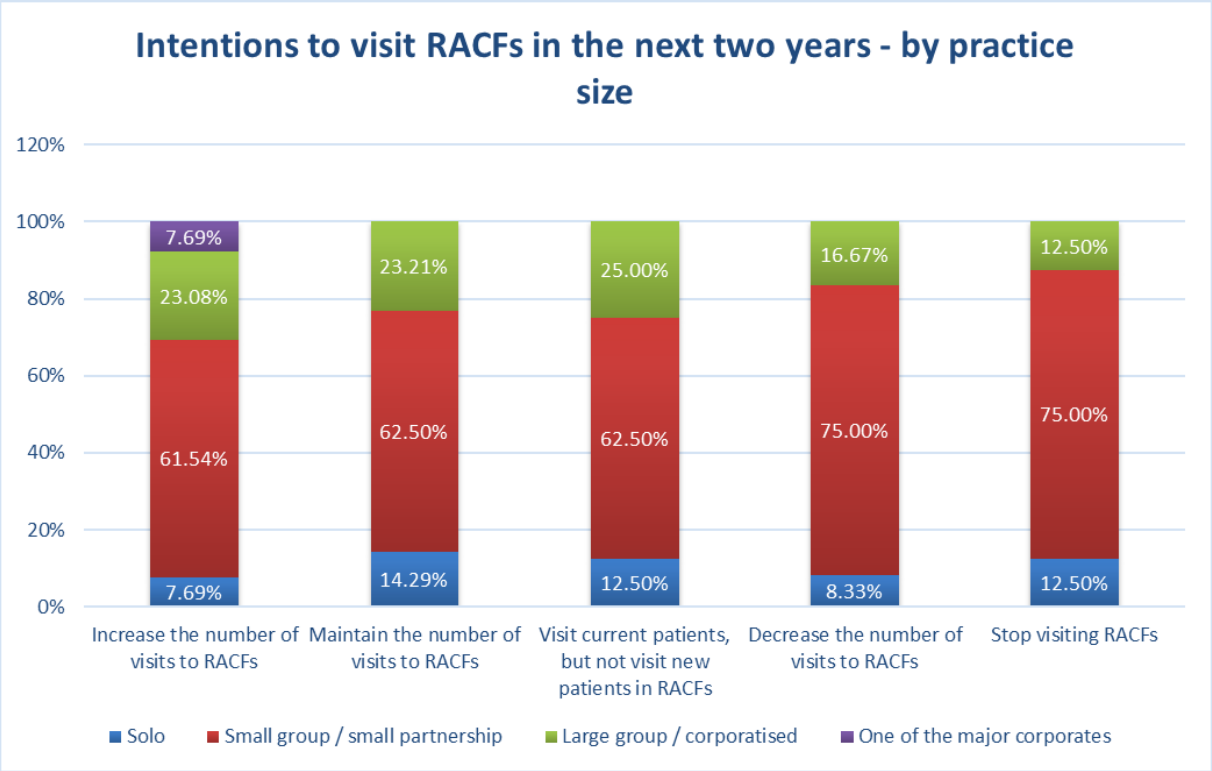

Figure 30: Intentions to visits RACFs over the next two years, differences in practice size (n=109).

A common reason for either decreasing or no longer visiting RACFs is that some respondents will retire in the two year timeframe. For this reason, results were stratified by age to determine the extent of potential retirement being a primary factor (Figure 31). This showed that 72.72 per cent of respondents who intend to stop visiting RACFs are aged 61 and over, followed by 41-60 years of age. However, sample size was small for this intention category (n=11).

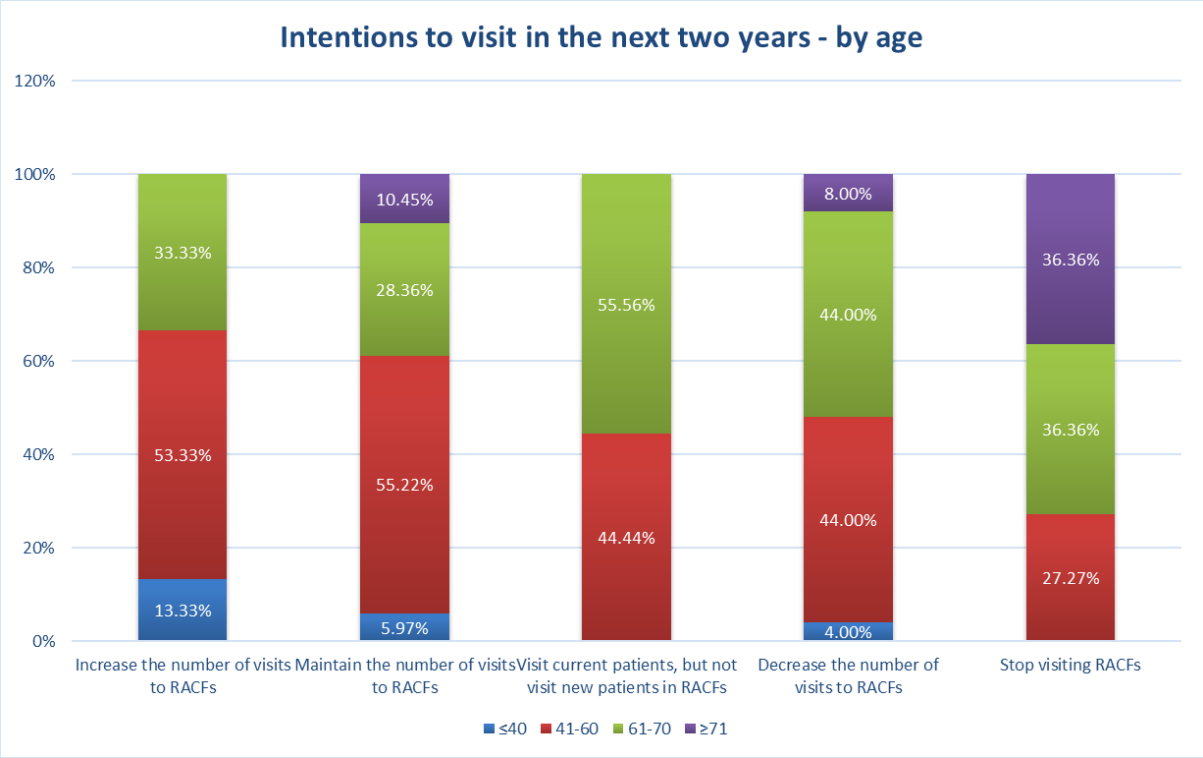

Figure 31: Intentions to visit RACFs in the next two years, stratified by age (n=127).

Factors influencing intentions to visit over past five years

Of those respondents who currently attend RACFs, 31.56 per cent reported that their visits have increased over the past five years, while 29.50 per cent report that they are decreasing, and 38.94 per cent report a constant volume of RACF visits.

Nearly half (48.11 per cent) of respondents who have increased their visits over the past five years are from the 41-60 age group (Figure 32). This age group represents a similar proportion of respondents who have decreased their visits (44.44 per cent) or maintained the same volume of visits (48.46 per cent). Of the other age groups who have decreased their visits, 14.14 per cent were aged 71 and over, 37.37 per cent were aged 61-70, and 4.04 per cent were aged 40 or under.

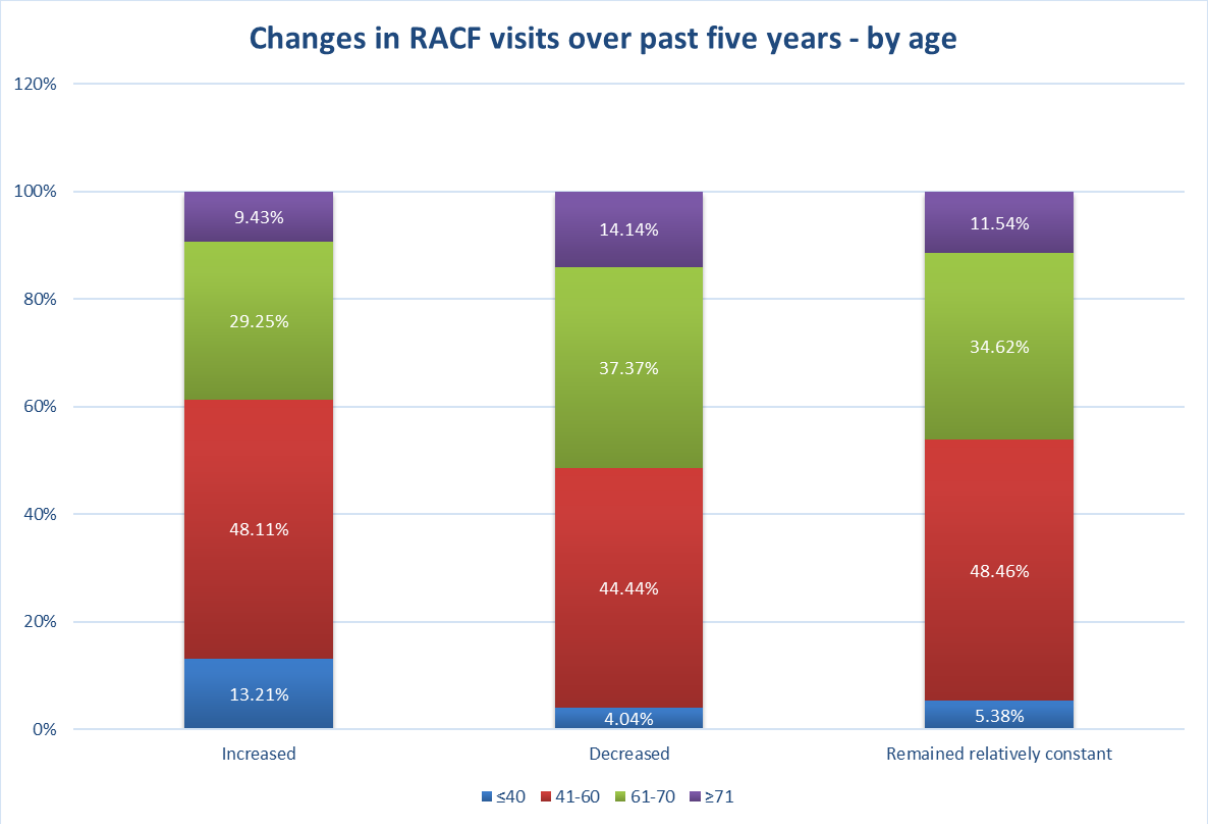

Figure 32: Changes to visit RACFs over the past five years by age (n=335).

Influences to increase visits

Nearly 60 per cent (57.14 per cent) of respondents agreed that the reason they have increased their visits to RACFs is due to an ageing patient profile (Figure 33), while 54.29 per cent attributed this to a sense of obligation, and 48.11 per cent agreed that it was because other medical practitioners were cutting down on RACF visits so there was no one else to do it. Nearly half (45.28 per cent) agreed that their reason to increase visits was because they enjoyed the work.

Meeting qualifying service levels of Aged Care Access Incentive payments was not reported to be a major influence for an increase in RACF visits, with 42.31 per cent strongly disagreeing with this statement.

Some respondents listed other reasons for increasing their visits to RACFs. This includes respondents implementing new business models that specialise in aged care, and providing a 'cradle to the grave' service.

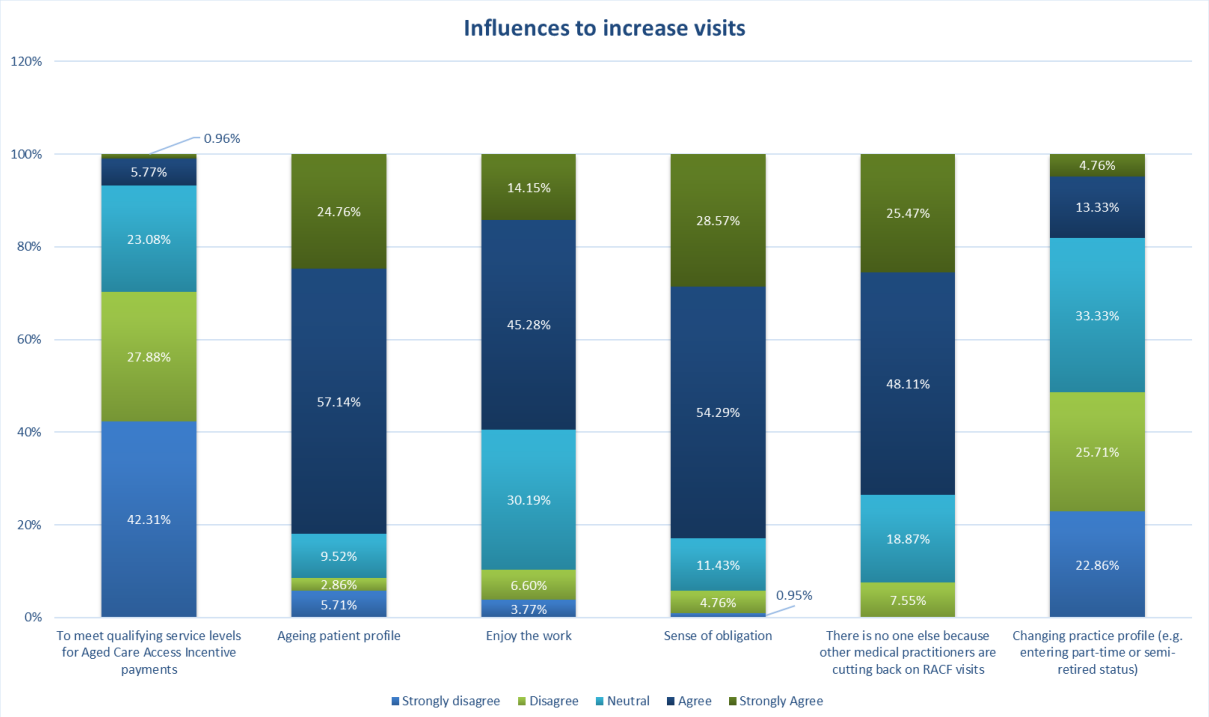

Figure 33: Influences to increase visits to RACFs (n=106).

Influences to decrease visits

Nearly half (48.48 per cent) of respondents agreed that the reason they had decreased their visits to RACFs was because unpaid non-face-to-face time is increasing (Figure 34), while 40.82 per cent agreed that the decrease was due to a too-busy practice. The two reasons that were rated the highest under the 'strongly agree' category include that unpaid non-face-to-face time is increasing (34.34 per cent) and that patient rebates are inadequate and do not compensate for lost time in the surgery (33.33 per cent).

Some respondents reported other reasons for decreasing their visits to RACFs. Most of these reported that they were in the process of retiring, while others reported that the patients who they had visited in the past had died. Other respondents listed specific frustrations around a lack of support from RACF management, Medicare, and the Pharmaceutical Benefits Scheme.

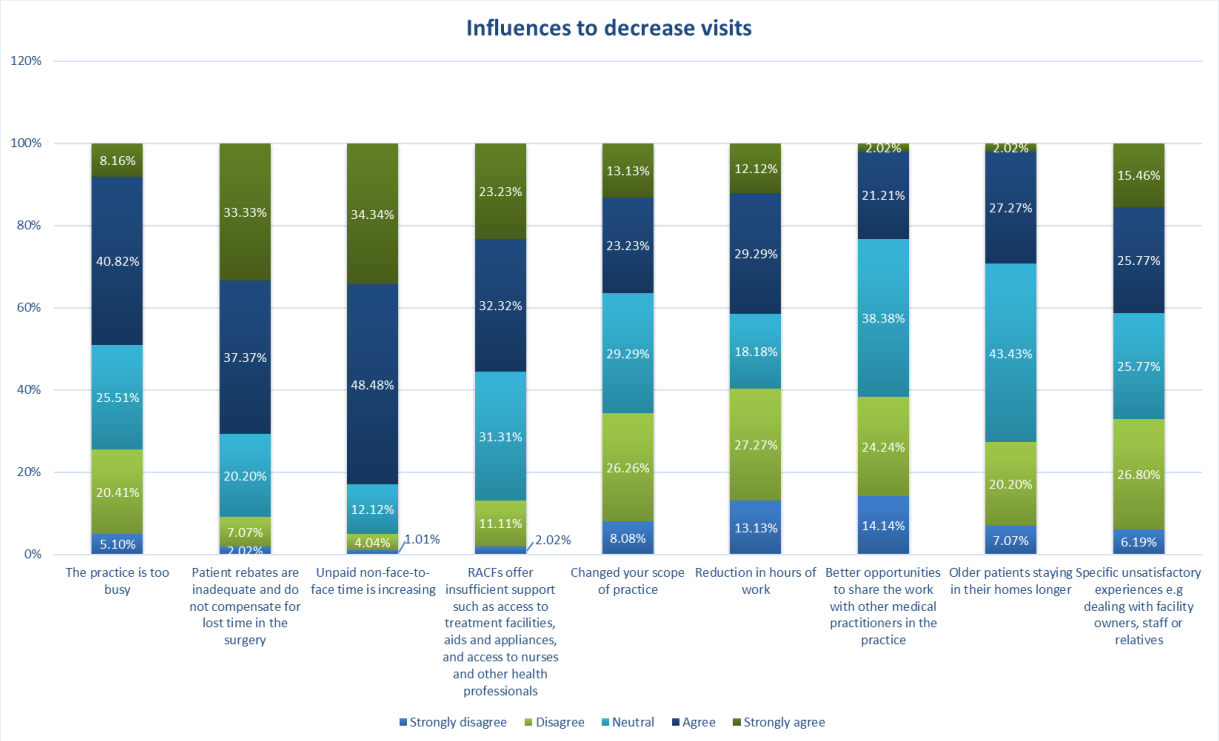

Figure 34: Influences to decrease visits to RACFs (n=99).

Influences to never visit

Similarly, influences to never visit RACFs (Figure 35) are mostly fee-related, with 35.29 per cent strongly agreeing that never visiting RACFs was due to an increase in unpaid non-face-to-face time, and 32.84 per cent strongly agreeing that patient rebates are not adequate and do not compensate for lost time in the surgery.

The highest proportion of responses for other reasons stated were mostly neutral, suggesting there are other reasons for respondents to never visit RACFs. Some respondents listed other reasons for never visiting RACFs, mostly commenting that they work in public hospitals, that they currently do not have any RACF patients, and that they do not have a RACF in their area. Others commented that visiting patients in RACFs was not in their scope of practice.

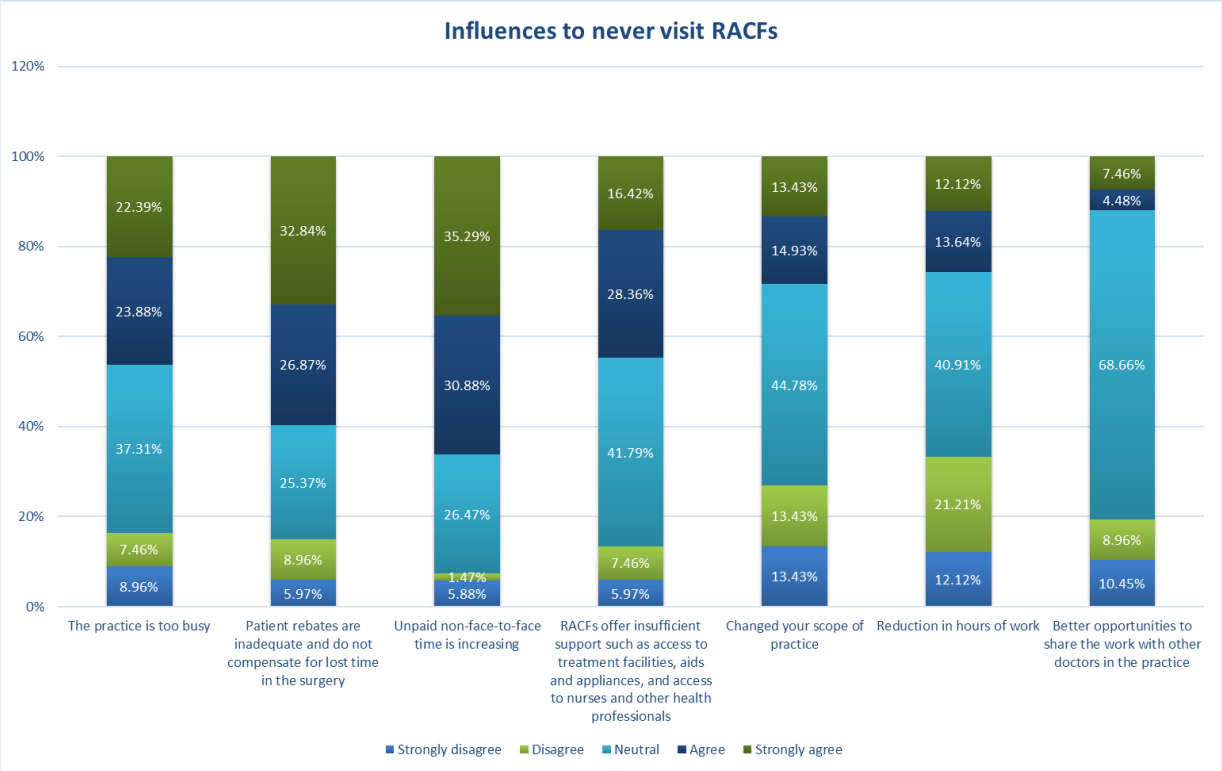

Figure 35: Influences to never visit RACFs (n=68).

Advocating for a better aged care system

Respondents were asked to rate how urgent particular aged care issues were to them in order to help guide AMA advocacy in the future.

In 2015, issues that received the highest proportion of 'urgent' and 'extremely urgent' were:

- increase Medicare rebates to ensure medical practitioners are properly compensated for spending time away from their surgery (56 per cent), and
- improved availability of suitably trained and experienced nurses and other health professionals (50 per cent).

In 2017, these issues were still rated as the most urgent, but 'improved availability of suitably trained and experiences nurses and other health professionals' (65.92 per cent) had overtaken the need for 'increasing funding for medical practitioners' (57.55 per cent). Other highly important issues include:

- improve access to palliative care services (54.10 per cent)
- improve access to mental health services in RACFs (53.17 per cent)
- reduce polypharmacy to reduce the risk of adverse health events in older people (51.23 per cent)
- improve access to specialist care (such as geriatrician, palliative care, psychiatric, renal, cardiac, diabetic) (49.29 per cent).

Figure 33 presents the priorities of respondents for advocating to improve access to medical care in RACFs.

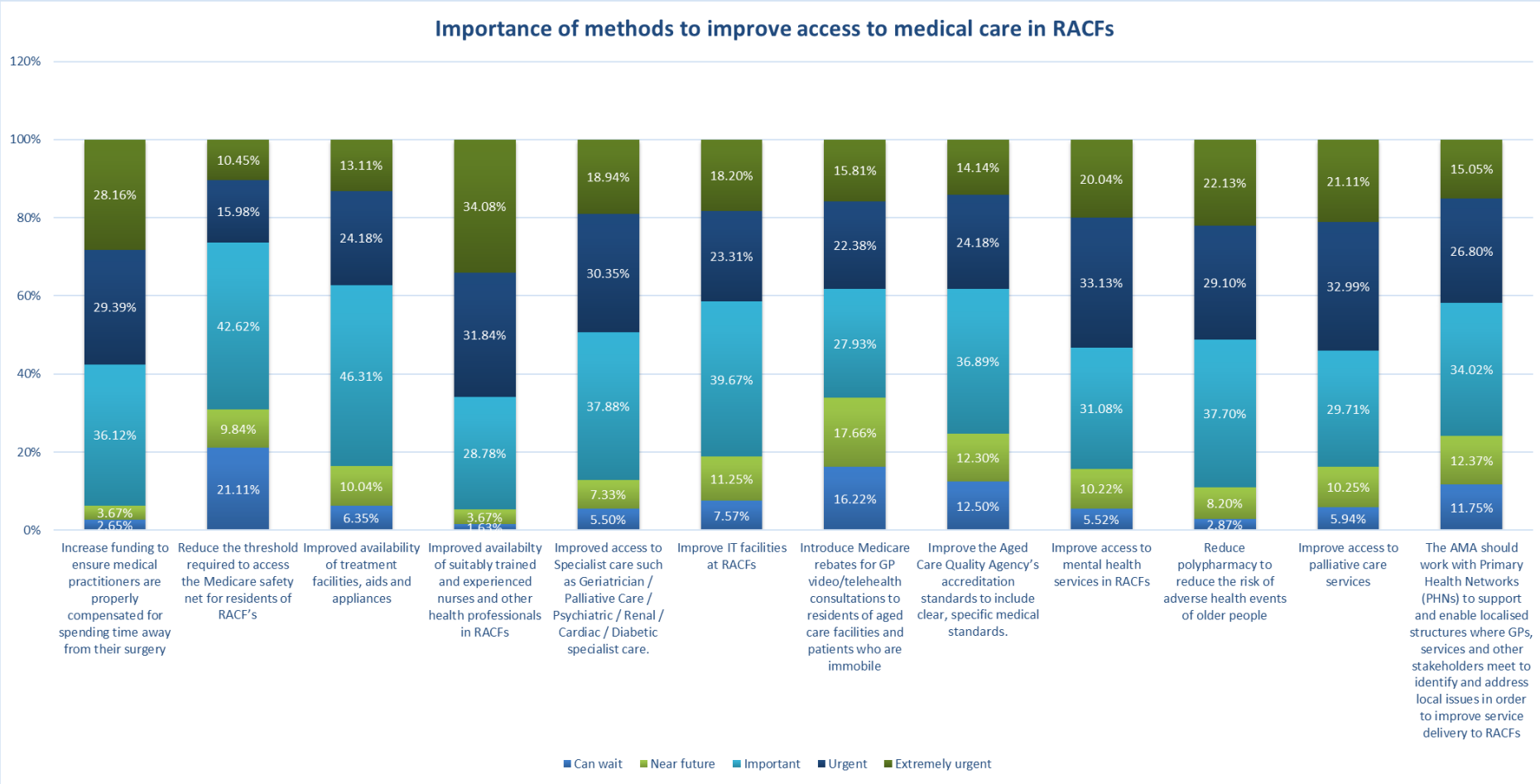

Figure 36: Ranking the importance of issues for future AMA advocacy (n=492).

Discussion

The survey aims to understand the current issues with the aged care system from a medical practitioner perspective. This perspective is important, as medical practitioner-led teams are a key part of the aged care workforce, and access to a regular general practitioner is integral to the health of an older person.

The results of this survey show that there is an urgent need for adequate funding to ensure Australia's ageing population has access to quality medical care through a quality aged care workforce. Respondents have prioritised access to nurses and other health professionals as the most 'urgent' and 'extremely urgent' method to improve access to medical care in RACFs. The proportion of registered nurses in RACFs is in decline[5]. AMA members have been reporting for some time that there is on occasion no nurse available for medical practitioners to carry out a clinical handover, and no nurse available to administer medicine after-hours in RACFs. This poses a serious risk to the health of patients living in RACFs.

For this reason, the AMA calls for a regulated minimum number of registered nurses in RACFs, in line with the care needs of current residents, that are available 24-hours a day. This will ensure older people's medical needs are met in a timely manner, and unnecessary hospital transfers are avoided.

The second priority is to increase funding to ensure medical practitioners are properly compensated for spending time away from their surgery. Respondents listed non-contact time and inadequate financial compensation as major influences to decrease visits, or never visit RACFs, over the past five years. Similarly, most respondents believe that the MBS fee must increase to compensate for the non-contact time spent with patients. Research has shown that unnecessary hospitalisations can be avoided by incorporating primary care services[6]. Older people have a right to obtain the highest achievable level of health, and timely access to a medical practitioner is essential to achieve this.

The survey reinforces the fact that the aged care system is failing older people when it comes to medical access. In the face of an ageing population, with an increasing prevalence of complex chronic conditions, improving the health and care of older people should be a national priority. The AMA calls on the government to urgently act on the multiple issues of the aged care system.

[5]Mavromaras et al (2016) *The aged care workforce, 2016*. Department of Health

[6]Mazza, D et al (2018) *Emergency department utilisation by older people in metropolitan Melbourne, 2008-12: findings from the Reducing Older Patient's Avoidable Presentations for Emergency Care Treatment (REDIRECT) study*. Australian Health Review. 42:181-188

[6]Morphet et al (2015) *Resident transfers from aged care facilities to emergency departments: can they be avoided?*. Emergency Medicine Australasia. 27:5, p412-418

2017
AMA Aged Care Survey Report

Appendix: Survey questions

Welcome to the AMA Aged Care Survey

Thank you for agreeing to complete the AMA 2017 Aged Care Survey. Please only complete this survey if you are an AMA Member.

This survey gives you an opportunity to comment on your experiences with aged care, and better inform our advocacy strategy, our position statements and our submissions. In developing our future advocacy resources, we want to focus our efforts on ensuring that medical practitioners who provide medical care to older Australians are supported, and their needs are highlighted to government.

The survey should take approximately 15 minutes to complete (maximum - there are different pathways depending on your answers to particular questions). Please complete the survey only once.

Your individual response will not be identifiable, however overall survey results will be published – click here to view the AMA's privacy policy.

Demographics

1. What is your gender

- ◯ Female
- ◯ Male
- ◯ Other

2. What is your age?

- ◯ 40 or under
- ◯ Over 40
- ◯ Over 60
- ◯ Over 70

3. What is your specialty area of practice?

4. How many years have you been in practice?

0 50 100

5. State in which your practice is located

- ◯ ACT
- ◯ NSW
- ◯ NT
- ◯ QLD
- ◯ SA
- ◯ TAS
- ◯ VIC
- ◯ WA

6. Location of practice

- ◯ Metropolitan
- ◯ Outer metropolitan
- ◯ Regional
- ◯ Rural
- ◯ Remote

7. Is your practice?:

- ◯ Medically owned
- ◯ Non-medically owned
- ◯ Not sure

8. What size of practice do you work in?:

- ◯ Solo
- ◯ Small group / small partnership
- ◯ Large group / corporatised
- ◯ One of the major corporates

Other (please specify)

9. Have you ever had to organise assessment by an Aged Care Assessment Team (ACAT) for your patients?

- ◯ Yes
- ◯ No
- ◯ Unsure

10. If yes, on average, how long do patients have to wait for initial assessment by an ACAT?

- ◯ <1 week
- ◯ <1 month
- ◯ 1 - 3 months
- ◯ 3 - 6 months
- ◯ > 6 months
- ◯ Unsure
- ◯ n/a

11. Have you had any experiences with the Federal Government'sMy Aged Care?

- ◯ Yes
- ◯ No
- ◯ Unsure

12. If yes, was My Aged Care useful for your patient?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ n/a

In what ways was it useful/not useful?

13. Do you undertake home visits for any patients over the age of 65?

- ◯ Yes
- ◯ No

14. Would you carry out more home visits if more people are able to stay supported at home through an increase in the availability of Home Care Packages?

- ◯ Yes
- ◯ No
- ◯ Unsure

15. Have you ever discontinued a service to a patient (that you usually saw in your practice) once they enter a Residential Aged Care Facility (RACF)?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please tell us why

* 16. Do you visit RACFs to see patients?

- ◯ Yes
- ◯ No

* 17. If you do not visit RACFs to see patients, please indicate which of the following best describes you:

- ◯ Stopped visiting RACFs at some point during the last 5 years
- ◯ Have never regularly visited an RACF
- ◯ Stopped visiting RACF’s more than 5 years ago
- ◯ n/a - I visit RACFs to see patients

Medical Practitioners who visit RACFs

18. How many of your patients reside in RACFs?

0 100 200

19. On average, how many times do you visit an RACF per month?

0 50 100

20. On average, how many patients do you see during a single visit to an RACF?

0 50 100

21. On average, how much time (in minutes) do you spend with each patient seen?

0 100 200

22. On average, how much non-contact time do you spend (in minutes, not including travel time) on each patient seen?

0 250 500

23. Please estimate the average time (including travel) away from your surgery (in minutes) while visiting a RACF

0 250 500

24. Please indicate your predominant practice approach:

- ◯ Regular “clinic” during business hours e.g. 3 or 4 hours duration on a weekly or fortnightly basis
- ◯ Visits in the evening after a full day at the surgery

Other (please specify)

25. What MBS fee increase would be appropriate to compensate for the non-contact time spent on a patient?

- ◯ The current MBS fees are satisfactory
- ◯ Increase by 20%
- ◯ Increase by 50%
- ◯ Increase by 100%
- ◯ Increase by 150%

Other (please specify)

26. Which medical services (not currently funded by the MBS) should attract a specific MBS item number when visiting RACFs or providing medical care for older people in their homes?

27. Do the RACFs you visit have doctor treatment/visiting rooms?

- ◯ Never
- ◯ Rarely
- ◯ Occasionally/sometimes
- ◯ Often
- ◯ Always

28. Please explain what IT facilities would be useful when visiting a RACF that are not currently provided

29. Please rate how important you think the access to these RACF infrastructure items are

	Not important	Low importance	Slightly important	Neutral	Moderately important	Very important	Extremely important
Parking	◯	◯	◯	◯	◯	◯	◯
Easy and safe access to RACFs	◯	◯	◯	◯	◯	◯	◯
Appropriate room/lighting/privacy to examine	◯	◯	◯	◯	◯	◯	◯
Health records communication (between RACFs and practice software)	◯	◯	◯	◯	◯	◯	◯
Internet access	◯	◯	◯	◯	◯	◯	◯

Comments

30. Please rate how difficult it is for your patients to access the following when they need it

	Very difficult	Difficult	Neutral	Easy	Very easy
Mobile X-ray and ultrasound	○	○	○	○	○
Pathology	○	○	○	○	○
Timely nursing care	○	○	○	○	○
Allied Health Professionals	○	○	○	○	○
Secondary support and consultation with specialists	○	○	○	○	○

Comments

31. In your opinion, what level of nursing expertise is required for you to conduct a professionally responsible handover for your patients' care?

32. Do your RACF patients have access to you (as their usual GP) after normal business hours, for example through telephone advice?

- ○ Yes
- ○ No
- ○ n/a – I am not a GP

What are your reasons for providing after-hours care?

33. Do the RACFs you visit have adequate processes in place for you to be able to handover necessary clinical information and instructions relating to your patients' care?

- ○ Never
- ○ Rarely
- ○ Occasionally/sometimes
- ○ Often
- ○ Always

* 34. Over the last 5 years have your visits to RACFs:

- ○ Increased
- ○ Decreased
- ○ Remained relatively constant

Increased number of visits to RACFs

35. If your visits have increased, please nominate the degree to which each of the following has influenced your decision to increase visits:

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
To meet qualifying service levels for Aged Care Access Incentive payments	○	○	○	○	○
Ageing patient profile	○	○	○	○	○
Enjoy the work	○	○	○	○	○
Sense of obligation	○	○	○	○	○
There is no one else because other medical practitioners are cutting back on RACF visits	○	○	○	○	○
Changing practice profile (e.g. entering part-time or semi-retired status)	○	○	○	○	○

Other (please specify)

Decreased number of visits to RACFs

36. If your visits have decreased, please nominate the degree to which each of the following has influenced you:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The practice is too busy	○	○	○	○	○
Patient rebates are inadequate and do not compensate for lost time in the surgery	○	○	○	○	○
Unpaid non-face-to-face time is increasing	○	○	○	○	○
RACFs offer insufficient support such as access to treatment facilities, aids and appliances, and access to nurses and other health professionals	○	○	○	○	○
Changed your scope of practice	○	○	○	○	○
Reduction in hours of work	○	○	○	○	○
Better opportunities to share the work with other medical practitioners in the practice	○	○	○	○	○
Older patients staying in their homes longer	○	○	○	○	○
Specific unsatisfactory experiences e.g dealing with facility owners, staff or relatives	○	○	○	○	○

Other (please specify)

Constant visits to RACFs

37. If you currently undertake regular RACF visits, over the next 2 years, are you likely to

- ◯ Increase the number of visits to RACFs
- ◯ Decrease the number of visits to RACFs
- ◯ Maintain the number of visits to RACFs
- ◯ Stop visiting RACFs
- ◯ Visit current patients, but not visit new patients in RACFs

Please tell us why

Never visited RACFs

38. If you have never visited an RACF, please nominate the degree to which each of the following has influenced you

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The practice is too busy	○	○	○	○	○
Patient rebates are inadequate and do not compensate for lost time in the surgery	○	○	○	○	○
Unpaid non-face-to-face time is increasing	○	○	○	○	○
RACFs offer insufficient support such as access to treatment facilities, aids and appliances, and access to nurses and other health professionals	○	○	○	○	○
Changed your scope of practice	○	○	○	○	○
Reduction in hours of work	○	○	○	○	○
Better opportunities to share the work with other doctors in the practice	○	○	○	○	○

Other (please specify)

Stopped visiting RACFs

39. If you stopped visiting RACFs at some point during the last 5 years, please nominate the degree to which each of the following has influenced you

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
The practice is too busy	○	○	○	○	○
Patient rebates are inadequate and do not compensate for lost time in the surgery	○	○	○	○	○
Unpaid non-face-to-face time is increasing	○	○	○	○	○
RACFs offer insufficient support such as access to treatment facilities, aids and appliances, and access to nurses and other health professionals	○	○	○	○	○
Changed your scope of practice	○	○	○	○	○
Reduction in hours of work	○	○	○	○	○
Specific unsatisfactory experiences e.g. when dealing with facility owners, staff or relatives	○	○	○	○	○

Other (please specify)

40. Please provide your opinion on the general quality of care patients receive from aged care providers

- ◯ Poor
- ◯ Fair
- ◯ Good
- ◯ Very good
- ◯ Excellent

Please tell us why

41. Do you think that having GPs employed by RACFs is beneficial to the patient?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please tell us why

42. Have you identified issues with elder abuse within aged care settings? Please comment on your experiences

(WHO definition of elder abuse: a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person)

43. Do you think the current Aged Care Quality Agency Accreditation Standards are appropriate to ensure quality care to older people?

- ◯ Absolutely inappropriate
- ◯ Inappropriate
- ◯ Slightly inappropriate
- ◯ Neutral/unsure
- ◯ Slightly appropriate
- ◯ Appropriate
- ◯ Absolutely appropriate

Please tell us why

44. To help guide AMA advocacy to improve access to medical care in RACFs, please indicate how important each of the following proposals are to you:

	Can wait	Near future	Important	Urgent	Extremely urgent
Increase funding to ensure medical practitioners are properly compensated for spending time away from their surgery	○	○	○	○	○
Reduce the threshold required to access the Medicare safety net for residents of RACF's	○	○	○	○	○
Improved availability of treatment facilities, aids and appliances	○	○	○	○	○
Improved availabilty of suitably trained and experienced nurses and other health professionals in RACFs	○	○	○	○	○
Improved access to Specialist care such as Geriatrician / Palliative Care / Psychiatric / Renal / Cardiac / Diabetic specialist care.	○	○	○	○	○
Improve IT facilities at RACFs	○	○	○	○	○
Introduce Medicare rebates for GP video/telehealth consultations to residents of aged care facilities and patients who are immobile	○	○	○	○	○
Improve the Aged Care Quality Agency's accreditation standards to include clear, specific medical standards.	○	○	○	○	○
Improve access to mental health services in RACFs	○	○	○	○	○
Reduce polypharmacy to reduce the risk of adverse health events of older people	○	○	○	○	○

	Can wait	Near future	Important	Urgent	Extremely urgent
Improve access to palliative care services	○	○	○	○	○
The AMA should work with Primary Health Networks (PHNs) to support and enable localised structures where GPs, services and other stakeholders meet to identify and address local issues in order to improve service delivery to RACFs	○	○	○	○	○

45. General comments:

End of survey

Thank you for taking the time to complete the AMA Aged Care survey. If you have any further comments, please contact the AMA Federal Secretariat at ama@ama.com.au.