1. I am a Geriatrician based at a Metropolitan Teaching Hospital. I have clinical and administrative responsibilities. In relation to the latter, I am Clinical Director of a Health Service for Older People that provides clinical care in inpatient, ambulatory care, community and residential aged care facility settings, across former Sydney South West Area Health Service (and currently the Sydney and South West Local Health Networks).

2. The Service manages large numbers of patients in acute care, subacute care and ambulatory and domiciliary settings.

3. The staff and services of the Clinical Directorate work in Emergency Departments, Acute Care units, Older Persons Rehabilitation Units, inpatient psychogeriatric units, consultation/liaison roles, Ambulatory Care Clinics, centre based rehabilitation (Day Hospitals), providing rehabilitation, assessment and case management in domiciliary settings, dementia and general day respite centres, in home respite, and carer support.

4. In addition, for residents of local Residential Aged Care Facilities (and the RACF staff and General Practitioners caring for these residents) the Clinical Directorate provides telephone advice and triage, facilitation of hospital admission where admission is required, consultations and interventions within the facilities by expert nurses, Geriatricians and Old Age Psychiatrists, and facilitation of end of life planning and management.

5. The aim of this component of activity is to facilitate the timely access of RACF residents to relevant specialist medical and nursing expertise in the most appropriate setting for care delivery for that resident at that time.

Avoidance of unnecessary Emergency Department attendances and/or Hospital admissions is a secondary outcome.

6. Health Services for Older People of similar structure and scope, but with variable resources, exist in most metropolitan regions of Australia.

Services to rural and remote communities are staffed and structured differently. Some are supported by visiting medical staff, or by Telehealth from metropolitan services.

7. I wish to comment on the draft Productivity Commission Report “Caring for Older Australians” from the above perspective.

8. The draft Report focuses on the future funding of accommodation and support care for older people.

9. In addition, the draft Report proposes a pathway for referral and access to Australian Government Aged Care Services that is relatively inflexible, technology dependent and that fails to differentiate according to the role of the referrer. For example, as proposed, it appears that health professionals with expertise in the care of older people will be required to enter the system at the same point as other referrers.

10. It is appropriate that the provision of accommodation and general support for older people is considered as a separate theme from issues relating to health care services for older people.

11. It is disappointing that the draft Report (including Appendix B – "New Aged Care Model Options") has given so little attention to the health needs of older people. I contend that a chapter on Health care Provision for Older People should be added to the document.

12. Older people require assistance because of disability arising from illness. The majority of people receiving, or in need of, High Level Residential Care have unstable physical health, impaired cognition, significant disability, and limited life expectancy.

13. "More older people are admitted for permanent (residential) care via hospitals than from the community" (AHIW, Movement from Hospital to Residential Care; 26 Nov 2008, Summary p xi).

14. There are high volume flows between Residential Care Facilities, Emergency Departments, Acute care, and Subacute care. While some transfers could be avoided if the health care services available in RACFs were more capable, and advance care planning was undertaken more consistency, many transfers (perhaps the majority) are the only means of accessing the health care that is required by the older person, and these transfers are justified.

15. Interventions must be based on Comprehensive Geriatric Assessment. This is more than matching current needs to available service provision as implied in the Report. Comprehensive Assessment includes formulation of an accurate diagnosis, verification that relevant treatments have been applied and given time to work, identification of potentially modifiable disability, provision of rehabilitation as appropriate, and estimation of prognosis, with the goal of maximising the function and optimising the health of the individual.

16. For the benefit of the individual and the Health Care System patient flows between must be managed efficiently.

17. The funding model for RACF entry should not impede discharges to new RACF care when such a transfer is clinically appropriate. The funding model should not impose

unreasonable burdens on older people and families who are dealing with serious illness, major disability, and limited lifer expectancy

18. The proposed pathway for access should be responsive to the type of referral that will arise form the health service (which will often include detailed clinical information), the timeframes within which the health service must operate, and existing service networks. It is clinically inappropriate to require that all assessments for Australian Government Aged Care Services are conducted in the person's usual home. Recent audits within Metropolitan Sydney have shown that up to 45 % of completed ACCRs are for people who were inpatient at the time of assessment, and that 75% of this group required the ACCR to enable hospital discharge (to access High Level Residential Care, or the Transitional Aged Care Program).

19. Workforce issues need more attention. While General Practice must remain the core provider of medical care to RACF residents within the facility, the current model of General Practice does not meet current, let alone future needs. In many situations, residents, RACF staff and family carers are unsupported.

20. The report should also explore options for enhancing the clinical skills of RACF staff, and the access of these staff to additional clinical expertise.

21. Multidisciplinary domiciliary rehabilitation teams already exist in many regions. The logic of establishing new regional teams, with similar goals, but uncertain clinical governance, for RACF residents only, needs to be questioned. Enhancement of existing teams would be a more appropriate strategy.

I will be pleased to discuss these comments as requested.

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