

OPAN Submission

Aged Care Legislation Amendment (Aboriginal and Torres Strait Islander Aged Care Commissioner and Other Measures): IAT escalation pathway amendment

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Executive summary

OPAN's preferred reform is a direct, authorised clinical override at the point of assessment. An appropriately qualified approved senior assessment service delegate with clinical expertise should be able to depart from an IAT-generated classification or priority outcome when it does not reflect the older person's needs or risks, record reasons and rely on relevant clinical and contextual evidence. Departmental assurance can manage misuse risks through audit and monitoring, without requiring prior approval for each override. Given the Department's evidence at the 24 September 2026 Senate Community Affairs Legislation Committee hearing, the Government should amend the current Aged Care Rules to provide this capacity.

OPAN's central recommendation is direct, reasoned clinical override before the end of 2026. If Schedule 4 proceeds instead, OPAN supports it only as an interim safeguard with the amendments and protections below, with the Rules needing to be released prior to the passage of the Amendments Bill

If the Government maintains that Schedule 4 is the only available pathway, OPAN would regard it as an interim safeguard and support it only with the amendments proposed in this submission. A qualified decision-maker must be able to override an IAT-generated outcome urgently and before the end of 2026. Review and remediation of the IAT's algorithm, underlying decision logic and wider assessment-to-support pathway must continue in parallel, and the Government should immediately release the findings of the rapid review.

OPAN's case material illustrates the practical consequences when IAT-informed outcomes cannot be corrected promptly:

- an older person with extensive dementia-related support needs assigned medium priority while a family carer was severely exhausted;
- an unchanged classification despite recognised deterioration;
- a standard assistive technology priority despite indicators demonstrating the person was at risk; and
- an incomplete telephone assessment that illustrates a gap beyond Schedule 4.

Accordingly, OPAN does not support Schedule 4 as the preferred approach. If it

proceeds, it should be time-limited in effect, monitored closely, independently reviewed at 18 months and reconsidered as part of the three-year review of the Aged Care Act. The Committee should seek the draft Rules before reaching a final view.

About OPAN

The Older Persons Advocacy Network (OPAN) is the national peak body for independent aged care advocacy. Our network comprises nine state and territory organisations that have delivered advocacy, information, and education services to older people across Australia for more than 30 years:

ACT	ACT Disability, Aged and Carer Advocacy Services	QLD	Aged and Disability Advocacy Australia (ADA Australia)
SA	SA Aged Rights Advocacy Service (ARAS)	TAS	Advocacy Tasmania
NSW	NSW Seniors Rights Service (SRS)	NT	Darwin Community Legal Service
VIC	VIC Elder Rights Australia (ERA)	NT	CatholicCare NT (Central Australia)
WA	Advocare (WA)		

OPAN receives funding from the Australian Government to deliver the National Aged Care Advocacy Program (NACAP). OPAN aims to provide a national voice for aged care advocacy and promote excellence and national consistency in the delivery of advocacy services under the NACAP.

The free services provided by OPAN's network members support older people and their supporters to understand and address issues relating to Commonwealth-funded aged care. In 2025–26, OPAN delivered 64,591 advocacy cases. This represents a 23.7% increase from the 52,206 advocacy cases delivered in 2024–25.

OPAN is always on the side of the older person. Its independence from government and service providers is a key strength of both individual and systemic advocacy.

Summary of recommended principles

OPAN recommends that the following ten principles in Table 1 guide the Rules and operating model for any Schedule 4 pathway. Where the Bill can still secure an enforceable right, OPAN maintains the amendments identified below. The second column indicates the primary implementation vehicle.

Table 1: Summary of recommendations

Principle	Primary vehicle
Person-led access: concerns raised by the person, representative, or relevant health professional must receive a prompt, reasoned response.	Rules / operating model
Supported participation: give reasonable time, flexible consent and information in a form the person can understand.	Act / Rules
Timely and risk-responsive correction: enforceable time limits, urgent triage and protection when a deadline is missed.	Act / Rules
Scope follows impact: all material IAT-informed outcomes need an effective correction route.	Act / review
Clinical override and informed human judgment: enable direct, reasoned correction; if Schedule 4 is used, require independent review with relevant clinical, cultural and contextual expertise.	Rules / assurance model
Practical effect and continuity: preserve support and give favourable outcomes effect without avoidable loss.	Act / systems
Coherent review rights: the operative decision must be reviewable and favourable outcomes protected.	Act
Accessible notice and reasons: communicate at every stage through the person's preferred and accessible channel.	Act / Rules
Transparent and co-designed detail: publish and consult on Rules, forms, guidelines and governance before commencement.	Rules / Government
Accountability and redress: review and remediate the IAT, monitor equity and timeliness, evaluate at 18 months, revisit in the three-year Act review and remedy earlier affected decisions.	Government / Rules

OPAN's position

OPAN's preferred pathway is correction at the original decision point. The Rules should authorise an appropriately qualified assessment service delegate to apply professional and clinical judgment, depart from the IAT outcome where the evidence supports it and record reasons. Departmental assurance should focus on retrospective audit, consistency and improvement, not prior approval that delays correction. These recommendations should be read alongside the wider Support at Home reforms OPAN recommended in July 2026.

The immediate safeguard should commence before the end of 2026 and should not wait for the wider reform program. In parallel, the Government should continue to work with peak bodies, older people and relevant stakeholders to review and remediate the IAT's algorithm, underlying decision logic and wider assessment-to-support pathway must continue in parallel. The Government should also immediately release the findings of the rapid review for public scrutiny.

If the Government demonstrates that direct clinical override is not legally achievable, or decides not to support it, Schedule 4 may provide an interim safeguard. OPAN's support is conditional on the proposed amendments and on Rules that make the pathway accessible, clinically informed, timely, fair and equitable. Because the Rules, approved form, guidelines, clinical governance framework and operating procedures are not yet available, OPAN cannot endorse the final framework, at least at a minimum the Rules are tabled.

OPAN's perspective and the test for reform

OPAN supports older people to understand and exercise their rights in aged care. Our assessment and review work shows that a classification on paper does not necessarily translate into timely support, an appropriate priority category or a clear explanation of what to do next. The first question is whether a trained decision-maker can correct an inadequate IAT outcome within the assessment process. If Schedule 4 proceeds as a separate pathway, it is valuable only if an older person can reach it, a reviewer can correct the relevant decision and the correction changes the person's practical position

without avoidable delay.

OPAN assessed the proposed approach against seven questions:

- Why can the outcome not be corrected at the original decision point?
- Who can start the process?
- Which decisions can actually be corrected?
- Can the person understand and participate in the process?
- How quickly must a decision be made where delay creates harm?
- What happens to allocation and funding when a decision changes?
- Can the older person then challenge the operative decision?

The Bill and the absence of draft Rules leave material gaps on each question. Table 2 identifies where later Rules or operational choices could alter the reach of the pathway.

Table 2: Analysis of where later Rules or operational choices could alter the reach of the pathway

Provision	Description of amendment intent	Potential operational issues
90A	Identifies prescribed classification and priority category decisions eligible for additional review.	Why are access, service type and some assistive technology or home modification decisions outside the specified scope? What may Rules further prescribe?
90B	An eligible approved needs assessor may request review in writing with the person's consent, ordinarily within seven days of the decision. Subsections 90B(4) and (5) allow longer periods and extensions.	Why is a separate request needed where a qualified assessor identifies that the IAT outcome does not reflect the evidence? How will concerns be addressed if the assessor does not refer? How will extensions and consent operate?
90C	Sets rejection and withdrawal arrangements, with notice directed to the assessor.	Will the older person receive reasons and an effective way to contest rejection or withdrawal?
90D	The System Governor or an uninvolved departmental delegate conducts the review.	What expertise, independence and access to specialist advice are guaranteed?
90E	Reviewer may affirm, vary or substitute. Subsection 90E(6) permits departure from	Why can comparable discretion not be exercised at the original decision point under the Rules? If Schedule 4 is used, will current evidence, clinical expertise and review-

	ordinary criteria, subject to procedural fairness and review-specific Rules.	specific Rules preserve meaningful discretion?
90F	Requires notice and reasons to the older person and requesting assessor within 14 days after the decision; permits discretionary backdating.	Where is the deadline to decide? Will a favourable change restore waiting time, allocation and access from the original effective date?
90G	Preserves ordinary review of the original decision, adjusts relevant time calculations and protects a more favourable additional review outcome against a less favourable reconsideration outcome.	Can the person seek reconsideration and Tribunal review of the varied or substituted decision itself? Are parallel processes intelligible?

Before relying on a separate escalation pathway, the Committee should ask the Government to identify the precise legal or policy barrier to amending the Rules so that an appropriately qualified assessment service delegate can make a reasoned clinical override. This process was started at the 24 September 2026 Senate Community Affairs Legislation Committee hearing. The supplementary explanatory memorandum describes a multidisciplinary approach and explains the policy intent for Schedule 4, but enforceable guarantees must appear in the Act or Rules. Intent in an explanatory document does not give an older person a right to a specialist review or a decision by a fixed date.

What OPAN advocacy experience shows

OPAN's advocates see what can happen when an assessment outcome does not reflect an older person's circumstances. The cases below concern experiences before the proposed pathway commences. They illustrate the risks a redetermination process should address; they do not show that Schedule 4 would necessarily have changed any individual outcome.

Case 1: High support needs, medium priority

An older person living with advanced dementia received the highest Support at Home classification after assessment, while the associated priority outcome was medium. A family member was providing continuous care and reported severe sleep deprivation. The classification recognised extensive need, but the priority result did not appear to reflect the risk that the caring arrangement could fail.

Why this matters. The preferred response is to enable an appropriately qualified assessor or assessment service delegate to correct the priority outcome at the original decision point and record the reasons. If Schedule 4 is retained, the person, carer, advocate or relevant health professional needs a way to raise the mismatch and receive a prompt response when a direct correction has not occurred.

Case 2: Deterioration recognised but classification unchanged

A provider and an assessor both identified an older person's declining function. Following reassessment, the Support at Home classification remained unchanged. The person faced a gap in essential support and paid privately for some services.

Why this matters. Direct clinical override should allow the decision-maker to use current clinical and functional evidence immediately. If a separate review is required, it must permit fresh evidence, including information from a general practitioner, practice nurse, Aboriginal health worker or other relevant health professional, and give reasons explaining why evidence of deterioration did or did not alter the decision. Access cannot depend entirely on the same uncorrected process that produced the disputed outcome.

Case 3: Assistive technology priority and safety

An older person whose needs were changing rapidly received standard priority for assistive technology/home modifications. An assessor agreed that several indicators in higher priority guidance appeared to apply, but understood the priority outcome to be determined by the assessment system. The resulting wait delayed equipment relevant to the person's safety.

Why this matters. The Rules should first enable a qualified decision-maker to override an IAT-generated priority where current evidence demonstrates a safety risk. If Schedule 4 is used, proposed subsection 90E(6) must preserve meaningful discretion to depart from ordinary classification and priority criteria. Urgent triage must respond to risk identified by the person, assessor, advocate or health professional and must not depend on the priority rating being challenged. A timely correction must also flow through to allocation and access to equipment.

Case 4: A gap in the proposed scope

After a telephone assessment, an older person received approval for limited entry-level domestic assistance that they did not understand or could not use. A later face-to-face visit identified substantial mobility, falls and vision concerns. This case illustrates an assessment and access problem; it does not establish that the IAT generated the initial outcome.

Why this matters for Schedule 4. Schedule 4 does not appear to reach every access or service type decision affected by incomplete assessment information. A separate, prompt route to reassessment and review is needed where the person's access to appropriate services is at issue, even if the additional review is retained only for prescribed decisions.

Process evidence also matters. OPAN network members have reported delays of roughly two to two and a half months even to acknowledge some existing reconsideration applications. That experience concerns the current review system, not the proposed additional review. It shows the risk of creating another process that can delay correction. A properly controlled clinical override should operate within the existing assessment timeframe. If Schedule 4 proceeds, it needs a statutory decision deadline, clear tracking, transparent data and a shorter notification period.

Individual case accounts cannot estimate the frequency of errors or demonstrate that Schedule 4 would have solved past cases. They do show why the system needs both an immediate clinical correction mechanism and formal remediation of the IAT. If the separate review pathway proceeds, the Government must demonstrate a route for the person to be heard, a reviewer able to use current evidence, a deadline matched to risk and a traceable change to allocation and service access. Current data on the volume and causes of disputed IAT-informed outcomes, disaggregated by decision type, and worked examples of both direct override and additional review are essential to determine whether the reforms will achieve their purpose.

The relationship of this amendment with existing review rights

The proposed additional process sits alongside ordinary reconsideration and Administrative Review Tribunal review. Its intended value is specialised correction of a narrow class of decisions, but it is more complex than correcting an inadequate result at the original decision point. If retained, its value depends on speed. Section 90G excludes the additional review period from relevant reconsideration and review time calculations and defers reconsideration requests made during that period. An older person should not have to choose between an expedited clinical check and preserving their ordinary rights, particularly when a short referral window might expire before they understand the reasons for the original decision.

Section 90G requires close scrutiny. As drafted, ordinary reconsideration addresses the original decision and disregards the additional review outcome for that purpose, while a more favourable additional review outcome prevails over a less favourable reconsideration outcome under subsection 90G(4). That protection is welcome, although it is not an absolute protection against a subsequent Tribunal outcome. Ordinary merits review remains available in relation to the original decision; the concern is that the person cannot directly seek reconsideration of the varied or substituted outcome now governing their support. This adds complexity when the new outcome remains inadequate. The notices must make clear which decision has practical effect, which decision can be challenged, and the relevant time limits.

For example, if an additional review increases a person's classification from Level 1 to Level 4 but the evidence supports Level 8, the person needs a review route directed to the operative Level 4 outcome. A direction to challenge only the original Level 1 decision would create needless complexity.

Principles for any Schedule 4 pathway

Important limitation. The Rules, approved form, guidelines, clinical governance framework and operating procedures have not been provided publicly. OPAN's preferred solution remains direct override by an appropriately qualified assessment delegate, supported by Departmental assurance, together with formal review and remediation of the IAT. If the Government does not adopt that approach, the recommendations below state the minimum safeguards expected for Schedule 4.

1. Person-led access and a duty to respond

The Rules and operating model should give the person or authorised representative an effective route to ask an assessor to consider a concern promptly. The assessor should provide written reasons if referral is declined, and the Rules should provide a rapid supervisory review of that refusal. Concerns raised by a relevant health professional with the person's consent should also receive a prompt response. A refusal or rejection must be contestable without the person losing ordinary reconsideration rights.

2. Supported participation and enough time to act

The period for requesting additional review should run from effective communication of the decision, not merely the date it is made. It should allow enough time to understand the decision, obtain advocacy or health advice and give informed consent, with flexible extensions where fairness requires. OPAN continues to recommend at least 14 calendar days from effective notice in the Act. If the Act is not amended, the Rules should prescribe that period and retain flexible extensions. The requirement in subsection 90B(3) for a written request is distinct from how the older person's consent is obtained and recorded. The Rules and approved form should permit documented verbal consent, supported decision making and assistance to complete the request, while preserving the person's informed choice.

3. Timely, risk-responsive correction with a consequence for delay

The Act should impose an enforceable maximum decision period, with a faster urgent stream supported by the Rules. This decision deadline is separate from both the period to request review and the 14-day notification requirement after a decision under section 90F. OPAN considers 14 calendar days after a valid request an appropriate outer benchmark, subject to faster action where health, safety, hospital discharge, carer breakdown or loss of support creates risk. Urgency should be capable of being identified by the person, assessor, advocate or relevant health professional; it must not depend on the existing priority rating that is under challenge. If the decision-maker misses the deadline, the request must remain active and the delay must not entrench the original outcome. The Rules should provide an immediate protective consequence—such as interim support, a temporary uplift or authority for an appropriately qualified assessor or other decision-maker to make an interim adjustment—until a reasoned decision is made. The pathway must permit movement across the full priority spectrum, including escalation to urgent status where the evidence shows an immediate or escalating risk. Relevant indicators of need should operate as alternatives where appropriate, rather than as cumulative hurdles requiring a person to satisfy several unrelated conditions.

4. Scope that follows the effect on the older person

Every material outcome affected by IAT limitations needs an accessible correction route. The Government should explain the exclusion of access and individual service type decisions, relevant assistive technology and home modification classifications, and End of Life and Restorative Care Program decisions. If Schedule 4 remains narrow, the Rules and wider review framework should identify an equally prompt pathway for excluded decisions, and the scope should be reviewed early after commencement using published evidence. The availability of another decision route, or the form of evidence supporting the original decision, should not by itself exclude additional review. End of Life, assistive technology and home modification decisions still require a prompt human correction route where the outcome does not reflect the person's circumstances.

5. Clinical override and independent human judgment

The Rules should first authorise an appropriately qualified assessment delegate to override an IAT-generated classification or priority outcome when the available evidence shows that it does not reflect the older person's needs or risks. The decision-maker should record the evidence, reasons and revised outcome. Departmental assurance should use retrospective audit, pattern monitoring, feedback and training; it should not require prior approval that adds delay. If Schedule 4 is used, the reviewer must be uninvolved in the original decision, able to vary or substitute the outcome and able to depart from ordinary criteria under subsection 90E(6). The process should include appropriate clinical oversight, culturally safe input where required, and consideration of current functional, clinical, social, housing and carer information. Criteria should guide rather than fetter judgment, and should focus on actual needs and risks rather than comparisons with other people or age-based labels.

6. Continuity and practical effect

A pending review must not interrupt an existing classification, priority category or allocation process. A favourable outcome should ordinarily take effect from the original decision date, including for waiting time and allocation, unless that would disadvantage the person. The operating model must trace the outcome through assessment records, priority queues, funding and service or equipment access, with a named accountable contact and a manual safeguard where systems cannot implement the result promptly.

7. Coherent rights to further review

The decision that has practical effect after escalation should be the decision the person can challenge through reconsideration and the Administrative Review Tribunal. A person should not have to challenge an obsolete original decision to seek a more adequate result. The protection under subsection 90G(4) for a more favourable escalation outcome against a less favourable reconsideration outcome should remain, and each notice should explain the operative decision, available review routes and time limits in plain terms.

8. Accessible information, notice and reasons at every stage

Section 90F already requires the final decision and reasons to be sent to the older person as well as the requesting assessor. OPAN seeks equivalent communication throughout the process, including acknowledgement and rejection or withdrawal notices under sections 90C and 90D, with notices also provided to an authorised representative where appropriate. Information must be provided in a way the person can understand and through their preferred communication channel. This includes interpreters, translated and Easy Read material, Auslan, augmentative or alternative communication, large print, telephone or recorded explanation where appropriate, and supported decision making. Notices should include reasons, relevant dates, the practical effect of the decision, advocacy contacts and review rights.

9. Transparent, co-designed Rules and governance

The Government should publish draft Rules, the approved form, System Governor guidelines, the clinical governance framework and operational procedures before commencement and consult with older people, peak bodies, assessors, clinicians, relevant health professionals, disability and communication experts, and First Nations organisations. The Rules should state whether and how a direct clinical override will operate. If the Government rejects that approach, it should publish its legal and policy reasons. The Rules must not narrow Schedule 4 to an undefined class of 'exceptional' cases. Worked examples should show consent, urgent triage, evidence, specialist input, allocation and review rights from beginning to end.

10. Public accountability, independent evaluation and redress

Schedule 4 pathway should be monitored from the first identified mismatch to actual support. Quarterly reporting should cover the volume and reasons for overrides, assurance findings, referrals declined, requests accepted, rejected or withdrawn, outcomes affirmed or changed, time from concern to decision and implementation, missed deadlines, subsequent review activity, and demographic and regional patterns with privacy safeguards. A formal independent review of the IAT should drive continuing

corrective work on the tool and the wider assessment-to-support pathway after the urgent override mechanism is in place. An independent effectiveness review at 18 months should test whether the correction arrangements are accessible, equitable, timely and effective, and recommend whether Schedule 4 should continue, be amended or be sunset. The issue should be revisited as part of the three-year review of the Aged Care Act.

Where the reforms need to sit

The Government should first identify whether the current Act permits the Rules to authorise a direct, reasoned clinical override. If it does, the Rules should specify who may exercise the override, the evidence and reasons required, how the older person participates, how the result takes effect and how Departmental assurance will operate. Guidance can support training and consistency, but should not turn the override into a prior approval process. If the Act prevents this approach, the Government should identify the provision and amend it.

If Schedule 4 proceeds, core rights that determine whether the person has an enforceable remedy should remain in the Act where amendments are achievable. The Rules must then give practical effect to those rights through flexible evidence and consent, supported decision making, accessible communication, urgent triage, interim protection when a deadline is missed, specialist input and the content of notices. Because the supporting material is unavailable, OPAN's recommendations describe the minimum outcomes the complete framework must achieve rather than endorsing an unseen mechanism.

Making a decision effective in practice

A favourable review can be of little use if it changes only an entry in the assessment record. The person needs to know the revised classification or priority category, its effective date, whether their place in an allocation queue changes, whether additional funding becomes available and who will arrange the next step. The Department should show the Committee a worked example of each main decision type, tracing a changed review outcome through allocation to services or equipment.

OPAN's earlier submission to the Senate Community Affairs Legislation Committee on Support at Home² also recorded advocates' difficulty tracing favourable reconsideration outcomes into the My Aged Care portal and increased funding. That is evidence from a different review pathway, but it identifies a concrete implementation risk for Schedule 4: a legally corrected classification must be transmitted to the allocation and payment systems and confirmed to the person. The Government should identify the agency responsible for each handoff and the maximum time allowed.

For urgent cases, the operating model should specify immediate risk triage, a named contact and an interim protection plan. It should show how the safeguards in principle 3 operate when a deadline is missed.

Worked decision notices should demonstrate the accessible communication required by principle 8, including how the evidence, reasons, effective date and further review rights will be explained to the person.

These protections matter for people in regional and remote areas and for Aboriginal and Torres Strait Islander older people, who may face additional barriers to specialist evidence, service availability or culturally safe assessment. The Bill should require appropriate cultural expertise where relevant. A changed priority cannot manufacture an unavailable local service; monitoring must therefore include the time from decision to actual allocation or commencement, not just the time to issue a notice.

An accountable route from decision to support

A best practice operating model should start with correction at the original decision point and, if Schedule 4 is retained, follow the person through the entire escalation process to actual support.

Table 3: Operating model for correction and implementation

Stage	Required action	Accountable lead
Assessment and original notice	Apply professional judgment; use an authorised clinical override where the IAT outcome does not reflect need or risk; record reasons; give the decision, effective date, escalation and reconsideration rights, and advocacy information in an accessible form.	Assessment service delegate / Department
Concern and triage	If no direct correction occurs, record concerns from the person, representative, advocate or relevant health professional; acknowledge them; assess urgency independently of the disputed priority rating; give reasons for any refusal to refer.	Department / assessor
Human review	Obtain current evidence and relevant specialist input; hear the person; decide within the enforceable period; preserve allocation and apply protective action if the deadline is missed.	System Governor or delegate
Apply outcome	Update the assessment record, priority queue and funding instructions; notify the person and provider; explain backdating and the expected date support can start.	Department / Services Australia
Further challenge	Explain the operative decision, the reconsideration and Tribunal options, time limits and access to funded legal help where needed.	Department / review body

The operating model should specify responsibility and maximum handoff times, including a manual workaround if digital systems cannot promptly implement a favourable outcome.

Equal access to the pathway

The ordinary seven-day request period in subsection 90B(4), running from the decision rather than effective communication, will particularly burden people who receive late or inaccessible notices, use a language other than English, need an interpreter or communication support, rely on supported decision making, are in hospital, live in rural/remote areas, or cannot quickly obtain clinical evidence. Subsections 90B(4) and (5) already provide for longer periods and extensions. These powers should operate flexibly for delayed or inaccessible notice, support needs and difficulty obtaining evidence, without requiring proof of an exceptional crisis. The Department should provide practical assistance at the time of notice and during the request period.

For Aboriginal and Torres Strait Islander older people, the reviewer should offer culturally safe communication and expertise appropriate to the person's circumstances, including community-controlled input where the person wants it. In regional and remote areas, remote review may help with speed but cannot replace a face-to-face assessment when the home environment or functional risk needs to be observed. The older person's choice about who supports them, and consent to share personal information, must be respected. Where geography or service delivery conditions mean a classification cannot purchase the services required to meet assessed needs and keep a person safely at home, the system must provide an equitable response. The concern should not be dismissed solely because it arises from the cost of service delivery.

Evaluation should examine whether these access arrangements work equitably, using the reporting and qualitative evidence described below.

Evidence and accountability after commencement

Quarterly reporting should distinguish the number of IAT-informed decisions, direct clinical overrides, potentially eligible Schedule 4 decisions, concerns raised and additional reviews requested. Without those denominators, a low volume may reflect either few problems or an inaccessible correction mechanism. Reporting should record who identified the concern; the reason for each override and assurance outcome; whether an assessor referred or declined an escalation; extensions, rejection and

withdrawal reasons; time from concern to decision, notification and implementation; favourable and unfavourable outcomes; missed deadlines and protective actions; effective dates; subsequent reconsiderations and Tribunal applications; and time until allocation or service delivery.

Data should be published by decision type, geography and remoteness, age, gender, Aboriginal and Torres Strait Islander status, cultural and linguistic background, communication and disability needs, and other relevant cohorts, subject to privacy and statistical reliability. Quantitative reporting should be supplemented by qualitative work with older people, advocates, assessors and health professionals. The Government should urgently commence and publish the formal IAT review, a time-bound remediation plan and regular progress reports on corrective work.

The Government should also publish its method for identifying potentially affected decisions made before 11 January 2027. A prospective correction process does not remedy earlier outcomes. A proactive program should set out an audit method, outreach and reassessment process, treatment of earlier waiting time and a route to remedy avoidable disadvantage.

At 18 months after commencement, an independent review should evaluate both direct clinical override, if implemented, and Schedule 4. It should examine accessibility, equity, timeliness, decision quality, outcomes, assurance findings and whether the IAT has been effectively remediated, and should recommend whether Schedule 4 continues, is amended or is sunset. Schedule 4 should not be sunset until a direct and accessible correction mechanism is demonstrably operating. The role of clinical override and Schedule 4 should then be reconsidered as part of the three-year review of the Aged Care Act.

Conclusion

Given the evidence provided by the Department at the 24 September 2026 hearing, OPAN does not agree that Schedule 4 is the preferred or sufficient response. OPAN's preferred response remains an appropriately qualified direct assessment delegate override at the original decision point, supported by urgent formal review and remediation of the IAT. The Government should explain why the current Rules cannot authorise an appropriately qualified assessor or assessment service delegate to depart from an IAT-generated outcome, with recorded reasons and Departmental assurance oversight.

However, if the parliament decides to proceed with the escalation pathway OPAN will continue to work with Government and the Parliament to ensure it operates as appropriate escalation with broad enough consideration to consider real life needs and nuance of the older persons situation and needs.

If the Government maintains that Schedule 4 is the only available pathway, OPAN would regard it as a first step only and support it only with the amendments proposed in this submission and Rules that establish a fair and equitable process. Schedule 4 must not be treated as the final solution. It must be closely monitored, independently reviewed at 18 months and revisited in the three-year review of the Act. A right to a corrected decision is meaningful only when the person can reach the pathway, participate in it, obtain a timely and reviewable outcome, and receive the resulting support before avoidable harm occurs.

OPAN member organisations by state or territory:



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