OPAN | Older Persons Advocacy Network

OPAN Submission

WHO Global Standards for Long-Term Care for Older People

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Core proposition

The global standards should establish a common rights-based framework across health, social care and long-term care. Older people must retain authority over everyday decisions and receive the support they need to exercise their rights, wherever they live and however their health or functional ability changes. Quality should be judged by whether those rights are respected in practice, as well as by access, safety and clinical outcomes.

Executive summary

The Older Persons Advocacy Network (OPAN) strongly supports the World Health Organization's development of the first global standards for long-term care for older people. The consultation draft provides an important foundation for governments to build long-term care systems that are rights-based, person-led, integrated, adequately financed and accountable.

OPAN particularly welcomes the draft's explicit recognition of statutory rights, supported decision-making, independent complaints mechanisms, independent advocacy across residential, home-based and community-based settings, public entitlements, financial protection, continuity across care transitions and the direct measurement of the experience of people receiving care.

OPAN's principal recommendation is to make human rights the organising framework for the standards. Rights must guide every service, funding decision and interaction with an older person. They include everyday control over routines, relationships, privacy and meaningful activities, alongside access to services, protection from abuse and effective remedies. A rights-based system supports the person to make decisions, including decisions others regard as risky, and acts when rights are restricted.

OPAN's Australian advocacy experience provides an implementation lens. Rights commitments need accessible processes, adequate services and financing, independent oversight and staff who are supported to uphold the older person's decisions. Assessment rules, service availability, care routines, charges and transitions can each determine whether the person retains control in practice.

OPAN therefore recommends that the global standards place greater emphasis on the full pathway from need to outcome. Monitoring should show not only the quality of services received, but also who is waiting, who is excluded, who is unable to activate approved support, who declines or reduces services because of cost, whose review outcome is not implemented, and whose health or living situation deteriorates while support is delayed.

Priority recommendations

- Place human rights and the older person's decision-making authority at the centre of every standard, including everyday care and system governance.
- Build a common set of rights-based requirements across all settings and sectors, supported by independent advocacy, complaints, review and remedies.
- Measure unmet need and access failure, including waiting, service non-commencement, provider refusal, cost-related reduction or refusal of care, and people receiving less support than assessed need.
- Set and monitor expectations for timeliness from first contact through assessment, decision, service commencement, reassessment, review, appeal and provision of assistive technology and home modifications.
- Recognise equal legal capacity and make supported decision-making available to everyone who wants or needs it, without using a capacity threshold as a gateway to autonomy.
- Require public financing to make rights and entitlements deliverable, including the enabling infrastructure required for quality care.
- Broaden equity requirements beyond income and geography and require disaggregated monitoring and targeted action for groups experiencing structural disadvantage.
- Clarify that 'the right place' is determined with and ultimately by the older person, with genuine options, decision support and periodic review.

- Strengthen accountability at transitions and interfaces so that responsibility is not transferred to the older person or family when systems do not coordinate.

- Treat assistive technology, home modifications, rehabilitation and allied health as integral to participation, including support to adapt when function declines.

- Protect older people from financial harm, including cumulative out-of-pocket costs, and monitor forgone or reduced care caused by contributions and charges.

- Require complaints, advocacy and incident intelligence to be analysed together and used for systemic quality improvement and public accountability.

About OPAN and the purpose of this submission

Formed in March 2017, the Older Persons Advocacy Network (OPAN) is Australia's national peak body for individual aged care advocacy. Through nine state and territory network organisations (see table below), OPAN delivers free, independent advocacy, information and education under the National Aged Care Advocacy Program. Our work supports older people to understand and exercise their rights, access appropriate government-funded aged care services and resolve concerns about their care. OPAN's systemic advocacy draws on frontline advocacy experience, engagement with older people through the National Older Persons Reference Group and collaboration across the aged care system.

Jurisdiction	OPAN network member
Australian Capital Territory	ACT Disability, Aged and Carer Advocacy Service (ADACAS)
New South Wales	Seniors Rights Service
Northern Territory (Top End)	Darwin Community Legal Service
Northern Territory (Central Australia)	CatholicCare NT
Queensland	Aged and Disability Advocacy Australia (ADA Australia)
South Australia	Aged Rights Advocacy Service (ARAS)
Tasmania	Advocacy Tasmania
Victoria	Elder Rights Australia
Western Australia	Advocare

This submission is primarily concerned with whether the proposed global standards will enable older people to exercise rights in real-world long-term care systems. OPAN supports standards that are ambitious enough to drive rights-based reform while remaining adaptable across countries with different levels of system maturity and resources.

OPAN draws on advocacy experience to identify how system rules and provider practices affect the exercise of rights. Australian examples in this submission illustrate issues that can arise in different long-term care systems; the recommendations are intended to be adaptable across national contexts.

A common rights framework across all settings

OPAN supports the breadth of the draft, but recommends changing its organising structure. WHO should bring the system responsibilities now addressed in Chapter 7 forward, immediately after the foundational concepts, and frame them as building and governing a rights-based long-term care system. Rights, accountability, equitable access and the relationships between systems should guide the service, carer, workforce, financing and monitoring standards that follow.

A common set of requirements should apply across home, community and residential settings: autonomy, everyday decision-making, privacy, relationships, community participation, access to healthcare, supported decision-making and responses to rights breaches. Setting-specific provisions should explain how to implement these requirements. Moving between settings or programmes must not reduce the person's rights.

Residential settings and everyday rights

Residential settings require explicit safeguards because daily routines, personal care, medicines, staffing and physical environments can either support rights or restrict them. WHO should address physical, chemical and environmental restraint; access to visitors and private relationships; privacy and communication; meaningful daily activity and food and fluid choices; access to primary, specialist, allied health, rehabilitation and palliative care; and the person's preferences for end-of-life care. These protections should apply alongside rights common to home and community care.

Providers should ask residents what they want to maintain or adapt when health or function changes, including their nutrition, hydration, routines and meaningful activities. People living with dementia or other cognitive impairment should receive communication and decision support, and should be asked privately about their experience where possible. Cognitive impairment must not be treated as a presumption that others should decide.

The next step is to make the standards more explicit about what happens when the system does not work as designed. A rights-based standard should ask: Can the person enter the system without digital, literacy, language or cognitive barriers? Is the assessment timely and fair? Does the person receive written reasons? Can they seek review? Does the review occur before harm is caused? Is the approved service actually available? Can the person afford it? Is essential equipment delivered in time? Can the person access independent advocacy without permission from the provider? If a transition fails, who is responsible for fixing it? These questions should be visible throughout the standards.

Clarify scope and core concepts

WHO should clarify that the standards concern older people, including people ageing with disabilities acquired earlier in life, and recognise that some populations experience age-related health and care needs earlier than conventional chronological age thresholds. This may include people experiencing homelessness and people living with HIV or chronic conditions. Eligibility and access should respond to functional ability, circumstances and support needs, rather than rely solely on chronological age. WHO should also explain how the standards relate to younger people requiring long-term care and ensure continuity at age-related programme boundaries. Dignity and autonomy remain essential whenever health or functional ability declines.

OPAN recommends WHO adopt a cross-cutting implementation test

For each standard, identify the right or entitlement, the responsible actor, the practical pathway for the older person to exercise it, the time expectation, the review or redress pathway where it fails, and the outcome measure that demonstrates whether it works in practice.

Use person-level and pathway-level measures alongside provider and system measures.

Require data on non-access and unmet need, not only quality among those who successfully receive services.

Rights must be operational and enforceable

OPAN welcomes the draft's recognition of rights, including Standard 28. However, rights protection should shape the whole framework, rather than depend on a later governance chapter or be understood mainly as prevention of detention, restraint, abuse and neglect. Core concepts should explain human rights as inherent to every person and applicable regardless of age, disability, health, care needs or living arrangement.

The existence of a right is not equivalent to the ability to exercise it. People may face cognitive or communication barriers, limited digital access, language barriers, fear of reprisal, poor understanding of the system, family conflict, provider dependence or an urgent deterioration in health. Rights therefore need an operational pathway.

WHO should require systems and providers to recognise everyday rights, support people to exercise them, identify restrictions and provide timely remedies. Accessible information, supported decision-making, independent advocacy, review, appeal, complaints and protection against retaliation are complementary ways to achieve this. Safeguarding should address human rights breaches, including abuse and neglect, without treating every breach as identical or overlooking routine restrictions.

Everyday rights and ageism

Rights-based care includes deciding when to get up, what to eat and wear, who to see, how to maintain intimate relationships, how to practise culture or faith, and which activities are meaningful. Privacy, communication and community access should not depend on staff convenience or family approval. WHO should include practical examples of providers supporting these decisions, and of routine practices that breach rights.

The standards should explicitly address ageism in policy, assessment and care delivery. Assumptions that older people cannot learn, decide or benefit from healthcare can restrict access and autonomy. Systems should identify these assumptions through education, supervision, direct feedback and review of rules and practices.

Dignity of risk and autonomy

The starting point must be the older person's authority to make decisions, including decisions involving risk. Providers should help people understand options, communicate their wishes and pursue what matters to them. Risk management should support those choices, rather than require a person to secure exceptional permission from staff or family. Any proposed restriction requires a specific justification, consideration of less restrictive alternatives and access to challenge and review.

Autonomy and supported decision making

OPAN supports strengthening Quality Statement 28.4 and applying it throughout assessment, everyday care, treatment, finances, complaints and decisions about where to live. The framework should recognise the person's equal legal capacity and make decision support available according to their wishes and communication needs.

Supported decision-making assists the person to understand, make and communicate their own decisions while retaining decision-making authority. Access to support and respect for autonomy must not depend on passing a capacity test. Age, diagnosis, disability, dementia, communication difficulty or an unconventional decision must not be used to assume that another person should decide.

WHO should distinguish rights-based care from labels such as "person-centred care" or "shared decision-making" that may be used without transferring actual authority to the older person. A person may choose to deliberate with professionals or others, but this does not transfer authority to them. A person-led service must demonstrate that the older person's will and preferences direct decisions. Self-managed funding is one possible arrangement, not a measure of rights in itself; people must receive rights-respecting care whether or not they wish or are able to administer a budget. Where domestic law still permits substituted decision-making, WHO should require safeguards and review, while directing systems towards supported decision-making and equal recognition before the law. Existing legal arrangements should not be presented as the preferred model.

Consent and decision support

Informed consent is essential to safeguards against unwanted treatment, but must not become a capacity-based gateway to everyday choice, choosing a supporter or receiving decision support. Supported decision-making should enable the person's own decision, rather than operate as an alternative to asking what the person wants. WHO should distinguish these matters from treatment and privacy safeguards, which should be implemented through accessible information, communication assistance, time and support for the person's decision.

The iSupport training component on supported decision-making in the consultation draft (line 2467) should be removed or rewritten. Its current wording conflates best interests with a person's will and preferences. Replacement material should explain how supporters help a person express and act on their own will and preferences, without substituting another person's view of best interests.

Family members and unpaid carers should participate in care planning and personal decisions only where the older person chooses their involvement. Their presence must not be assumed, and their views must not displace the person's own. Every care plan should be developed with the older person, with support adapted to their communication needs; involvement should not be reduced to a discretionary indicator. Where the person reports pressure or fear, or there is a risk of coercion, abuse or overprotection by a relative, they should be able to speak privately with a trusted worker or independent advocate and receive support in their own right.

Ageing in the right place

OPAN supports the draft's attempt to move beyond an assumption that remaining at home is always the preferred or safest outcome. However, the phrase 'the right place' risks being interpreted as a professional or system judgement. The standard should clarify that the right place is determined with and ultimately by the older person, with access to supported decision-making and genuine choices. Resource scarcity or service unavailability should not be reframed as evidence that another setting is 'right'.

Independent advocacy throughout the care pathway

OPAN strongly welcomes Quality Statement 28.3, which recognises independent advocacy and support across residential, home-based and community-based settings. The draft also recognises the power imbalance between people receiving care and the institutions that provide and fund it, and calls for advocacy to be independent from providers and commissioning parts of government.

Quality Statement 28.3 already provides a valuable basis for independent advocacy across settings. OPAN recommends strengthening its implementation so that people can obtain advocacy at decisions, delays, transitions and disputes, before harm occurs. Advocacy should help the person exercise their own authority and should sit alongside the responsibilities of governments and providers to uphold rights in every interaction.

The global standard should therefore require advocacy information and access at predictable points of risk: initial assessment; disputes about eligibility or classification; reassessment; care planning; service commencement delays; provider refusal; changes or reductions in service; financial hardship or debt; assistive technology and

home modification delays; transitions; complaints; safeguarding concerns; review and appeal; and provider closure or exit.

For people with cognitive impairment, sensory impairment, communication needs, low literacy, low digital confidence, language barriers, trauma histories, limited informal support or fear of reprisal, passive information provision is often not enough. Warm referral and outreach advocacy should be available where the person's circumstances indicate that they may otherwise be unable to exercise their rights.

> **Australian experience and global application**
>
> OPAN's Support at Home policy work identifies decisions, service delays, disputes, financial hardship and transitions as points at which advocacy may prevent harm. The global implication is that countries should provide timely, direct and independent advocacy at defined stages of the pathway, with outreach adapted for communication, cognitive, language, cultural and digital barriers. The test is whether people can reach advocacy when they need it, not simply whether a service exists.

Access assessment navigation and timeliness

Standards 1 and 2 are central to whether a long-term care system functions for older people. OPAN supports accessible entry, comprehensive assessment, personalised care planning, care coordination and timely home and community-based services. These standards should include clearer requirements for procedural fairness and timeliness.

A person should be able to enter the system through accessible digital and non-digital channels. Assessment should occur within defined time expectations that reflect urgency. Decisions about eligibility, level of support or service scope should be explained in accessible language and accompanied by written reasons. A person should be able to request reassessment when needs change and seek internal review and independent external appeal when they disagree with a decision.

The system should also measure the time from approval to actual service commencement. Approval without a provider, workforce, equipment or service pathway does not meet the person's need. Where delays create an immediate safety or health risk, systems should provide interim or urgent support.

> **Australian implementation lesson: review and correction mechanisms must themselves be timely**

Issue demonstrated: Assessment, reassessment and administrative review.

OPAN advocacy evidence has identified cases in which older people have waited extended periods for reassessment or review, and situations where administrative review pathways risk becoming an additional barrier rather than an effective safeguard.

Systemic implication: Global standards should measure acknowledgement, allocation, decision and implementation times for reviews and reassessments, not simply whether a review mechanism exists.

Home and community-based care Assistive Technology-Home Modifications and maintaining functional ability

OPAN supports timely home and community services, assistive products and home modifications as practical means of exercising rights. Healthy ageing and functional ability should not become tests of a person's worth or the success of their care. People whose function declines should be supported to adapt activities, use assistance and pursue meaning, relationships and autonomy, including when restoration is not possible.

The standard should make the relationship between assistive technology and home modifications (AT-HM), allied health, rehabilitation and ongoing support more explicit. Access may depend on assessment and prescription, correct fit or installation, training, repair, maintenance and timely follow-up. A funding model that pays for an item but not the professional input required to use it safely does not deliver the intended outcome.

WHO should also require systems to distinguish between low-risk items that can be accessed quickly and complex interventions that require professional assessment. Excessive assessment requirements for simple items can introduce unnecessary delay, while inadequate clinical input for complex equipment can create safety risks.

Australian advocacy example - faulty installation and remediation

Issue demonstrated: AT-HM quality, repair and accountability.

> An older person had a bidet installed through their aged care package, but the installation was faulty and later required plumbing work costing more than $700. After the person attempted to resolve the issue directly, advocacy intervention resulted in the provider agreeing to reimburse the cost.
>
> Systemic implication: Standards should address not only access to an item, but also correct installation, warranties, responsibility for repair and remediation when poor installation causes cost or safety consequences.

Meaningful participation and access to healthcare

Social connection should reflect relationships and activities the person values. The standards should avoid treating prescribed social contact as an outcome in itself. People should be able to choose participation, privacy or time alone without losing opportunities or being labelled uncooperative. Support should address transport, communication, cultural connection and access to the wider community in every setting.

People receiving long-term care should have timely access to healthcare, including primary care, oral health, mental health care, rehabilitation and palliative care according to their needs and preferences. Responsibilities should be integrated even where the same organisation or worker delivers health and social support. Information exchange alone does not establish integrated care.

Equity, cultural safety and inclusion

OPAN supports Standard 22 but recommends broadening its conception of equity. Income and geography are important, but equitable access also depends on culture, language, disability, cognitive status, gender, sexuality, housing security, digital access, social support, remoteness and experiences of discrimination or trauma.

The standards should explicitly require countries to identify population groups experiencing poorer access or outcomes, collect appropriately disaggregated data and take corrective action. National averages can conceal severe local or cohort-specific inequities.

Indigenous older people

OPAN recommends more explicit recognition of Indigenous older people in the global standards. Long-term care systems should be required to support culturally safe, community-led models, recognise the continuing effects of colonisation and

institutional harm, and enable the participation of Indigenous organisations and older people in governance, service design and evaluation.

In the Australian context, this includes explicit attention to Aboriginal and Torres Strait Islander older people, access to culturally safe assessment and services, the role of Aboriginal community-controlled organisations, trauma-aware and healing-informed approaches, and the need to ensure that financial and administrative rules do not compound disadvantage.

Language and communication access

Accessible information should mean more than plain language in the dominant language. Systems should provide qualified interpreters, translated information, accessible formats, Easy Read where appropriate, screen-reader compatible content and communication support. The quality of care should include whether a person can understand the information required to make a decision.

Financing affordability and protection from hardship

OPAN strongly supports Chapter 6. The draft makes an important connection between financing and the reality of rights and entitlements. A service cannot be treated as an effective entitlement where the public financing is insufficient to deliver it, where the person cannot find a provider, or where out-of-pocket charges lead the person to decline necessary care.

Standards 19 and 24 should therefore require transparent assessment of whether the financing envelope is sufficient to deliver the defined entitlement and quality expectations. Funding should account for complexity, geography, communication support, cultural safety, workforce costs and the additional cost of delivering services in rural and remote areas.

OPAN also strongly supports financial protection. Long-term care often involves ongoing costs over many years. Contribution policies should consider cumulative exposure, protect a minimum level of disposable income and ensure that hardship mechanisms are simple, accessible and timely. Where possible, hardship protection should be applied automatically through existing income information rather than requiring people in distress to navigate a complex application.

Quality monitoring should include whether people refuse, reduce or delay care because of cost. A system can appear financially sustainable while shifting unmet need onto households, unpaid carers, hospitals or residential care.

> **Australian advocacy example - debt and service reduction**
>
> Issue demonstrated: Debt, affordability and continuity of essential support.
>
> A 65-year-old Aboriginal client with complex care needs and recent hospital presentations was told they had incurred more than $2,700 in debt and had services reduced from four days per week to one. Advocacy resolved the debt, restored services and supported reassessment to a higher classification.
>
> Systemic implication: Financial rules and budget administration can create immediate harm when debt or overspend leads to reduced care for a person with high or changing needs.

Coordination transitions and system responsibility

OPAN strongly supports Standard 29 and the draft's recognition that fragmented systems transfer navigation burden onto older people and families. Coordination should be treated as a system responsibility rather than an individual skill.

At transitions, one organisation should have clear responsibility for ensuring that essential support is in place. This is particularly important when an older person is moving between hospital and home, home and residential care, short-term and ongoing support, or long-term care and adjacent health, disability, housing or social protection systems.

Transitions should preserve essential support and the older person's authority over decisions about their life. Information should follow the person through privacy-respecting arrangements that explain what is shared, with whom and why, and support the person to make and communicate choices. A named organisation should coordinate the transition, resolve gaps and ensure that the receiving support is ready. Monitoring should capture service gaps, unwanted moves, extended hospital stays and other consequences of failed transitions.

Importantly, language used to describe these problems should not imply that older people are responsible for system congestion. Where a person is medically ready to

leave hospital but cannot return home safely because services, equipment, modifications or provider capacity are unavailable, this is a system design and service availability issue.

Support unpaid carers without assuming their availability

Assessment should establish whether the older person wants a carer's involvement and whether that person is willing and able to provide the proposed support. A family member, neighbour or community must not be treated as a guaranteed source of unpaid care. People without informal support must have equitable access to formal care and decision support. Older spouse and partner carers should be recognised as a distinct group who may be managing their own health, mobility, social connection and financial needs while providing care.

Carers should be offered a separate, proportionate assessment of their health, wellbeing, social connection, willingness, capacity, financial and employment impacts and support needs, repeated when circumstances change. They should have access to flexible, timely planned and emergency respite before crisis and during care transitions, as well as accessible and voluntary training and capacity-building. Support for a carer must not replace the older person's formal entitlement or transfer inappropriate clinical responsibilities to unpaid or community carers. Family members can also be a source of coercion, abuse or overprotection; services should provide the older person with private access to support and advocacy, identify risk, provide alternatives and safeguard rights while addressing the carer's needs.

Accountability complaints review and redress

OPAN supports Standards 27, 28 and 32. Effective accountability requires several complementary pathways: the ability to raise a concern directly with a provider, independent complaints handling and investigation, regulatory oversight, administrative review of eligibility or funding decisions, access to external appeal where appropriate, and independent advocacy.

These pathways should operate as a coherent system. An older person should not be required to identify the correct agency before their concern is heard. A no-wrong-door approach should allow concerns to be referred to the responsible body without requiring the person to start again.

Complaints processes should have defined response timeframes, accessible communication, protection against reprisal, reasons for outcomes and a clear path for escalation or review. Independent advocacy should be available before and throughout the process, and the use of advocacy should never be treated as adversarial conduct or as a reason to alter access to care.

Regulators should draw on complaints, advocacy and incident intelligence to identify patterns of risk. Individual matters often reveal failures that administrative performance data cannot see. Aggregated advocacy data can identify emerging issues earlier, provided confidentiality and the independence of advocacy organisations are protected.

Older people's participation in governance must be meaningful and consequential

OPAN strongly supports the draft's requirements for stakeholder participation. Participation should be resourced, accessible, continuous and capable of influencing decisions. It should not be limited to one-off consultation or to a small group of designated representatives.

Older people should participate in the design, reform, monitoring and evaluation of long-term care systems. Participation mechanisms should include accessibility support, language access, remuneration or expense support where appropriate, and feedback showing how input affected the final decision.

The perspectives of older people, families and unpaid carers are all important but should not be collapsed into a single 'consumer and carer' voice. Where views differ, the older person's will and preferences must remain central to decisions about their own care.

Equip and protect the workforce to uphold rights

Workforce standards should require practical training in everyday rights, ageism, supported decision-making and recognition of rights breaches, alongside clinical competence. Supervision and risk systems should enable workers to support the older person’s choices and proportionate risk-taking. Workers need clear escalation routes and protection from retaliation for raising concerns or supporting rights-respecting practice. Training should address dementia, communication support, restrictive practices, meaningful daily life and end-of-life care in residential settings.

WHO should explicitly include whistleblower protections in Quality Statement 17.3. Staffing, supervision and organisational policies should allow workers to spend time understanding the person and supporting their decisions. Respecting autonomy and enabling meaningful lives should be recognised as central to rewarding, high-quality care work.

Safety standards should require prevention of abuse and neglect and action on every occurrence. The phrase “avoidable harm, neglect and abuse” should be revised so that it cannot imply an acceptable category of unavoidable abuse or neglect. Safety measures should assess rights restrictions as well as clinical risks.

Measure what matters to older people

OPAN supports Chapter 8 and particularly the inclusion of care recipient experience as a core quality measure. However, the proposed quality monitoring framework should be expanded beyond the quality of services received to include whether people can access those services in the first place.

A mature long-term care monitoring framework should follow the older person's experience from first contact to outcome. It should show where people are waiting, where assessment or review stalls, where approved services do not commence, where providers refuse referrals, where care is reduced because of cost, where AT-HM is delayed, where transitions fail and where support arrives too late.

Quality measures should ask older people whether they feel in control of their lives, whether everyday choices are respected and whether support enables what is meaningful to them. Accessible direct reporting should complement clinical and administrative indicators. A completed consent form or a recorded care-planning meeting is not sufficient evidence of autonomy.

WHO should consider a core set of indicators covering:

- unmet long-term care need, including among people not yet receiving formal services;
- time from first contact to triage, assessment, decision, approval and first service;
- time to reassessment and review, and time to implement a favourable review outcome;
- provider refusal, service non-commencement and service discontinuity;
- AT-HM and allied health waiting times, including time to delivery, installation and repair;
- care declined, reduced or delayed because of cost and the outcomes of hardship applications;
- support to maintain or adapt functional ability, pursue meaningful activities, sustain chosen relationships and remain in the preferred setting;
- everyday rights, control over decisions, access to decision support, privacy and freedom from unwanted restrictions;
- access to independent advocacy, complaints and review pathways and outcomes;
- failed or delayed hospital and care transitions and related health outcomes; and
- disaggregated outcomes by population group, geography and other equity dimensions.

The draft appropriately describes its indicative measures as developmental. OPAN recommends using the consultation period to strengthen the balance between input/process measures and outcome measures. The ultimate test should be whether older people receive support that enables them to live with dignity, autonomy, safety, connection and control.

Conclusion

The final standards should establish a common rights-based foundation for long-term care across settings and its interfaces with health and social care. Older people should retain authority over their lives and receive practical support to exercise their rights, including when they live with declining function or require extensive assistance.

WHO should make these expectations visible in each standard, with clear responsibilities, adequate resources and measures of lived experience. Access, affordability and timely support remain essential: a nominal entitlement cannot enable autonomy where services are unavailable or unaffordable.

Independent advocacy, effective complaints and review mechanisms are important supports for this framework. They complement the everyday responsibility of governments, providers and workers to respect the person's will and preferences and correct rights breaches.

The final global standards should enable countries to answer a simple question: when an older person needs long-term care and support, can they obtain the right support, at the right time, in the place they choose, in a way they can understand and afford, while remaining in control of their own life?

Appendix A: Recommendations by standard

Appendix A is the consolidated recommendations schedule. It translates the priority recommendations in the executive summary and the detailed arguments in the main submission into standard-specific amendments. The entries are organised using WHO's draft numbering solely to aid consultation; they do not indicate endorsement of the present sequence. Appendix B provides proposed quality-statement wording and indicative measures for selected recommendations. The common rights framework proposed by OPAN is intended to apply across all 34 standards.

WHO standard	Recommended strengthening
Entry, assessment and care coordination	Add defined timeframes, accessible digital and non-digital entry, dementia-capable assessment, supported decision-making, advocacy, reasons for decisions, reassessment, review and appeal; monitor the full pathway to service commencement. Explicitly report acknowledgement, allocation, decision and implementation times for review and reassessment; provide reasons, independent appeal and urgent interim care.
Supporting independent living at home	Retain timeliness and AT-HM; add urgent/interim support, allied health and rehabilitation links, low-risk fast pathways, maintenance/repair and unmet-need measures. Monitor the full AT-HM pathway from identified need through installation, effective use, repair and replacement, including adverse outcomes of delays.
Community-based health services	Strengthen responsibility across primary care, hospital, allied health, rehabilitation, palliative care and medicines; monitor failed interfaces and access to specialist care.
Social support and community participation	Measure meaningful participation and social connection from the person's perspective; include transport, technology, language and cultural connection.
Respect for fundamental human rights	Broaden beyond admission and restraint to privacy, relationships, movement, communication, advocacy, participation, food and fluid choices, security of tenure, freedom from reprisal and daily rights in residential care.
Adequate service provision	Require timely access to clinical, specialist, allied health, oral health, rehabilitation and palliative care as needed; measure outcomes, continuity and end-of-life preferences, not only care plans.

WHO standard	Recommended strengthening
Safe and empowering environments	Explicitly include dignity of risk, proportionate risk enablement, least restrictive practice, resident access to visitors, meaningful daily life and individual routines.
Transparency and accountability	Require accessible information on fees, rights, advocacy, complaints, staffing, quality and provider responses to identified problems.
Early identification and needs assessment - unpaid carers	Assess carer willingness and capacity separately, including older spouse and partner carers; reassess wellbeing and support needs over time; do not assume family care or reduce formal entitlement because a carer is present.
Respite care	Require flexible, timely planned and emergency respite across settings and transitions, before crisis, with choice, cultural safety and safeguards against involuntary or de facto permanent placement.
Education and skills training - unpaid carers	Make training and capacity-building voluntary, accessible and available to unpaid and community carers; prevent transfer of inappropriate clinical responsibility to families.
Social protection and financial security - unpaid carers	Retain income, pension and employment protections and monitor gender and socioeconomic impacts.
Engagement and recognition - unpaid carers	Involve unpaid carers only where the older person chooses; provide decision support and preserve privacy; distinguish the older person's voice from the carer's own needs and rights.
Workforce competencies and training	Include rights, ageism, supported decision-making, dementia, communication, cultural safety, trauma, safeguarding, restrictive practices, nutrition, complaints, advocacy and end-of-life care.
Staffing and workload	Require measurable staffing adequacy based on need and acuity; monitor missed care, continuity and workloads that undermine person-led care and everyday rights.
Working conditions, well-being and rights	Retain strong worker protections and link workforce stability with continuity and quality for older people.
Supervision, teamwork and accountability	Strengthen escalation, handover, whistleblower protection and learning from complaints and advocacy intelligence; protect workers who support rights-respecting choices.
Workforce profile considerations	Add workforce diversity, language capability, cultural safety, disability inclusion and rural/remote distribution.

WHO standard	Recommended strengthening
Coverage of entitlements	Require explicit, understandable entitlements backed by sufficient financing and clear responsibility where programs overlap. Publish entitlements and assess whether financing delivers them in practice.
Needs-oriented allocation	Base eligibility on functional ability and support need rather than diagnosis/prognosis alone; avoid cliffs; include reasons, review, appeal and monitoring of excluded need.
Shared responsibility	Clarify continuing public responsibility; prevent cost-shifting to older people and families; do not assume unpaid care.
Equity	Broaden beyond income and geography; require disaggregated monitoring and corrective action for groups experiencing structural disadvantage, including Indigenous older people, with explicit recognition of older Aboriginal and Torres Strait Islander people in the Australian context.
Financial protection	Protect against cumulative costs, simplify hardship, prohibit denial/interruption of essential care due to inability to pay, and measure forgone care. Use capacity-to-pay contributions, simple timely hardship arrangements and prevent interruption of essential care while hardship is determined.
Adequacy and quality alignment	Require transparent testing of whether funding can deliver entitlements and quality, including complexity, rural costs and communication/cultural needs.
Regulatory framework	Require enforceable rights, transparent eligibility and appeal, older-person participation, operational review and assessment of administrative burden/unintended effects.
Licensing and registration	Make provider information meaningful and require continuity plans for closure, suspension or market exit.
Oversight and enforcement	Ensure independent, adequately resourced oversight across home/community and residential care; use complaints and advocacy intelligence.
Rights protection	Retain and strengthen independent advocacy across all settings; embed access throughout the care pathway; strengthen supported decision-making, review, appeal and remedies. Provide direct independent advocacy without provider permission, with sufficient resourcing, outreach, routine referral at key decisions and use of de-identified advocacy intelligence for oversight.

WHO standard	Recommended strengthening
Coordination across sectors and levels of government	Require named responsibility at transitions, no-wrong-door navigation, continuity of essential support, respect for the person's chosen destination and monitoring of failed or delayed transitions.
Quality measurement and data systems	Add unmet need, waits, non-commencement, provider refusal, financial hardship, rights, autonomy, function, social participation, advocacy and review or appeal outcomes. Report provider refusal, non-commencement, cost-related forgone care and downstream harm in monitoring.
Inspection and assessment	Require private, accessible engagement with older people, communication support or advocacy, home and community oversight, and follow-up that tests lived improvement.
Complaints and feedback	Require no-wrong-door complaints, advocacy, timeframes, reasons, escalation and review, protection from reprisal and systemic analysis.
Quality improvement	Include older people, carers and advocates in improvement priorities and require system-level action where failures are structural.
Public transparency and accountability	Provide accessible, current information on quality, staffing, complaints, enforcement, fees and service scope; transparency must not substitute for regulation.

Appendix B: Proposed wording and measures

The proposed amendments below should be read with OPAN's recommendation to restructure the standards around a common rights framework. Current quality statement numbers are retained as consultation locators. This appendix presents OPAN's proposed wording and measures, rather than reproducing the WHO draft text. It is a selected drafting schedule, not a review of every quality statement.

Standard 1. Entry assessment and care coordination

QS 1.1 Accessible entry to services

Proposed wording

People who may need home- and community-based long-term care can obtain clear, accessible information and enter the long-term care system through multiple digital and non-digital pathways, with assistance, supported decision-making and independent advocacy available where needed.

Proposed indicative measures

Input: Multiple accessible entry channels, including non-digital channels, are formally established. Process: People identified as needing navigation or decision support are offered supported decision-making and/or independent advocacy. Output: Proportion of requests reaching assessment without repeat referral or redirection. Outcome: People who need long-term care can identify, enter and progress through the system regardless of disability, language, literacy, digital access or availability of family support.

QS 1.2 Comprehensive needs assessment

Proposed wording

People seeking home- and community-based long-term care receive a timely, comprehensive and proportionate assessment of health, functional ability, social circumstances, risks, resources, support networks, will, preferences and goals, with communication support, supported decision-making and independent advocacy available where required.

Proposed indicative measures

Process: Median and 90th percentile time from request/referral to completed assessment, stratified by urgency and population group. Output: Proportion of assessments documenting the person's goals, preferences and participation. Outcome: Assessed need is consistent across population groups and accurately reflected in approved support.

QS 1.3 Personalized care planning

Proposed wording

People eligible for home- and community-based long-term care have a care and support plan developed with them, in accordance with their will, preferences and goals, that clearly states agreed outcomes, funded or available supports, responsibilities, contingency arrangements and review points.

Proposed indicative measures

Process: All plans are developed with the older person and appropriate decision support; monitor the proportion meeting this requirement. Family, supporters or advocates participate where the person chooses their involvement. Output: Proportion of plans that identify responsibilities, service commencement expectations and review triggers. Outcome: People report that their plan reflects what matters to them and can be changed when their circumstances or preferences change.

QS 1.4 Care coordination

Proposed wording

People receiving home- and community-based long-term care have a named point of coordination who is responsible for helping them activate, coordinate and review supports across providers and sectors, including resolving gaps and escalating delays where services do not commence as planned.

Proposed indicative measures

Process: Proportion of people with a named coordinator/contact and documented escalation pathway. Output: Rate of unresolved service gaps or failed referrals after assessment. Outcome: People experience continuity across providers and are not required to coordinate fragmented systems themselves.

Standard 2. Supporting independent living at home

QS 2.1 Timely and responsive services

Proposed wording

People receive approved home- and community-based long-term care within timeframes proportionate to urgency and risk, and services respond promptly when needs change. Interim or urgent support is available where delay would create a foreseeable risk to health, safety, functional ability or living arrangements.

Proposed indicative measures

Input: National or subnational time expectations from assessment/approval to first service, including urgent pathways. Process: Median and 90th percentile time to first service and to service change after reassessment. Output: Proportion commencing within the relevant timeframe. Outcome: Deterioration, hospital use or loss of preferred living arrangement associated with delayed service commencement.

QS 2.4 Home modifications and assistive devices

Proposed wording

People have timely access to assessment, prescription where required, provision, fit or installation, training, maintenance, repair and replacement of home modifications and assistive products that support functional ability, adaptation to changing needs, safety, autonomy, communication and chosen social participation.

Proposed indicative measures

Process: Time from identified need to assessment, approval, delivery, installation and effective use, stratified by urgency and complexity. Output: Proportion of identified AT-HM needs met within defined timeframes; proportion of low-risk items accessed through streamlined pathways. Outcome: Unmet AT-HM need; person-reported impact on independence, participation and ability to remain in the preferred setting; adverse events caused by delay or faulty installation.

Standard 5. Respect for fundamental human rights

QS 5.1 Ethical admission

Proposed wording

Admission to, continued residence in, and exit from a long-term care facility are based on the older person's free and informed decision, with accessible information and supported decision-making provided as required. Any departure from the person's will

and preferences must have a clear legal basis, be necessary and proportionate, use the least restrictive alternative, and be subject to independent review and safeguards.

Proposed indicative measures

Process: Proportion of admissions documenting the person's own decision, communication and decision support offered and provided, and any chosen supporter or family involvement; proportion of involuntary admissions or restrictions subject to independent review. Outcome: Residents report that they chose the setting and understand their rights to review, leave or change arrangements.

QS 5.2 Freedom from restraint and coercion

Proposed wording

Long-term care facilities prevent and eliminate the use of restraint and coercion for behaviour management, staff convenience or organisational control. Any restrictive intervention used in an immediate emergency is a last resort, least restrictive, time-limited, documented, clinically and legally justified, communicated to the person and subject to prompt independent review, with a plan to prevent recurrence.

Proposed indicative measures

Output: Rate, duration and reason for physical, chemical and environmental restraint, disaggregated by cognitive status and other relevant characteristics. Outcome: Reduction in restrictive practices and person-reported freedom, safety and autonomy.

Standard 8. Transparency and accountability

QS 8.1 LTCFs are accountable to residents and their families

Proposed wording

Long-term care facilities are accountable first to residents for the quality, safety and rights-respecting nature of care. Residents participate in decisions affecting them and in service governance, have accessible complaint and advocacy pathways, and may involve family, supporters or representatives in accordance with their wishes and legal rights.

Proposed indicative measures

Process: Proportion of residents offered participation in governance and informed about advocacy/complaints. Outcome: Residents report influence over decisions and freedom to raise concerns without reprisal.

Standard 9. Early identification and needs assessment

QS 9.2 Comprehensive assessment

Proposed wording

Identified unpaid carers, including older spouse and partner carers, are offered a separate, proportionate assessment of their needs, health and well-being, capacity, willingness, social connection, financial and employment impacts, risks and preferences, distinct from assessment of the older person's long-term care entitlement. Assessment is repeated when circumstances change and linked to timely, flexible planned and emergency respite.

Proposed indicative measures

Outcome: Carer-reported burden, well-being, social connection and willingness, including outcomes for older carers; proportion of care plans relying on unpaid care that has been freely agreed; access to planned and emergency respite before crisis.

Standard 13. Engagement and recognition

QS 13.1 Partners in care

Proposed wording

Health and social care providers recognise unpaid carers as partners where the older person wishes this, while maintaining the older person's authority, privacy, will and preferences. The older person is supported to decide who is involved and what information may be shared. Providers respect these decisions and protect privacy; a supporter does not acquire authority to decide for the person.

Proposed indicative measures

Outcome: Older people report control over who is involved in their care; carers report receiving information within the boundaries chosen by the older person and applicable privacy safeguards.

Standard 19. Coverage of entitlements

QS 19.1 Defined public entitlement

Proposed wording

Older people have a clear, publicly defined entitlement to long-term care services and supports, including the enabling supports necessary to use those entitlements, and public financing is sufficient to make the entitlement deliverable in practice.

Proposed indicative measures

Output: Gap between assessed/approved entitlement and services actually received. Outcome: Unmet need after eligibility/approval and time to activation of entitlement.

QS 19.2 Coordination across publicly financed programmes

Proposed wording

Where long-term care needs are met through multiple publicly financed programmes, governments establish no-wrong-door coordination, clear responsibility for interfaces and continuity of entitlement so that older people do not lose access or repeat assessments because of programme boundaries.

Proposed indicative measures

Process: Rate of cross-program referrals requiring repeat assessment or causing service gaps. Outcome: Unmet need attributable to programme boundaries.

Standard 20. Needs-oriented allocation

QS 20.1 Needs-based assessment for eligibility

Proposed wording

Eligibility for long-term care is determined through transparent, accessible and consistently applied assessment of functional ability, support need, risk, circumstances, goals and preferences, and is not restricted solely by diagnosis, prognosis, age cut-offs or categorical programme rules.

Proposed indicative measures

Output: Reasons for ineligibility by criterion and population group. Outcome: Unmet need among people found ineligible; successful review/appeal rates.

QS 20.2 Graded benefits across severity and settings

Proposed wording

Benefits increase progressively with assessed need and are portable across appropriate care settings, with safeguards against abrupt eligibility or funding cliffs and with sufficient flexibility to support the arrangement that reflects the person's will, preferences and goals.

Proposed indicative measures

Output: Distribution of benefit levels relative to assessed need; frequency of unmet need at benefit boundaries. Outcome: Ability to remain in preferred setting.

QS 20.3 Periodic review of eligibility benefits and contributions

Proposed wording

Eligibility, benefit levels and contribution rules are reviewed periodically at system level and can be reassessed promptly for an individual when needs, circumstances or preferences change, with accessible review and appeal rights.

Proposed indicative measures

Process: Time to reassessment and review; outcome: proportion of changed-need cases with timely adjustment.

Standard 21. Shared responsibility

QS 21.2 Capacity-aligned contributions

Proposed wording

Contributions by individuals and households are progressive and aligned with capacity to pay, protect a minimum standard of living, and do not assume that family members are available or obliged to provide unpaid care or financial support.

Proposed indicative measures

Outcome: Effective contribution rate by income; financial hardship; care forgone due to required contributions.

Standard 22. Equity

QS 22.1 Income-related contributions and co-payments

Proposed wording

Individual contributions and co-payments are progressive, transparent and capped so that they do not cause financial hardship or deter, delay or reduce access to necessary long-term care.

Proposed indicative measures

Outcome: Care declined, delayed or reduced because of contributions; out-of-pocket spending by income group.

QS 22.2 Geographic equity of entitlements

Proposed wording

Older people have equivalent long-term care entitlements and reasonable access to services regardless of where they live, supported by financing and commissioning

arrangements that address additional costs, workforce constraints and service availability in rural, remote and underserved areas.

Proposed indicative measures

Outcome: Waiting, provider availability and unmet need by geography.

Standard 23. Financial protection

QS 23.1 Protection from catastrophic costs

Proposed wording

Older people and households are protected from catastrophic and cumulative long-term care costs through clear limits on required payments over time and protection of income and assets necessary for an adequate standard of living.

Proposed indicative measures

Outcome: Incidence of catastrophic LTC spending and cumulative out-of-pocket burden.

QS 23.2 Protection for those with limited resources

Proposed wording

Older people are not excluded from, or required to reduce or interrupt, essential long-term care because of inability to pay. Financial hardship protections are timely, simple and proactively applied where possible, with essential services maintained while eligibility for relief is determined.

Proposed indicative measures

Process: Time to hardship decision and administrative steps required. Output: Service reductions/suspensions during hardship assessment. Outcome: Unmet need and adverse events associated with inability to pay.

Standard 24. Adequacy and quality alignment

QS 24.1 Funding adequate to deliver quality standards

Proposed wording

Public and other system funding is demonstrably sufficient to enable providers to meet adopted quality standards, deliver defined entitlements and sustain the workforce, with adequacy reviewed against cost, demand, unmet need and outcomes.

Proposed indicative measures

Input: Transparent costing methodology. Outcome: Relationship between funding adequacy, service availability, workforce stability and unmet need.

Standard 25. Regulatory framework

QS 25.3 Eligibility and entitlements

Proposed wording

Eligibility criteria and entitlements are clear, accessible and consistently applied through transparent assessment, with written reasons for decisions, information about independent advocacy, and timely internal review and independent external appeal.

Proposed indicative measures

Output: Proportion of decisions accompanied by reasons and review/appeal information. Outcome: Review/appeal timeliness and overturn rates; unmet need pending review.

QS 25.4 Periodic review and reform of the regulatory framework

Proposed wording

Regulatory frameworks are periodically reviewed with structured participation by older people, carers, workers and advocates, using evidence on outcomes, unmet need, administrative burden, unintended consequences, complaints, appeals and implementation experience.

Proposed indicative measures

Outcome: Documented regulatory changes responding to operational evidence and lived experience.

Standard 27. Oversight and enforcement

QS 27.1 Regular inspection across settings

Proposed wording

All registered or licensed long-term care providers are subject to regular, risk-informed and, where appropriate, unannounced external inspection across residential, home and community settings, informed by complaints, incidents, advocacy intelligence and direct engagement with older people.

Proposed indicative measures

Process: Inspection coverage and use of unannounced/risk-triggered inspections across settings. Outcome: Time from serious signal to regulatory assessment.

QS 27.5 Channels for concerns and complaints

Proposed wording

Older people, families, unpaid carers, workers, advocates and others can raise concerns directly with the regulator through accessible channels without first exhausting provider processes, with protection against retaliation, clear triage and escalation, and feedback on action taken where appropriate.

Proposed indicative measures

Process: Time to triage serious concerns; proportion of channels accessible in multiple formats/languages. Outcome: Confidence in reporting and protection from reprisal.

Standard 28. Rights protection

QS 28.1 Statutory recognition of rights

Proposed wording

The rights of older people who need or receive long-term care are recognised in law or formal policy and are supported by enforceable duties, accessible information, supported decision-making, independent advocacy, complaints, review, appeal and effective remedies. Rights of families and unpaid carers are recognised without displacing the older person's rights, will and preferences.

Proposed indicative measures

Outcome: Rights-related complaints and remedies; person-reported control over everyday routines, relationships, privacy and decisions; freedom from retaliation.

QS 28.3 Advocacy and support across settings

Proposed wording

All older people who need or receive long-term care have timely, direct access to independent advocacy across residential, home and community settings throughout the long-term care pathway, including assessment, care planning, service changes, transitions, financial hardship, complaints, review and appeal. Advocacy is structurally

and operationally independent from providers and from bodies whose decisions may be challenged, is accessible to people with cognitive, communication, sensory, language or digital barriers, and is sustainably resourced according to population need.

Proposed indicative measures

Input: Independent advocacy is established and sustainably resourced across settings and jurisdictions. Process: Routine information and warm referral to advocacy at defined decision points; direct access without provider permission. Output: Coverage, reach, waiting time and uptake by population group and pathway stage. Outcome: Older people report increased ability to understand options, participate in decisions, challenge decisions and obtain remedy; aggregated advocacy intelligence contributes to systemic improvement.

QS 28.4 Legal capacity and supported decision-making

Proposed wording

Older people have equal recognition before the law and access to the information, communication assistance, time and decision support needed to make and communicate their own decisions in accordance with their will and preferences. Access to decision support and respect for autonomy do not depend on a capacity threshold. Cognitive impairment, disability, diagnosis or communication difficulty does not by itself justify substituted decision-making. Systems work towards supported decision-making. Where domestic law permits substituted decisions, these arrangements are tightly constrained, subject to independent safeguards and periodic review, and directed by the person's known will, preferences, values and rights.

Proposed indicative measures

Process: Access to supported decision-making and communication support. Output: Use and duration of substituted decision-making arrangements. Outcome: Older people report participation and control over decisions; reduction in decisions made without the person's involvement.

Standard 29. Coordination across sectors and levels of government

QS 29.1 Coordination across sectors and levels of government

Proposed wording

Governments establish accountable cross-sector coordination among health, long-term care, housing, disability, social protection and other relevant systems, with no-wrong-door access, clear interface responsibilities, privacy-respecting information sharing that supports and gives effect to the person's decisions and mechanisms to resolve gaps that would otherwise fall to older people or families.

Proposed indicative measures

Outcome: Referrals lost or repeated across sectors; unmet need attributable to interface failure.

QS 29.2 Continuity across care transitions

Proposed wording

At every transition between long-term care, health and other relevant services or settings, a named organisation or professional is accountable for coordinating the transition, confirming that essential services, medicines, equipment, information and follow-up are in place, and escalating gaps before responsibility is transferred.

Proposed indicative measures

Process: Proportion of transitions with named accountability and documented confirmation of receiving supports. Output: Delayed/failed transitions. Outcome: Readmissions, extended hospital stays, emergency presentations or unplanned institutional entry attributable to transition failure.

Standard 30. Quality measurement and data systems

QS 30.1 Defined quality indicators across domains

Proposed wording

Quality indicators cover rights, safety, effectiveness, person-led outcomes, equity, access, timeliness, continuity, functional ability, social participation, financial protection and system responsiveness, using a balanced set of structure, process, output and outcome measures.

Proposed indicative measures

Input/Output/Outcome: Indicator set explicitly includes access, timeliness, equity, rights and financial protection, not only provider quality domains.

QS 30.2 Care recipient experience as core measurement

Proposed wording

The experience and outcomes reported directly by people receiving long-term care are core components of quality measurement, including dignity, everyday autonomy, communication, cultural safety, control over decisions and routines, meaningful activities, chosen relationships, continuity and ability to raise concerns without reprisal. Proxy reporting is used only when direct reporting is not possible and is identified separately.

Proposed indicative measures

Process: Validated accessible mechanisms for direct reporting, including communication support and multiple languages/formats. Output: Response rate and representativeness. Outcome: Person-reported experience by provider and population group.

Standard 31. Inspection and assessment

QS 31.2 Inspection methods include direct observation

Proposed wording

Inspection methods include direct observation and private, accessible engagement with people receiving care, using communication support and independent advocacy where requested or needed, so that people with cognitive, sensory, communication or language barriers can participate safely.

Proposed indicative measures

Process: Proportion of inspections including private direct engagement; availability of advocacy/communication support. Outcome: Issues identified through direct engagement that were not apparent in provider records.

Standard 32. Complaints and feedback

QS 32.1 Accessible complaints processes

Proposed wording

People receiving long-term care, families and supporters can make complaints or provide feedback through clear, accessible, no-wrong-door channels, with independent advocacy available before and throughout the process and protection against retaliation.

Proposed indicative measures

Process: Availability of channels, languages, formats and advocacy referral. Outcome: Person-reported confidence to complain and experience of reprisal.

QS 32.2 Timely investigation and response

Proposed wording

Complaints are acknowledged, investigated and resolved within defined maximum timeframes proportionate to risk; complainants are kept informed, receive reasons for decisions and remedies, and can seek review or appeal when dissatisfied.

Proposed indicative measures

Input: Maximum timeframes and escalation rules. Output: Proportion resolved within timeframe. Outcome: Remedy implemented, satisfaction with fairness and recurrence of issue.

QS 32.3 Analysis of complaints data

Proposed wording

Complaint, incident, safeguarding, review, appeal and independent advocacy data are analysed together, while protecting confidentiality and advocacy independence, to identify systemic issues, inequity, emerging risks and recurring failures and to trigger regulatory or system-level improvement.

Proposed indicative measures

Process: Regular cross-source analysis. Output: Systemic issues and high-risk patterns identified. Outcome: Documented actions and measurable improvement following intelligence.

Standard 33. Quality improvement

QS 33.2 System-level support for improvement

Proposed wording

Public authorities provide system-level quality-improvement support and take responsibility for correcting structural problems that cannot be resolved by individual providers, including financing, workforce, access, assessment and interface failures.

Proposed indicative measures

Output: System-level improvement actions for recurrent cross-provider issues. Outcome: Reduction in system-wide recurrence.

Three additional quality statements proposed by OPAN

In addition to amending existing wording, OPAN recommends three new quality statements to address gaps that are difficult to resolve through minor drafting changes to the current structure.

Proposed QS 22.3 Equity across population groups

Proposed wording

Long-term care entitlements, access, service quality and outcomes are equitable across population groups, with governments identifying and addressing disparities affecting Indigenous peoples, culturally and linguistically diverse communities, people with disability or cognitive impairment, people experiencing housing or financial insecurity, LGBTQ+ older people, rural and remote communities and other groups experiencing structural disadvantage in the national context.

Proposed indicative measures

Input: Equity variables and priority populations are defined with affected communities. Process: Access and outcome indicators are routinely disaggregated. Output: Material disparities trigger targeted corrective action. Outcome: Reduction in inequities in waiting, unmet need, quality and outcomes.

Why a new QS is needed

Standard 22 currently covers income-related contributions and geography but does not provide a general population-equity statement.

Proposed QS 28.5 Review appeal and effective remedy

Proposed wording

Older people have accessible, timely and independent mechanisms to seek review or appeal of decisions about eligibility, assessment, entitlements, funding, service reduction or other matters that materially affect their long-term care, with written reasons, independent advocacy, protection of essential support while urgent matters are determined, and effective remedies when decisions are changed or rights are breached.

Proposed indicative measures

Input: Review and appeal pathways and maximum timeframes are defined. Process: Reasons and advocacy information are provided with reviewable decisions. Output: Time to review/appeal and time to implement changed decisions. Outcome: Unmet need or harm while review is pending; proportion of remedies fully implemented.

Why a new QS is needed

The draft contains complaints mechanisms but does not clearly establish procedural rights for administrative decisions about entitlement and funding.

Proposed QS 30.5 Access timeliness and unmet need

Proposed wording

Long-term care quality monitoring includes the full pathway from identified need to effective support and measures need, unmet need, waiting, assessment and review timeliness, service non-commencement, provider refusal, service interruption, cost-related forgone care and the consequences of delayed or unavailable support.

Proposed indicative measures

Input: Common definitions for need, unmet need and pathway waiting periods. Process: Data link the stages from request to assessment, decision, approval and service commencement. Output: Waiting and unmet-need rates by pathway stage and population group. Outcome: Deterioration, hospital use, carer strain, financial hardship or loss of preferred living arrangement associated with unmet need or delay.

Why a new QS is needed

Current Chapter 8 largely measures quality among people already receiving care; a global quality framework should also capture failures to access care.

Additional proposed amendments

Foundational principles and Standards 5, 14 and 17 should expressly cover everyday rights, supported decision-making and ageism across all settings. For Quality Statement 17.3, add protection from retaliation for workers who report rights breaches and clear escalation and follow-up responsibilities. Measures should test whether workers feel safe to raise concerns and whether those concerns lead to action.

Quality Statement 29.2 should require the older person's decisions and chosen decision support to be respected throughout transitions. Record whether the person was supported to choose the destination and whether essential services were in place; monitor unwanted moves and interruptions to support as well as hospital outcomes.

Quality measures should distinguish support to maintain function from support to adapt when function declines. A person's reported control and ability to pursue meaningful activities should remain quality outcomes even when clinical or functional improvement is not possible.

Residential care: Strengthen Standards 5–8 so that residents' rights are explicit in everyday routines and relationships. Cover access to visitors and private relationships, privacy, choice over routines, food and fluids, meaningful activities, community access, clinical and specialist healthcare, allied health and rehabilitation, palliative and end-of-life care, and safeguards against physical, chemical and environmental restraint. Measures should include residents' reports of control, connection, nutrition, continuity and access to healthcare.

Carer support: Under Standards 9–13, identify and assess older carers separately, provide flexible planned and emergency respite before crisis and during transitions, and recognise carers' own rights and wellbeing. Capacity-building should be voluntary and accessible to unpaid and community carers; it must not condition formal care on family availability or transfer inappropriate clinical duties.

Supported decision-making training: Remove or rewrite the iSupport component identified at consultation draft line 2467 so that it does not conflate best interests with the person's will and preferences. Training should focus on communication, decision support and respect for the person's authority.

OPAN Older Persons Advocacy Network

OPAN member organisations by state or territory

ACT
ADACAS Advocacy

NSW
Seniors Rights Service

NT - Central
CatholicCare NT

NT - Top End
Darwin Community Legal Service

QLD
ADAAustralia Your Aged and Disability Advocates

SA
aras Aged Rights Advocacy Service

TAS
Advocacy Tasmania in your corner

VIC
ERA Elder Rights Australia Promoting the human rights of all older people

WA
Advocare Empowering older people in WA

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