TO ALL STAKEHOLDERS

Dear Sir/Madam

REVIEW OF THE LICENSING OF PRIVATE SECTOR HEALTH AND OTHER FACILITIES IN WESTERN AUSTRALIA

The Health Department of Western Australia, through the Private Sector Licensing Unit and the Facilities and Asset Branch, currently manages risk in private sector health service delivery through the monitoring and certifying of proprietor appropriateness, health care operational standards and facility appropriateness for health purposes.

The Department's activities currently impact on private sector hospitals, nursing homes, psychiatric hostels, nursing posts and day surgeries. The Health Department also provides advice on facility standards in the public sector by the provision of guidelines, and deemed-to-comply documentation.

Oceana Consulting P/L undertook a Review of the Licensing of Private Sector Health Facilities in Western Australia. The report of the Review was received on 7 November 1998.

Before formulating its advice to Government on the outcomes of the Review, the Department wishes to engage in a period of stakeholder and community consultation. For that reason, I now wish to invite you as a key stakeholder to comment on the Report's 38 Recommendations. A copy of the Report is enclosed for your information. Additional copies of the report can be downloaded from the Health Department of Western Australia's Internet site (**http://www.health.wa.gov.au**) or by contacting Megan Hathaway on telephone (08) 9222 4426.

The Report proposes major changes in the regulation of public and private sector health care facilities, aged care facilities and psychiatric hostels. Input from all stakeholders is encouraged before further consideration is given to the Report's recommendations to ensure that, as far as possible, this key reform of the health industry meets stakeholders' needs and expectations.

Comments can be considered only if submitted in writing to the following address: **Licensing Feedback, Health Department of WA, PO Box S1400, GPO PERTH WA 6001** or by e-mail to **LicensingFeedback@health.wa.gov.au** by 28 February 1999.

Yours faithfully

(signed)

Alan Bansemer
COMMISSIONER OF HEALTH

22 January 1999

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Oceana Consulting PL

Report

A REVIEW OF THE LICENSING OF PRIVATE SECTOR HEALTH AND OTHER FACILITIES IN WESTERN AUSTRALIA

Health Department of Western Australia

[Submitted 7 November 1998]

2.

Table of Contents

Summary of Recommendations

We recommend:

1: Licensing Framework to apply to aged care hostels and to nursing homes

That, from 1 January 2000, the licensing framework and procedures applicable to nursing homes in Western Australia be extended to encompass aged care hostels.

2: Role of Commissioner to be retained

That the statutory authority for and obligation upon the Commissioner of Health with respect to the licensing of aged care facilities in Western Australia be retained.

3: Commonwealth certification from 1 March 1999

That, from 1 March 1999, the granting by the Commissioner of Health of a licence for the establishment and continuing operation of new or existing nursing homes (and from 1 January 2000 of aged care hostels) be contingent solely upon the granting of certification by the Commonwealth to the operators of such nursing homes and hostels, and that HDWA play no role in the setting or monitoring of standards for such institutions.

4: Automatic annual renewal of licence

That, pending any necessary amendments to State legislation to give effect to our recommendations with respect to aged care facilities, the Commissioner of Health grant automatic annual renewal of each licence issued in respect of a nursing home or aged care hostel throughout the currency of the instrument of certification.

5: Commonwealth accreditation from 1 January 2001

That, from 1 January 2001, the granting by the Commissioner of Health of a licence for the establishment and continuing operation of new or existing nursing homes and aged care hostels be contingent solely upon the granting of accreditation by the Commonwealth to the operators of such nursing homes and hostels.

6: State/Commonwealth consultation arrangements

That there be instituted a more regular and more formal mechanism for ensuring proper consultation between the State and the Commonwealth with respect to the standards of care and facilities in aged care hostels and nursing homes.

7: Standards for psychiatric hostels, day care facilities, nursing posts

That, as a matter of urgency, the standards required of proprietors, of facilities, and of care in psychiatric hostels, day care facilities, nursing posts and the like be developed and adequately documented.

8: Duration of licences

That, depending upon the quality of each facility and the care provided, and upon the level to which it complies with the relevant published standards, the duration of each licence granted vary so that one-year, two-year or three-year licences are granted, and that, pending any necessary amendments to

State legislation to give effect to this recommendation, the Commissioner of Health grant automatic annual renewal of each licence issued throughout the currency of the relevant approved licence period.

9: Date of renewal of licences

That each licence granted become subject to renewal upon the relevant anniversary of its initial granting, and that appropriate records and data-bases be developed and maintained by HDWA to ensure adequate advance notification to licence-holders to enable them and the Department to undertake all steps necessary to facilitate re-licensing prior to the expiry of a licence.

10: Conditional Licences

That relevant legislation be amended to enable the granting by the Commissioner of Health of conditional licences where a particular facility does not completely meet the required published standards, but where the level of non-compliance is not sufficient to warrant outright refusal to grant a licence (in the case of new facility applications) or withdrawal of licence (in the case of applications for re-licensing).

11: Duration and scope of Conditional Licence

That the legislation provide that conditional licences have a maximum duration of one year (during which remedial work required to enable the facility completely to meet the required published standards must be completed), that a conditional licence may be renewed as a conditional licence if remedial work is required, and that the conditional licence specify the particular deficiencies required to be corrected.

12: Definition of psychiatric hostels

That the definition of a psychiatric hostel contained in the *Hospitals and Health Services Act 1927* be revised in consultation with mental health care professionals and with the industry to eliminate ambiguity as to what does and does not constitute a psychiatric hostel requiring a licence.

13: Role of Chief Psychiatrist

That, in determining whether or not to grant a licence with respect to a psychiatric hostel, the Commissioner of Health take into account not only the recommendations of the HDWA unit responsible for licensing matters, but also the conclusions and recommendations contained in a written report required to be submitted by the Chief Psychiatrist, and that this requirement be included in future legislative amendment.

14: Transfer of certain functions to Mental Health Division

That all functions currently undertaken by the PSLU and related units within the Finance and Resource Management Division with respect to the administration, payment, monitoring and recording of subsidy payable to psychiatric hostels be transferred immediately to the Mental Health Division.

15: Financial viability of the proprietor

That future applicants for new licences (in every case) and that applicants for renewal of licences (at least every six years) be required to submit with their application a clear authorisation to enable HDWA, at the applicant's expense, to commission Dun and Bradstreet (or a similar company of

repute) to prepare and submit to the Commissioner a report on the sufficiency of the material and financial resources available to the applicant to comply with the requirements of this Act.

16: Proprietor appropriateness

That the authorisation enable Dun and Bradstreet (or a similar company of repute), at the applicant's expense, to attest to the fact that the applicant has attained the age of 18 years, and (by reference to criminal and police records) to offer a view on whether the applicant is a person of good character and repute and a fit and proper person to conduct a private health care facility.

17: Industry and community esteem

That the report submitted by Dun and Bradstreet (or a similar company of repute), at the applicant's expense, include in relation to the applicant, written references provided by members of the community, health care professionals, and representatives of the industry into which the new applicant desires entry or in which the renewal applicant desires to remain.

18: Patient/resident/carer/staff consultation

That, in relation to applications for licence renewal, each application be required to provide evidence that the views of patients and/or residents and/or carers and/or family members and/or staff have been sought in relation to the standard of care received and service offered.

19: Legislative Amendments

That the various legislative enactments governing licensing be revised and amended to support the recommendations made in this Report, and (inter alia) to address the following issues:

- clarification of the definitions of the types of services requiring licensing: hospitals, aged care facilities, day surgeries, nursing posts, psychiatric hostels etc.;
- introduction of differential licence periods to reflect varying standards of facilities and service;
- formalisation of conditional licensing as an improvement mechanism;
- making more explicit the option of revocation of license for non-compliance with licence conditions;
- removal of the "pro forma" nature of license renewal;
- entrenchment and definition of standards as a benchmark in licensing;
- inclusion of discretionary elements to enable the legislation to cope with structural/cultural change (eg. "aging-in-place" in aged hostels);
- application of meaningful penalties for non-compliance.

20: Allocation of risk and cost

That a better balance be struck between public sector licensing and private sector service provision with a more appropriate allocation and acceptance of risk and cost, and that this balance be achieved by adopting a framework for licensing (except in the aged care area) which requires:

- future applicants for new licences (in every case) and applicants for renewal of licences (at least every six years) to be required to submit with their application for a licence a Compliance Certificate submitted under affidavit by an architect or engineer or building surveyor (the Accredited Certifier) of the applicant's choice;

- the Accredited Certifier to be professionally registered in Western Australia (with the professional registration number identified on the certificate);

- the Accredited Certifier to be accredited by HDWA (with the accreditation number identified on the certificate);

- the Accredited Certifier to be the holder of appropriate professional indemnity insurance (with the company and policy number identified on the certificate);

- the Accredited Certifier not to be the architect, builder or any other person consulting to or contracting to the works (with a statement to this effect to be explicitly made on the certificate);

- the Accredited Certifier may be privately employed, be employed by a local government authority or be employed in the State public service;

- the Accredited Certifier not to be or to have been involved in any aspect of the design or documentation of the building (with a statement to this effect to be explicitly made on the certificate);

- the Accredited Certifier not to have a direct or indirect financial interest in the building or in any body associated with the building (with a statement to this effect to be explicitly made on the certificate);

- the Accredited Certifier not to be employed by any person or body associated with any aspect of the building, except only for their employment as Accredited Certifier (with a statement to this effect to be explicitly made on the certificate).

- the Compliance Certificate to assert that the Accredited Certifier has read and understood the officially published standards relevant to the facility for which a licence or licence renewal is sought;

- the certificate to confirm either:

    - that the facility for which the licence or licence renewal is sought fully meets the officially published standards relevant to the facility; or

    - that the facility for which the licence or licence renewal is sought does not fully meets the officially published standards relevant to the facility, in which case the certificate is to specify in precise terms those elements of the officially published standards relevant to the facility which are not met and provide a program and timeframe in accordance with which it is proposed that the deficiencies identified are to be remedied.

21: Assessment of certificate and grant of licence

That, on the basis of the certificate submitted, HDWA assess the application and

- where the certificate confirms that the facility for which the licence or licence renewal is sought fully meets the officially published standards relevant to the facility, considers whether or not to grant a full licence for the relevant period; or

- where the certificate confirms that the facility for which the licence or licence renewal is sought does not fully meet the officially published standards relevant to the facility, considers whether or not to grant a conditional licence for the relevant period, taking into account the submitted program and timeframe in accordance with which it is proposed that the deficiencies identified are to be remedied.

22: Role of Executive Director Public Health

That the Executive Director Public Health become more involved with the licensing process through on-going discussion and consultation with local government authorities and, as a last resort, by using his/her powers under the *Health Act 1911* to make orders binding the local authority to act to ensure that health inspections undertake regular inspections of licensed health and aged care institutions in Western Australia.

23: Formulation of Standards

That HDWA adopt as a principle the formulation of a three-tiered approach to the setting of standards for licensed health care facilities involving:

- formal adoption of Building Code of Australia and/or Australian Standards Association standards (where available, and as amended from time to time);

- incorporation of Western Australian local government and statutory requirements (including fire and public health regulations, local authority building codes etc.); and

- augmentation of the above standards by the preparation and promulgation by HDWA of additional requirements only as strictly required to meet specific and otherwise unmet Western Australian and Departmental needs.

24: Content of Standards

That HDWA standards for each type of licensed care fully address requirements against which assessments can be made of the:

- fitness and propriety of the applicant, including the sufficiency of the material and financial resources available to the applicant in terms of legislative requirements;

- suitability of the proposed premises for the designated purpose; and

- arrangements proposed for the satisfactory maintenance of appropriate clinical standards, and for the management, equipment and staffing of the facility.

25: Process for developing Standards

That HDWA adopt the following formal process for the formulation, publication and revision of Standards:

- Draft Standards, in accordance with the provisions of Recommendations 23 and 24, and draft revisions to existing Standards to be prepared by HDWA;

- the Draft Standards and draft revisions to be released and widely circulated for a period of 60 days during which industry and public comment, reaction and input can be obtained;

- industry and public comment, reaction and input received to be assessed and considered within 30 days by a formally constituted Standards Reference Committee representative of the Department, the relevant industry group, consumers and health care professionals;

- amended Standards and revisions to be prepared and endorsed by the Standards Reference Committee for submission to the Commissioner of Health;

- Standards and Revised Standards to come into effect only upon their formal authorisation by the Commissioner of Health and their publication by him.

26: Application of Standards and licensing to public sector

That public sector health and aged care services be subject to the same standards and licensing arrangements and processes as apply to similar private sector services, and, in the case of services other than aged care services, that:

- where a public sector facility is assessed as fully meeting the relevant Standard, a licence be granted for an appropriate duration;

- where a public sector facility is assessed as not fully meeting the relevant Standard, a conditional licence be granted for an appropriate duration, with the licence being conditional upon agreement between HDWA and the licensee with respect to the adherence by the licensee to a program of corrective action to address the deficiencies identified in the Compliance Certificate provided by the accredited certifier.

27: Budget restriction on public sector facilities holding conditional licence

That, where a public sector service is granted a conditional licence for an appropriate duration, that service have imposed upon it a budget restriction to the effect that an identified portion of each annual budget appropriation to that service be by way of a "tied-for-purpose" component, with the purpose being specified as action required to remedy over an agreed period the deficiencies identified in the Compliance Certificate provided by the accredited certifier.

28: Complete deregulation not a viable option

That complete deregulation of private health care provision by the removal of any legislative or regulatory requirement for State licensing be deemed an inappropriate response.

29: Supplementation of resources for existing activity not a viable option

That full supplementation of resources for existing activity be deemed an inappropriate response.

30: Full cost recovery not a viable option

That full cost recovery for existing activity be deemed an inappropriate response.

31: Administration Charge required

That there be implemented in the context of the adoption of our other recommendations the setting by regulation of an Administration Charge or fee of around $100 to be paid at the time any application for a new licence or for the renewal of an existing licence is submitted

32: Contracting out and employee buy-out not viable options

That contracting out the current in-house processes and/or pursuit of a potential employee buy-out of current in-house activity be deemed inappropriate responses.

33: Random inspection program

That State licensing activity, based on professional certification, be supported by an on-going program of random inspection designed to ensure maximum reasonable coverage of the facilities and services licensed.

34: Accreditation

That any professionally registered architect, engineer or building surveyor be entitled to seek accreditation from the Commissioner of Health as an Accredited Certifier, and that the process of managing the accreditation process not be managed by the HDWA licensing area.

35: Sanctions

That the relevant legislation be amended to ensure that the Western Australian licensing framework is supplemented with effective sanctions by way of withdrawal of licence or the imposition of an appropriate penalty for non-compliance with established standards, including specific sanctions, both remedial and punitive, against breaches of duty of care by Accredited Certifiers.

36: Establishment of a Health and Aged Services Licensing Unit

That the PSLU, the F&A Branch and the TSU be abolished, and that there be established within the Finance and Resource Management Division of HDWA a Health and Aged Services Licensing Unit with a Standards Section of around five (5) personnel for development of formal standards on proprietors, services and facilities, and a License Administration Section of some four (4) personnel.

37: Staffing the Health and Aged Services Licensing Unit

That all positions in the new Unit be filled after advertising within HDWA with careful attention being paid to the selection of the most appropriate person to manage the Unit, and that innovative staffing practices be adopted, including staffing some positions in the new Unit by way of short-term secondment from other parts of the state health system and from the private sector.

38: Shared or Common Services Agency

That F&A Branch/TSU functions and staff not drawn into the new Health and Aged Services Licensing Unit should be considered for incorporation into the proposed shared services division or agency currently under consideration within HDWA.

Introduction

1. On 9 September 1998, Oceana Consulting PL was engaged by the Commissioner of Health to undertake a review of the Licensing of Private Sector Health Facilities in Western Australia.

2. The Terms of Reference of the Review, developed by the Health Department of Western Australia (HDWA) and endorsed by the Commissioner of Health, were as follows:

Introduction

The current roles of the Private Sector Licensing Unit and the Facilities and Asset Branch, in relation to health service delivery risk management, include the monitoring and certifying of proprietor appropriateness, health care operational standards and facility appropriateness for health purposes within the Western Australian private health care sector. This includes Hospitals, Nursing Homes, Psychiatric Hostels, Nursing Posts and Day Surgeries. They also provide advice on facility quality in the public sector by provision of guidelines, and deemed- to-comply documentation.

Scope

The Review should include the following parameters:

Review the current legislative requirements of the Department with regards Private Sector Licensing.

Review sufficiency of current standards.

Undertake analysis of resources and total cash and accrual costs involved in meeting legislative and risk management obligations.

Identify potential risk management issues and recommend appropriate strategy to address these issues.

Investigate possible fee for service arrangement or "user pay" option.

Provide report on possible deregulation of the Aged Care Sector.

Investigate alternative options to current management model and possible outsourcing.

Objective

The objective of the Review is to

Assess, report on and make recommendations concerning the efficiency of the Unit's effectiveness in these areas and the potential risk exposure within the current environment.

It is anticipated that a Report will be produced indicating any deficiencies and making recommendations for improvement.

Working Arrangements

Oceana Consulting or its nominee will report to the Commissioner of Health and be based at the East Perth Government Offices. Regular progress meetings will occur with key stakeholders of the Review and the Commissioner of Health. These meetings will discuss the progress of the Review and any significant issues arising.

Methodology of the Review

3. The Review identified the legislative provisions under which licences are granted to private sector health and aged care providers, and assessed the functions of the HDWA organisational units directly engaged in meeting those legislative provisions. The Review also took into account some other more peripheral functions bearing on the licensing process.

4. The Review was not required to address the validity of the need for State licensing of private sector providers and facilities.

5. All employees in the organisational units involved in licensing were given an opportunity to have discussions with the Review team to contribute both factual and observational matters; the majority did so. A selected number of senior departmental stakeholders and external clients of the licensing process were also interviewed.

6. A list of personnel interviewed is at **Attachment 1**.

7. The Review team took the opportunity to canvass with the Commonwealth Government Aged and Community Care Unit within the Department of Health and Aged Care the developing Commonwealth processes with respect to standards and subsidisation of residential aged care services. It also discussed licensing issues and impacts with representatives of the private residential psychiatric hostel sector.

8. The factual situation was established from organisational documents, while existing licensing processes, particularly where informally defined by customary activity, were discussed with operational personnel. From the various views, observations and perceptions expressed by those participants, there emerged underlying facts about current licensing practice.

9. Internal licensing processes were also tested against the views of stakeholders and external personnel as to suitability and need in the current operational environment.

10. Risk management concepts and best practice in operational management were used to assess existing and preferred practice and to identify a reliable process for licensing of private sector service providers. This ensured that preferred licensing practice was not allowed to subvert provider accountability for the standard of services delivered.

11. Inevitably, the Review confronted the interface between private and public health care sectors and identified matters of significance to the regulation of health care. While not contemplated by the terms of reference of the Review, these issues are canvassed within the Report.

Legislation Applicable

12. Western Australian State licensing of private sector health and aged care services currently occurs under legislation and associated regulation. The relevant Western Australian legislation is:

    - *Hospitals and Health Services Act 1927*
    - *Mental Health Act 1996*
    - *Health Act 1911*

13. Copies of relevant extracts of the Western Australian Acts are at **Attachments 2, 3 and 4.**

14. Associated Commonwealth involvement in residential aged care services standards and subsidisation is mandated under the:

    - *Aged Care Act 1997*

15. The general thrust of the Western Australian legislation is that:

    - a licence is required for lawful operation of most private health care services;
    - a person, firm or body corporate can obtain a licence if that person, firm or body corporate is considered to be a fit and proper person of good character and repute possessing sufficient material and financial resources to deliver the services, and subject to their fully understanding the obligations imposed by the Act;
    - a licence cannot be issued unless proposed management, equipment and staffing are satisfactory;
    - a licence cannot be issued unless proposed premises are considered suitable for approval.

16. Licences are usually conditional upon specific service or facility issues considered necessary for adequate health care delivery. Licences are renewable annually, and are subject to non-renewal or cancellation as a consequence of non-compliance with the terms of approval.

17. Non-compliance with licence conditions is not an offence under legislation, and penalties are non-existent or of such minor financial consequence as to not constitute leverage. Closure for non-compliance with orders for remedial work on premises is enabled by the legislation.

18. Licences are issued and cancelled by the Commissioner of Health (or his/her delegate) and decisions to not issue a licence or cancel an existing licence are appealable. There are specific timeframes prescribed for decisions.

19. The legislation provides that the Commissioner may issue guidelines governing adequacy of physical facilities for private health care services.

20. Transfer in late 1997 into the *Hospital and Health Services Act 1927* of the licensing powers included in the *Mental Health Act 1996* unintentionally included a broader range of facilities, such as some boarding houses and the like, into the category of facilities requiring State

licences as private psychiatric hostels. Proposals to amend these provisions are being developed, but meanwhile the legislative obligation exists and will continue to exist for such facilities to be licensed.

21. Commonwealth and State jurisdictions overlap in the aged care field where State licensing of nursing homes but not aged care hostels exists, and Commonwealth certification and accreditation of approved providers of all forms of aged care services as a condition of future receipt of Commonwealth financial subsidisation is evolving under the *Aged Care Act 1997*. The overlap has potential for duplication and conflict in standards of care and facilities between the Commonwealth and the State.

22. Overall, the legislation provides an adequate, if non-specific, framework within which the Commissioner of Health may ensure the sufficiency of private health and aged care services by the licensing of proprietors, conditional upon personnel, organisational and facilities standards.

23. It is possible within that existing legislative framework to achieve significant improvement in departmental processes supporting the licensing of private health and aged care service delivery.

Relevant Commonwealth Initiatives

24. The Commonwealth impact on State licensing of private sector providers is felt in the area of residential aged care services where continuation of Commonwealth residential care subsidies for the aged past 1 January 2001 will be dependent upon accreditation of approved providers by the Aged Care Standards Agency under the provisions of the *Aged Care Act 1997*.

25. This accreditation framework involves assessment of aged care service providers against accreditation standards in management, staffing and organisation; in health and care; in residential life style; in physical environment; and in safety. Coupled with these standards is certification of buildings for adequacy and acceptable resident ratios and prudential arrangements. (See **Attachment 5**).

26. Accordingly the Commonwealth Aged Care Standards and Accreditation Agency and the Department of Health and Aged Care are undertaking assessment of all aged care service providers in Western Australia (and in other states), both for nursing homes and for aged care hostels, in a structured process that will be implemented by 1 January 2001. This approach duplicates the State processes used for State nursing home licensing, and provides a process for aged care hostels that is not encompassed licensing by Western Australian licensing arrangements.

27. The Commonwealth approach eliminates the separation of nursing homes and aged hostels in the light of the practical and commercial realities, including "aging in place" in hostels. Recognition of the variability of service standards is addressed by a longer-term (10 years) "continuing improvement" approach to care and facilities standards, leveraging progressive improvement on the potential non-continuation of subsidisation.

28. At the process level, the Commonwealth approach also embodies reliance upon the existing regulatory and monitoring capabilities of Government and industry, based on outsourced assessment and certification.

Developments in the Aged Care Regulatory Framework

29. At present the Commissioner of Health licenses high dependency private aged care services at nursing homes, but not low dependency private aged care services through aged hostels. Licensing as a regulatory mechanism for achieving acceptable standards of care and lifestyle for the aged has been successful, as demonstrated by the standards achieved in nursing homes and hostels in Western Australia as compared with the rest of Australia. Comparative interstate data is at **Attachment 6**.

30. The distinction between aged care hostels and nursing homes has blurred with "aging-in-place" in hostels and increased emphasis on resident lifestyle issues impacting on the traditional care based distinction between residential types. This has been reinforced by Commonwealth attitudes to subsidisation of all aged care facilities. The elimination of this separation, based as it is upon contemporary approaches to aged care, is one which Western Australia would do well to emulate.

Recommendation 1: Licensing Framework to apply to aged care hostels and to nursing homes

31. *We recommend that, from 1 January 2000, the licensing framework and procedures applicable to nursing homes in Western Australia be extended to encompass aged care hostels.*

32. The Commonwealth initiatives under the *Aged Care Act 1997*, as mentioned earlier, have closely linked Commonwealth funding and allocation of places to approved corporate providers of aged care services in accordance with a set of principles relating to staffing ability/experience, financial management capability, good care, and conduct generally.

33. Further, the continuation of Commonwealth funding post 1 January 2001 is dependent on accreditation of aged care services under a quality assurance system managed by the Commonwealth Aged Care Standards and Accreditation Agency. The accreditation system promotes and encourages continuing improvement in better quality care, by an arms length certification and accreditation process developed by the Agency.

34. The new Commonwealth framework involves accreditation against standards of management systems/staffing/organisation; health and personal care; resident lifestyle, and physical environment/safety. Accreditation also encompasses certification of building quality, prudential arrangements, resident ratios and user rights.

35. Registered auditors, either Agency employees or independent auditing firms, undertake accreditation audit. Accreditation periods range up to three years, with marginal facilities accredited for shorter periods, such as one year, to reinforce the continuous improvement fundamental to the system.

36. These approved provider and accreditation systems are overall better codified and recorded than equivalent Western Australian methodologies. They are therefore more readily understood and less open to interpretative debate, providing a fully transparent mechanism directly linking quality of care provided with availability of places and Commonwealth subsidisation. This reflects a goal of continuous staged improvement over the medium to long term.

37. To date, co-operation between State and Commonwealth authorities has avoided duplication in "licensing" but proprietors see the places and subsidy linked Commonwealth system as being of

greater financial and performance benefit. There has been little difficulty with jurisdictional co-operation as the Western Australian licensing system (for nursing homes, but not hostels) has more developed standards for aged care facilities than have systems in other states. Western Australian standards relating to residents per room, minimum room spaces, minimum common area space per resident and minimum populations per ablution facilities surpass all other States' requirements.

38. At this stage of higher State standards for nursing homes in Western Australia than for other states, and in the face of Commonwealth subsidisation linked approval/accreditation processes for all aged care facilities throughout Australia that seek funding, there would seem to be cogent reason for the Western Australian licensing process to rely solely upon the existing and developing infrastructure of Commonwealth certification and accreditation, especially at a time of State administrative resource pressure. This would apply to all Western Australian residential aged care facilities whether seeking funding or not.

39. In the case of aged care hostels (which also provide residential aged care although at the low-dependency end of the spectrum), there seems little justification for maintaining the licensing distinction between them and nursing homes, especially given that aging in place is becoming the norm in aged care hostels. The definitional boundary between hostels and nursing homes has become blurred. Accordingly, this Review believes that all aged care residential facilities should fall within the same regulatory regime, and believes further that hostels should be subject to the same licensing changes and implementation dates that are being suggested for nursing homes.

40. It is therefore proposed that licensing of residential aged care in Western Australia under current legislation move towards phasing out HDWA assessment of proprietors, care and facilities. In its place the provision of certification and accreditation by the Commonwealth would become the administrative pre-requisite for decisions by the Western Australian Commissioner of Health on whether to license a specific aged care facility.

41. A two-staged implementation of this proposal is envisaged. As "arms length" certification of Western Australian aged care facilities by the Commonwealth has already occurred, and as most HDWA assessments under the current State licensing methodology concentrate on physical facilities and their appropriateness for the provision of high dependency care, it is proposed that Western Australian licensing be based solely on State use of Commonwealth certification commencing 1 March 1999.

Recommendation 2: Role of Commissioner to be retained

42. *We recommend that the statutory authority for and obligation upon the Commissioner of Health with respect to the licensing of aged care facilities in Western Australia be retained.*

Recommendation 3: Commonwealth certification from 1 March 1999

43. *We recommend that, from 1 March 1999, the granting by the Commissioner of Health of a licence for the establishment and continuing operation of new or existing nursing homes (and from 1 January 2000 of aged care hostels) be contingent solely upon the granting of certification by the Commonwealth to the operators of such nursing homes and hostels, and that HDWA play no further role in the setting or monitoring of standards for such institutions.*

Recommendation 4: Automatic annual renewal of licence

44. *We recommend further that, pending any necessary amendments to State legislation to give effect to our recommendations with respect to aged care facilities, the Commissioner of Health grant automatic annual renewal of each licence issued in respect of a nursing home or aged care hostel throughout the currency of the instrument of certification.*

45. As continuing Commonwealth allocation of residential aged care places and subsidisation are dependent upon the attainment of full accreditation status by 1 January 2001, it is further proposed that Western Australian State licensing activity be based solely on State use of the relevant Commonwealth accreditation commencing from the date of individual proprietor accreditation or 1 January 2001, whichever is the earlier. The Commonwealth Department of Health and Aged Care agrees with this proposal.

Recommendation 5: Commonwealth accreditation from 1 January 2001

46. *We recommend that, from 1 January 2001, the granting by the Commissioner of Health of a licence for the establishment and continuing operation of new or existing nursing homes and aged care hostels be contingent solely upon the granting of accreditation by the Commonwealth to the operators of such nursing homes and hostels.*

47. In this way, aged care facilities in Western Australia will be geared to one clear set of standards that integrate with place allocations and subsidisation, potential duplication between two levels of government will be avoided, and administrative resource pressure on State licensing actively will be mitigated.

48. At the same time, the Commissioner of Health will retain his legislative authority and accountability for licensing aged care nursing homes (and hostels), with the authority to re-implement State assessment processes should that become necessary from a public policy perspective. Such an outcome is, however, unlikely.

49. It is not likely that the pre-eminent standards achieved by Western Australia in licensed private residential aged care will deteriorate, given the Commonwealth recognition of that pre-eminence and its intention over the next ten years to raise the existing lower standards of facilities in other states to the Western Australian level, using the accreditation framework.

50. There is validity in combining standards, assessment, accreditation and funding of residential aged care into an integrated package Australia wide, with public accountability and funding responsibility resting with the one administration.

51. Nonetheless, the interests of both Western Australia and the Commonwealth would be better served if there was to be instituted a more regular and more formal mechanism for ensuring proper consultation between the State and the Commonwealth with respect to the standards of care and facilities in aged care hostels and nursing homes. In this way the Commonwealth responsibility for funding and certification/accreditation of aged care facilities could better relate to the ongoing State responsibility for the planning and development of aged care services in Western Australia.

Recommendation 6: State/Commonwealth consultation arrangements

52. *We recommend that there be instituted a more regular and more formal mechanism for ensuring proper consultation between the State and the Commonwealth with respect to the standards of care and facilities in aged care hostels and nursing homes.*

Current HDWA Licensing Arrangements

53. Within the parameters of legislative requirements on licensing and given the practicalities of achieving good quality care services and facilities, HDWA has developed the Private Sector Licensing Unit (PSLU) as its licensing management infrastructure, with significant inputs on facility standards from the Facilities and Assets Branch (F&A). The Technical Services Unit (TSU) provides further inputs on facilities and services. All three units are components of the Finance and Resource Management Division of HDWA.

54. This arrangement reflects the legislative emphasis on proprietor/staffing suitability and competency, and on standards of facilities provided by private sector proponents. The legislation, as mentioned, is less explicit with respect to actual standards of health services.

55. Conceptually the licensing process is predicated on identification of:

- an acceptable standard of proprietor (person, or corporate entity);
- an acceptable standard of health care;
- an acceptable standard of facility to underpin the level of health care,

with assessment and certification of a proponent proposal or service as meeting those standards.

56. It should follow that policy and standards in all three areas are well documented so that proponent knowledge of required standards would be clear and not open to misinterpretation. In the case of hospital services, standards are clearly established through the Australian Council of Health Standards processes. The standards required of proprietors and of care in aged care facilities, psychiatric hostels, day care facilities, nursing posts and the like are much less adequately documented. Similarly, facility standards so well developed for hospitals are less well developed in the case of aged care facilities and are still under development for psychiatric hostels.

Recommendation 7: Standards for psychiatric hostels, day care facilities, nursing posts

57. *We recommend that, as a matter of urgency, the standards required of proprietors, of facilities, and of care in psychiatric hostels, day care facilities, nursing posts and the like be developed and adequately documented.*

58. Viewed objectively, there has been within HDWA, for historical reasons and, it is suspected, from association with capital works delivery processes, a resource emphasis on development and assessment of facility standards for private hospitals and aged care nursing homes. At the same time, standards for and assessment of proprietors, staffing and non-hospital based care have been much more reliant on informal networks, personal knowledge and unstructured processes.

59. This under-developed arrangement is highly dependent on the continued availability of several key staff and could be regarded as an inadequately resourced response to a legislated function.

60. Current practice is that new private health service proposals are provisionally cleared at an initial "in principle" phase. If facilities are to be newly constructed or refurbished, there are construction documentation and post-construction clearance assessments before final licensing

proceeds. Staged approvals carry with them no commitment to later formal approvals. Licence renewal tends to put greater emphasis on continuing standards of care and facilities.

61. The PSLU is the responsible HDWA unit for managing the licensing process. As a small operational unit of 5 persons, it relies heavily on its informal knowledge of proponents and their customary standard of operation in the health services field.

62. The facility standards area of the F&A Branch has a more developed arrangement of codified standards for facilities, which incorporate HDWA standards, Australian standards, statutory codes, and industry best practice. These standards are developed in consultation with health care practitioners and the building design/construction industry, and represent an industry standard that is clear to all parties. As a virtual design primer for private professionals, the standards consume a significant level of resource input to achieve, and represent a hidden public subsidy to private sector commercial interests.

63. At the same time, the standards do not address all health care facilities, given that private hospitals and nursing homes are covered, but aged hostels are currently excluded from the licensing arrangements and psychiatric hostels have not yet had standards completed. Success in the standards setting field is not without a major resource load incurred in the iterative process of formulation, consultation and amendment, together with a heavy concentration on inspection and oversight of private sector professional work.

64. Overall it appears that the current distribution of resource emphasis in PSLU and F&A Branch is systemically unbalanced given the objective of achievement of adequate private proprietor/health care standards, as distinct from facilities.

65. Licensing applies to both new proposals and existing services, and the duration of licenses is set at a fixed period of one year, with the anniversaries of new licences adjusted to fall at the end of each calendar year. There are two drawbacks to this practice. One is an unnecessary bunching of licence renewal workloads to the one time of the year, and the other is that the limited duration of the licence does not distinguish between "highest/best quality" facilities and "older less excellent" facilities.

66. Apart from resource demand being evened out with staggered renewal dates, differentially longer licence periods for the more reliable providers would permit licensing resource emphasis to be concentrated on the more "deserving" cases.

Recommendation 8: Duration of licences

67. *We recommend that, depending upon the quality of each facility and the care provided, and upon the level to which it complies with the relevant published standards, the duration of each licence granted vary so that one-year, two-year or three-year licences are granted, and that, pending any necessary amendments to State legislation to give effect to this recommendation, the Commissioner of Health grant automatic annual renewal of each licence issued throughout the currency of the relevant approved licence period.*

Recommendation 9: Date of renewal of licences

68. *We recommend that each licence granted become subject to renewal upon the relevant anniversary of its initial granting, and that appropriate records and data-bases be developed and maintained by HDWA to ensure adequate advance notification to licence-holders to enable them and the Department to undertake all steps necessary to facilitate re-licensing prior to the expiry of a licence.*

69. Licensing practice overcomes the legislative deficiency of "no effective penalty" for breaching licence terms by the issue of conditional licenses, thus using the threat of non-renewal as leverage. Given the standard one-year license period, the single renewal date, and the absence of real penalties for non compliance, licensing practice could be described as implicitly co-operative rather than regulatory, as (no doubt) legislatively intended.

Recommendation 10: Conditional Licences

70. *We recommend that relevant legislation be amended to enable the granting by the Commissioner of Health of conditional licences where a particular facility does not completely meet the required published standards, but where the level of non-compliance is not sufficient to warrant outright refusal to grant a licence (in the case of new facility applications) or withdrawal of licence (in the case of applications for re-licensing).*

Recommendation 11: Duration and scope of Conditional Licence

71. *We recommend further that the legislation provide that conditional licences have a maximum duration of one year (during which remedial work required to enable the facility completely to meet the required published standards must be completed), that a conditional licence may be renewed as a conditional licence if further remedial work is required, and that the conditional licence specify the particular deficiencies required to be corrected.*

72. A further aspect of current licensing practice is that it has been selective in use, oriented to health care services including facility improvement in some categories, while not focussing on legislative obligations in others. The situation where, through definitional looseness in the *Mental Health Act 1996,* the licensing arrangement applicable to psychiatric hostels was unintentionally expanded by licensing requirement provisions to a range of facilities not required or intended to be so covered does not, of course, justify the lack of activity to date in proceeding to license all psychiatric hostels.

73. These problems with respect to the licensing of psychiatric hostels are further compounded by continuing ambiguity as to what does and does not constitute a psychiatric hostel requiring licence, and the undertaking by the PSLU of some administrative functions relating to subsidy payment and recording which should rightfully by done by the Mental Health Division. Furthermore, the role and responsibility of the Chief Psychiatrist in the licensing of psychiatric hostels is not sufficiently recognised in the current arrangements.

Recommendation 12: Definition of psychiatric hostels

74. *We recommend that the definition of a psychiatric hostel contained in the* Hospitals and Health Services Act 1927 *be revised in consultation with mental health care professionals and with the industry to eliminate ambiguity as to what does and does not constitute a psychiatric hostel requiring licence.*

Recommendation 13: Role of Chief Psychiatrist

75. *We recommend that, in determining whether or not to grant a licence with respect to a psychiatric hostel, the Commissioner of Health take into account not only the recommendations of the HDWA unit responsible for licensing matters, but also the conclusions and recommendations contained in a written report required to be submitted by the Chief Psychiatrist, and that this requirement be included in future legislative amendment.*

Recommendation 14: Transfer of certain functions to Mental Health Division

76. *We recommend that all functions currently undertaken by the PSLU and related units within the Finance and Resource Management Division with respect to the administration, payment, monitoring and recording of subsidy payable to psychiatric hostels be transferred immediately to the Mental Health Division.*

77. Facility standards are a compilation of not always consistent requirements of local government regulations, Building Code of Australia standards, Australian Standards, and HDWA guidelines. Practice has been for the assessment of the compliance of private sector proposals against these criteria to be undertaken solely by HDWA staff or HDWA contracted employees. There has been no reliance upon the private sector for compliance assessment for licensing purposes, notwithstanding that such practice is now common in other regulatory areas of facility construction such as compliance with local government planning and building regulations.

78. Current licensing practice does not extend to keeping extensive and updated records on proprietor appropriateness and integrity, financial viability, prudential arrangements for public funding, nor on care standards achieved. Licensing practice does not currently incorporate independent commercial professional checks on proponents' financial capacity to meet future obligations, nor does it require independent substantiation of professional reputation or the provision of evidence of the absence of relevant criminal records, or any evidence that (in relation to licence renewal) the views of those most affected by the services offered (namely patients, residents, carers, staff etc) are taken into account. These deficiencies should be corrected.

Recommendation 15: Financial viability of the proprietor

79. *We recommend that future applicants for new licences (in every case) and that applicants for renewal of licences (at least every six years) be required to submit with their application a clear authorisation to enable HDWA, at the applicant's expense, to commission Dun and Bradstreet (or a similar company of repute) to prepare and submit to the Commissioner a report on the sufficiency of the material and financial resources available to the applicant to comply with the requirements of this Act.*

Recommendation 16: Proprietor appropriateness

80. *We recommend further that the authorisation enable Dun and Bradstreet (or a similar company of repute), at the applicant's expense, to attest to the fact that the applicant has attained the age of 18 years, and (by reference to criminal and police records) to offer a view on whether the applicant is a person of good character and repute and a fit and proper person to conduct a private health care facility.*

Recommendation 17: Industry and community esteem

81. *We recommend further that the report submitted by Dun and Bradstreet (or a similar company of repute), at the applicant's expense, include in relation to the applicant, written references provided by members of the community, health care professionals, and representatives of the industry into which the new applicant desires entry or in which the renewal applicant desires to remain.*

Recommendation 18: Patient/resident/carer/staff consultation

82. *We recommend further that, in relation to applications for licence renewal, each application be required to include evidence that the views of patients and/or residents and/or carers and/or family members and/or staff have been sought in relation to the standard of care received and service offered.*

83. In summary, private health services licensing activity by HDWA could be described as being under significant resource pressure, and of exercising varying intensities of examination of the different aspects of private proposals/proponents. Overall HDWA could be exposed to risk through inadequate or non-existent standards in some areas, lack of appropriate inquiry and knowledge in areas relating to proprietors, and over-developed involvement in physical facilities development. In all cases, HDWA carries as much accountability for the adequacy of the service provision as it places on the provider by regulatory/legislative prescription.

84. The establishment of standards and the monitoring of the level of care and facilities provided by the private sector under licence has not been paralleled by equivalent attention to the continuing standards of public sector health services and facilities. Desirable managerial devolution in the public sector has improved systemic responsiveness and accountability at the local level, but consistency of standards particularly in facility and infrastructure maintenance has dissipated within the public system. National competition policy and transparency requirements would indicate that there are good reasons for public sector health services to fall within the same regulatory regime as private sector heath care services. This issue is addressed later in this Report.

Current HDWA Licensing Structure

85. Resources currently deployed on the private sector licensing function are:

Private Sector Licensing Unit:

Extent of current functions in support of licensing:	• processing new licence applications including facility check
	• reviewing existing licenses annually
	• setting, promulgating and monitoring standards of care and facilities
	• coordinating facility checks of new buildings and refurbishment
	• investigating complaints
	• liaison with industry
Staffing deployed on licensing	• 6 personnel
Public funding	• $300,000 p.a. – excluding overheads
Workload	• All the work of the Unit is devoted to private sector licensing

Facilities and Assets Branch:

Extent of current functions in support of licensing:	• develop, promulgate and achieve industry acceptance of policies and guidelines on facility standards in support of expected health outcomes
	• inspection and assessment of proposed and existing facilities for advice on licensing suitability
Staffing deployed on licensing	• 4 departmental personnel, 2 outsourced

	personnel
Public funding	• $412,000 p.a. excluding overheads
Licensing workload	• 20% of total Branch workload is incurred in licensing

Technical Services Unit:

Extent of current functions in support of licensing	• Support to PSLU in fire and security areas, and in sterilising services and imaging
Staffing deployed on licensing	• Around 1 person-year in fire and security, and minor components on sterilising and imaging
Public funding	• $50,000 p.a. excluding overheads
Licensing workload	• 20% of total Unit workload is incurred by licensing

Staffing numbers

86. The aggregate resource usage in licensing of private sector health care facilities can be established at some 13 personnel years (FTEs) and $762,000 per annum excluding overheads.

Resource budget.

87. In early 1998 "cost recovery" of all costs incurred in licensing private health care services was estimated as around $1.7 million p.a. inclusive of overheads.

88. The three units (PSLU, F&A and TSU) have recently been relocated into the Finance and Resources Management Division of HDWA, maintaining the unit separation that existed in their previous divisions. While still separately structured, there appears no difficulty in the functionality of these arrangements from an operational licensing perspective. The Units are, however, readily adjustable to accommodate the various recommendations made in this Report.

Current Western Australian Situation

89. The extent of private health care facilities in Western Australia under the relevant State Acts is set out below. The extent of similar public facilities is provided for comparison.

Facility:	Private:	Public:
Hospitals	29	102
Nursing Homes	109	4
Aged Care Hostels	172	0
Psychiatric Hostels	27	0
Day Surgeries	10	0
Nursing Posts	19	34

Issues Raised by Current Practice

90. Current HDWA practices in licensing of private health care services give rise to a range of issues relevant for consideration in any refinement of licensing arrangements. These issues include both legislative and operational arrangements.

91. Legislative provisions under which licensing occurs have some inadequacies. Statutory requirements relevant to private sector licensing are contained in three separate Acts, infer more than is prescribed, and provide little sanction for non-compliance. The three Acts, the *Health Act 1911*, the *Hospital and Health Services Act 1927*, and the *Mental Health Act 1996*, establish a licensing framework which works but could work more effectively with changes.

92. Characteristics which need improvement include:

- clarification of the definitions of the types of services requiring licensing: hospitals, aged care facilities, day surgeries, nursing posts, psychiatric hostels etc.;
- introduction of differential licence periods to reflect varying standards of facilities and service;
- formalisation of conditional licensing as an improvement mechanism;
- making more explicit the option of revocation of license for non compliance with licence conditions;
- removal of the "pro forma" nature of license renewal;
- entrenchment and definition of standards as a benchmark in licensing;
- inclusion of discretionary elements to enable the legislation to cope with structural/cultural change (eg. "aging-in-place" in aged hostels);
- application of meaningful penalties for non-compliance.

Recommendation 19: Legislative Amendments

93. *We recommend that the various legislative enactments governing licensing be revised and amended to support the recommendations made in this Report, and (inter alia) to address the following issues:*

- *clarification of the definitions of the types of services requiring licensing: hospitals, aged care facilities, day surgeries, nursing posts, psychiatric hostels etc.;*
- *introduction of differential licence periods to reflect varying standards of facilities and service;*
- *formalisation of conditional licensing as an improvement mechanism;*
- *making more explicit the option of revocation of license for non-compliance with licence conditions;*

- *removal of the "pro forma" nature of license renewal;*
- *entrenchment and definition of standards as a benchmark in licensing;*
- *inclusion of discretionary elements to enable the legislation to cope with structural/cultural change (eg. "aging-in-place" in aged hostels);*
- *application of meaningful penalties for non-compliance.*

94. Improvements in these areas could best be effected by legislative change, but many interim improvements consistent with the recommendations of this Review can also be effected in whole or in part by regulatory and operational practice changes alone.

95. The shouldering of risk by private sector providers in relation to the levels and standards of services and facilities supplied is not currently inherent in the manner in which the licensing process is managed. The overly detailed HDWA involvement in "approval" or "endorsement" of the documentary and physical attributes of facilities to be provided precludes proper risk transfer to the private provider. HDWA involvement is prescriptive and operational rather than performance or outcome oriented.

96. There is an imbalance in the levels of HDWA attention to details of standards required of licensees. Overly detailed involvement in facilities standards contrasts with under-detailed involvement in standards setting for proprietor fitness, care, prudential arrangements etc.

97. The net result is that risk management in the licensing process operates to attempt to preclude difficulties arising, rather than to have the private sector provider carry the operational risks of meeting a given set of standards. Any inaction in the face of public knowledge of private sector non-compliance in a regulated area carries public accountability.

98. Under these circumstances, accountability for outcomes (or lack thereof) by private sector service providers is difficult to define. This public sector mingling of regulatory and participatory roles tends to generate public accountability for what is clearly private risk, and undermines the valid government or public sector role arising from the regulation of the quality of service provision.

99. Current management arrangements in licensing incur peaks and troughs of activity because the licence renewal dates have been consolidated to occur at the same time each year. The downstream effect is an intensity of administration and inspection activity that would be better handled if spread throughout the year.

100. A further misapplication of scarce resources is inherent in the practice of using a standard duration of licence rather than using differing periods appropriate to varying standards of facilities and service. Longer duration licence periods would require lower resource levels in licence renewal.

101. As mentioned earlier, current licensing practice for nursing homes entails a high degree of duplication with the Commonwealth approval and accreditation processes for allocation of places and subsidisation.

102. The extent of HDWA involvement in private sector provider proposals for licenses also represents a hidden subsidy to the providers and to the private consulting industry. Cost recovery at this level has been judged not to be publicly supportable.

103. Little use is made of the accountability of other levels of government, or of private sector professionals, and yet HDWA relies to a large extent upon such inputs for licensing decisions. The apparent preference for "in-house" HDWA assessments feeds back into the reduction of risk to the proprietor at the expense of the public.

Risk Management Characteristics and Outcome

104. Licensing was designed to be a mechanism whereby the community would be assured of receiving health care services that met at least a minimum community standard set by the regulator. Risks associated with providing the services were intended to rest with the licensee.

105. Maintenance of an appropriate allocation of risk requires the licensing authority and its agents to be clear about the outcome required in terms of community standards, and to be rigorous about non-interference in the licensee's delivery of service. Non-involvement in the licensee's delivery of service ensures that risk resides with the provider.

106. In practice, a paternalistic view by the licensing authority's employees about the ability of licensees and potential licensees to deliver services, especially services dependent upon facility standards, has led to detailed involvement by HDWA as licensing authority in the private sector development of facilities by proprietors.

107. Despite its best intentions with respect to care outcomes, this detailed involvement results in HDWA being unable to avoid at least partial accountability for the health care outcomes. This is not desirable from either the public or the commercial viewpoints, and the risk management outcome is not appropriate.

108. Insufficient separation of outcome risks is partly the result of the fact that HDWA is the detailed monitor and assessor of inputs in the delivery process, particularly for the provision of facilities. This does not necessarily have to be the case, as sources of relevant professional service exist within the community and are supported by effective indemnity arrangements.

109. Carriage of risk for the adequacy or otherwise of facilities related to private health care delivery could quite readily be undertaken by registered professional consultants engaged by proprietors certifying compliance with HDWA standards, and supported by the normal professional indemnity arrangements. Discussion with professional indemnity insurance brokerage indicates that where an insured professional (such as a registered architect, engineer, building surveyor, etc.) certifies documents or facilities as complying with guidelines, standards, statutory and local authority regulations and the like, the results flowing from that certification action would be covered by normal professional indemnity insurance policies. The normal requirement for the professional to keep the insurer informed about the nature of the business stream applies.

110. This approach is common in similar situations in town planning, property development and the construction industry in many parts of Australia, and is a component of the proposed new *Building Act* for Western Australia. Effective arrangements leading to the acceptance of full responsibility, the avoidance of conflict of interest, and the maintenance of an independent role are covered in the draft proposals. Relevant provisions of the proposed *Building Act* are at **Attachment 7**.

Recommendation 20: Allocation of risk and cost

111. *We recommend that a better balance be struck between public sector licensing and private sector service provision with a more appropriate allocation and acceptance of risk and cost, and that this balance be achieved by adopting a framework for licensing (except in the aged care area) which requires:*

- *future applicants for new licences (in every case) and applicants for renewal of licences (at least every six years) to be required to submit with their application for a licence a Compliance Certificate submitted under affidavit by an architect or engineer or building surveyor (the Accredited Certifier) of the applicant's choice;*

- *the Accredited Certifier to be professionally registered in Western Australia (with the professional registration number identified on the certificate);*

- *the Accredited Certifier to be accredited by HDWA (with the accreditation number identified on the certificate);*

- *the Accredited Certifier to be the holder of appropriate professional indemnity insurance (with the company and policy number identified on the certificate);*

- *the Accredited Certifier not to be the architect, builder or any other person consulting to or contracting to the works (with a statement to this effect to be explicitly made on the certificate);*

- *the Accredited Certifier may be privately employed, be employed by a local government authority or be employed in the State public service;*

- *the Accredited Certifier not to be or to have been involved in any aspect of the design or documentation of the building (with a statement to this effect to be explicitly made on the certificate);*

- *the Accredited Certifier not to have a direct or indirect financial interest in the building or in any body associated with the building (with a statement to this effect to be explicitly made on the certificate);*

- *the Accredited Certifier not to be employed by any person or body associated with any aspect of the building, except only for their employment as Accredited Certifier (with a statement to this effect to be explicitly made on the certificate).*

- *the Compliance Certificate to assert that the Accredited Certifier has read and understood the officially published standards relevant to the facility for which a licence or licence renewal is sought;*

- *the certificate to confirm either:*

    - *that the facility for which the licence or licence renewal is sought fully meets the officially published standards relevant to the facility; or*

    - *that the facility for which the licence or licence renewal is sought does not fully meets the officially published standards relevant to the facility, in which case the certificate is to specify in precise terms those elements of the officially published standards relevant to the facility which are not met and provide a program and timeframe in accordance with which it is proposed that the deficiencies identified are to be remedied.*

Recommendation 21: Assessment of certificate and grant of licence

112. *We recommend further that, on the basis of the certificate submitted, HDWA assess the application and*

- *where the certificate confirms that the facility for which the licence or licence renewal is sought fully meets the officially published standards relevant to the facility, considers whether or not to grant a full licence for the relevant period; or*

- *where the certificate confirms that the facility for which the licence or licence renewal is sought does not fully meet the officially published standards relevant to the facility, considers whether or not to grant a conditional licence for the relevant period, taking into account the submitted program and timeframe in accordance with which it is proposed that the deficiencies identified are to be remedied.*

113. Another aspect of risk that should properly be allocated and accepted is compliance by local government with its responsibilities under the *Health Act 1911*. The variable (in)frequency of health inspections undertaken by some local authority inspectors can result in the need being filled by HDWA monitoring. More appropriate shouldering of responsibility by private providers could be achieved by HDWA, not through PSLU/F&A licensing and monitoring mechanisms, but by the Executive Officer Public Health using his/her powers under the *Health Act 1911* to make orders binding the local authority to act.

Recommendation 22: Role of Executive Director Public Health

114. *We recommend that the Executive Director Public Health become more involved with the licensing process through on-going discussion and consultation with local government authorities and, as a last resort, by using his/her powers under the* Health Act 1911 *to make orders binding the local authority to act to ensure that health inspections undertake regular inspections of licensed health and aged care institutions in Western Australia.*

115. The proper allocation and acceptance of risk by private sector proprietors and their agents also includes allocation of attendant financial risk, within a competitive framework relying on "value for money". Consequential financial risks could be underwritten through professional indemnity cover applied to the quality of professional input to the processes.

Sufficiency of Current Standards

116. As mentioned earlier, the development of standards used as performance benchmarks for the licensing of private sector services and facilities is quite variable. Apart from content areas that are perceived by HDWA itself to be under-developed, there is an industry perception of lack of guidelines in some areas, and overly demanding non-commercial and continuously changing requirements in other areas.

117. In the case of hospitals, the content of national (ACHS) standards of service is seen as an appropriate means of identifying and monitoring standards of care. On the other hand, the HDWA "Private Hospital Guidelines" for construction, establishment and maintenance of private hospitals (including refurbishment) are seen as clearly, if on occasions prescriptively, providing a straight forward functionally-based set of criteria.

118. What is questioned from time to time is the extent to which those guidelines call for criteria over and above relevant Australian Standards issued by the Australian Standards Association and local government codes. Also questioned is the claimed tendency for HDWA to require further improvements over the standards, whether by code changes after development has commenced, or by varying personal interpretation(s) of the guidelines.

119. There is no documented standard of suitability of individuals or corporations as proprietors or principals; acceptable standards appear to be solely a matter of HDWA perception or judgment. If those judgments were supported by detailed background analysis, then licensing standards could be regarded as acceptable in this aspect. Such analysis is, however, in fact rare. Similarly financial and prudential requirements are undocumented.

120. In residential aged care services, HDWA licensing addresses only upper end or nursing home care, with hostels not being addressed. The situation with respect to proprietor suitability and care standards for nursing homes is rudimentary and is reliant upon judgment and perception for effectiveness. On the other hand, the Nursing Home Design Guidelines of 1996 provide highly prescriptive requirements for building attributes and generalist requirements for engineering services. In both cases, HDWA provides many requirements over and above the Australian Standard or code relevant to the subject matter.

121. The guidelines for nursing home facilities are more demanding in many respects than the standards set by the Commonwealth for aged care place allocation and funding, which raises legitimate questions as to what standards really are appropriate for residential care. Careful liaison has to date avoided conflicts between State and Commonwealth requirements, but Commonwealth accreditation will ultimately bring into question the legitimacy of the more demanding (overall) state licensing requirements.

122. The state "guidelines" for hospital and aged care facilities are predicated on a regime of assessment, monitoring and approved by public sector personnel at progressive stages of approval in principle, documentation, construction, and post-construction. The guidelines contemplate incorporation of other regulatory body approvals, but do not rely upon those clearances in any real way. Use of private professional risk shouldering in assessment or compliance monitoring is not contemplated in the guidelines, nor is such risk shouldering currently incorporated in licensing practice.

123. At the present time no HDWA standards similar to those for aged care and health facilities exist for psychiatric hostels. While the industry is aware that some are under development, a concern is held that an imbalance will arise between those proposed standards and the affordability inherent in the level of pensions or disability payments made to residents. Day surgeries, nursing posts etc. have no dedicated guidelines.

124. The standards/guidelines have two areas of weakness. One fundamental difficulty is that there is a process prescription underlying the guidelines, rather than an outcome performance requirement. Traditional public sector methods entailing detailed scrutiny of process often mean that accountability for adequacy of results rests with the scrutinising party, whereas achievement of a result by the other party is the goal. It could be that the association of guideline development with traditional public sector capital works processes has influenced the conceptual basis of the guidelines, rather than the regulatory role of licensing.

125. The other area of weakness in the standards is that they are absolute, and as a result the desirable licensing practice of progressive upgrading over consecutive licence periods can often involve interim acceptance of standards lower than prescribed in the documents.

Recommendation 23: Formulation of Standards

126. We recommend that HDWA adopt as a principle the formulation of a three-tiered approach to the setting of standards for licensed health care facilities involving:

- *formal adoption of Building Code of Australia and/or Australian Standards Association standards (where available, and as amended from time to time);*
- *incorporation of Western Australian local government and statutory requirements (including fire and public health regulations, local authority building codes etc.); and*
- *augmentation of the above standards by the preparation and promulgation by HDWA of additional requirements only as strictly required to meet specific and otherwise unmet Western Australian and Departmental needs.*

Recommendation 24: Content of Standards

127. *We recommend further that HDWA standards for each type of licensed care fully address requirements against which assessments can be made of the:*

- *fitness and propriety of the applicant, including the sufficiency of the material and financial resources available to the applicant in terms of legislative requirements;*
- *suitability of the proposed premises for the designated purpose; and*
- *arrangements proposed for the satisfactory maintenance of appropriate clinical standards, and for the management, equipment and staffing of the facility.*

Recommendation 25: Process for developing Standards

128. *We recommend further that HDWA adopt the following formal process for the formulation, publication and revision of Standards:*

- *Draft Standards, in accordance with the provisions of Recommendations 23 and 24, and draft revisions to existing Standards to be prepared by HDWA;*

- *the Draft Standards and draft revisions to be released and widely circulated for a period of 60 days during which industry and public comment, reaction and input can be obtained;*

- *industry and public comment, reaction and input received to be assessed and considered within 30 days by a formally constituted Standards Reference Committee representative of the Department, the relevant industry group, consumers and health care professionals;*

- *amended Standards and revisions to be prepared and endorsed by the Standards Reference Committee for submission to the Commissioner of Health;*

- *Standards and Revised Standards to come into effect only upon their formal authorisation by the Commissioner of Health and their publication by him.*

Future Scope of Licensing

129. Earlier sections of this Report have addressed the existing framework of licensing and illustrate that the extent and coverage of current licensing exhibit some piecemeal characteristics developed over time through legislative and regulatory practice.

130. Evolution of private health care services has led to a widening of the extent and categories of service on offer, and to changing relative competencies of public and private health care services. Services provided by both sectors can be variable.

131. With the continuing development of private sector services and the implications of national competition policy, there is a need to address the different basis of treatment of services depending on sector of origin. With private sector services being subject to licensing for public certainty of achievement of set standards of services and associated facilities, there appears little reason not to apply the same standards regime to public sector services (including health services).

132. While existing legislative provisions in licensing apply only to privately sourced services and are not legally oriented to publicly sourced services, applicable standards can be applied administratively to those publicly provided services. In most cases those standards are currently and readily achievable by the public sector. It is therefore proposed that the private sector licensing standards and assessment/certification regime also apply to public sector health services. The equivalent of private sector compliance could be achieved by using the concept of a corrective tied-for-purpose component being designated into the usual one line appropriation to public health care organisations, if and where necessary.

Recommendation 26: Application of Standards and licensing to public sector

133. We recommend that public sector health and aged care services be subject to the same standards and licensing arrangements and processes as apply to similar private sector services, and, in the case of services other than aged care services, that:

- *where a public sector facility is assessed as fully meeting the relevant Standard, a licence be granted for an appropriate duration;*

- *where a public sector facility is assessed as not fully meeting the relevant Standard, a conditional licence be granted for an appropriate duration, with the licence being conditional upon agreement between HDWA and the licensee with respect to the adherence by the licensee to a program of corrective action to address the deficiencies identified in the Compliance Certificate provided by the accredited certifier.*

Recommendation 27: Budget restriction on public sector facilities holding conditional licence

134. *We recommend further that, where a public sector service is granted a conditional licence for an appropriate duration, that service have imposed upon it a budget restriction to the effect that an identified portion of each annual capital budget appropriation to that service be by way of a "tied-for-purpose" component, with the purpose being specified as action required to remedy over an agreed period the deficiencies identified in the Compliance Certificate provided by the accredited certifier.*

135. This Review has earlier proposed the extension of licensing of private sector residential aged care services (ie. nursing homes) to include aged care hostels under a common Australia wide process of certification and accreditation. Any publicly provided residential nursing home and aged care hostel should also fall within the same framework.

136. In the case of psychiatric hostels, relevant legislation includes, through definitions of care and size of resident population, an overly wide range of establishments subject to licensing. Current HDWA proposals for legislative amendment (as well as those suggested by this Review) would remove general residential establishments from this coverage by accurately defining both the duration of residency and extent of care attributes for psychiatric hostels subject to licensing.

137. Private day surgeries and nursing posts are licensed through current arrangements, and both private and public sector services would, under the reforms recommended, meet the same regime.

138. The existing licensing framework exhibits its most effective results in the regulation of private hospital services where industry competence and understanding of care and facilities is most developed. No changes are proposed in the coverage requirements for private hospital licensing, but the amendments proposed to the framework of licensing in this Report should apply.

139. Some other aspects of public hospital services are addressed near the end of this Report.

Resource Demands

140. It is abundantly clear from HDWA employee comments, and from observations by the private sector health care industry, that the current level of HDWA resources deployed on the present method of conducting the licensing process is inadequate to support the currently required level of licensing activity.

141. This Report earlier proposed that licensing of aged care services and facilities be integrated with and be dependent upon the Commonwealth approval and accreditation process. That proposed change would significantly reduce the demand on resources in the HDWA licensing area.

142. This Review has indicated that some further alleviation of HDWA licensing resource demand is possible by administrative fine-tuning. This would include variable licence periods with automatic, inspection-free licence renewal for multiple year periods for service providers who fully meet or exceed the prescribed standards, with a staggering of renewal dates away from the current single end of calendar year timing for all renewals.

143. Even so, the extent of industry complaint about lack of customer service and delayed turnaround times for approvals at each stage of the current licensing process is indicative of a mismatch between the demand for licensing and the capacity to respond. Forecast increases in the number of providers and facilities can only exacerbate the situation.

144. Consideration therefore needs to be given to structural changes in licensing methodology that could achieve a more efficient level of resource use in the public sector while providing every incentive for clear, simple and effective licensing arrangements to meet both public and private sector expectations.

Future Management of Licensing - Options

145. Several options emerged during the Review for managing the underlying workload of licensing of private health care services. These range from full deregulation to increased public sector funding and staffing of current operational methods. These options, and the relative merits of each, are explored.

146. Deregulation of private health care provision by the removal of any requirement, legislative or regulatory, for licences by the State has some superficial attractiveness and simplicity, but raises the old debate about where the appropriate interface should be between public and private interest. Apart from the requirement for significant legislative change, such an approach could be expected to have, in some cases, an adverse impact on the standards of health care delivered privately. While there would be an associated public sector saving of around $650,000 per annum excluding overheads, any deregulation is unlikely to be publicly, privately, or politically acceptable.

Recommendation 28: Complete deregulation not a viable option

147. *We recommend that complete deregulation of private health care provision by the removal of any legislative or regulatory requirement for State licensing be deemed an inappropriate response.*

148. An increase in public resources deployed on licensing activities would need to be in the order of around $500,000 per annum to fully resource current methods of licensing. While the improvement that this would permit in the response times related to the licensing process would no doubt be welcomed by the private health care sector, such a resource increase in the prevailing climate is unlikely to be achieved. Although a service culture would be easier to develop in the licensing processes with increased resources, there would be little incentive for continuing refinement and development of those activities, and unchanged risk allocation between the private health sector and the public sector licensing authority would remain. An opportunity for on-going improvement would be lost.

Recommendation 29: Supplementation of resources for existing activity not a viable option

149. *We recommend that full supplementation of resources for existing activity be deemed an inappropriate response.*

150. There have been proposals in the past that the resource issue be addressed by recovery from the private sector of the full cost of licensing activity. This would be by a substantial increase in the fees currently charged for licenses and associated activity, or by a cost-incurred charge-back regime. Apart from having the same deficiencies mentioned above in the discussion of a proposed increase in public resources devoted to licensing activities, this cost recovery proposal is unlikely to be privately or politically acceptable. It would be to abandon the opportunity for refinement and development of licensing processes, and would require frequent regulatory updating of fee levels, or require the implementation of a full accrual based charging system for administrative activity. The major deficiency is the unchanged nature of risk carriage by the public sector. Nonetheless, an Administrative Charge (of around $100) should be applied to all applications submitted for consideration.

Recommendation 30: Full cost recovery not a viable option

151. *We recommend that full cost recovery for existing activity be deemed an inappropriate response.*

Recommendation 31: Administration Charge required

152. *We recommend further that there be implemented in the context of the adoption of our other recommendations the setting by regulation of an Administration Charge or fee of around $100 to be paid at the time any application for a new licence or for the renewal of an existing licence is submitted*

153. A further proposal is that the licensing activity undertaken by HDWA be outsourced either by contracting out the current in-house processes, or by pursuing a potential buy-out of that in-house activity by a group of employees. Outsourcing would require the establishment and ongoing management of a performance-based contact for services, and a buy-out would require similar continuing contract management. The underlying need would be for the adoption of benchmark standards, and for the monitoring and evaluation of processes already under pressure. While there is a likelihood of some improvement in licensing process efficiency and customer service culture, there remains potential for increases in public sector costs and, because private sector service delivery remains, little or no change in the risk allocation between public and private health sectors, would ensue.

Recommendation 32: Contracting out and employee buy-out not viable options

154. *We recommend that contracting out the current in-house processes and/or pursuit of a potential employee buy-out of current in-house activity be deemed inappropriate responses.*

155. A licensing proposal warranting consideration is one in which the public sector and the private sector combine jointly to achieve on a mutually supportive basis the real goal of the regulatory process; that is, private sector delivery of services (and facilities) at the requisite standard established by the public sector. Assessment and certification of compliance with public standards is a function requiring professional and technical skills, and there is a developing community practice of private sector professionals undertaking assessment, monitoring and certification of public regulatory compliance on behalf of private proprietors. Provisions precluding potential conflicts of interest, sanctions for biased judgments, and indemnity insurance for professional service insufficiency are attributes of this approach.

156. In the health care services licensing field, such a proposal would involve redirection of public sector resources towards improvement of the care and facilities standards framework of licensing. In parallel, private proprietors would engage private sector professionals for the assessment and certification of compliance. State licensing would be based on that professional certification, and be supported by a random program of inspection.

Recommendation 33: Random inspection program

157. *We recommend that State licensing activity, based on professional certification, be supported by an on-going program of random inspection designed to ensure maximum reasonable coverage of the facilities and services licensed.*

158. Private professional services would, under this model, be sourced from a range of state registered professionals accredited with HDWA at the discretion of the Commissioner of Health, and the undertaking of adequate and relevant professional indemnity insurance would

be one of the terms of that accreditation. The straightforward accreditation process would not be managed by the HDWA licensing area.

Recommendation 34: Accreditation

159. *We recommend that any professionally registered architect, engineer or building surveyor be entitled to seek accreditation from the Commissioner of Health as an Accredited Certifier, and that the process of managing the accreditation process not be managed by the HDWA licensing area.*

160. Improvement in the relevance of standards, particularly in facilities, would be achieved by the public sector convening an ongoing consultative forum with private (and public) providers of hospitals, hostels etc., so that public sector setting of standards was fully cognisant of providers' views. Authority for setting standards would be exercised through a transparent, consultative process, but would rest solely with the public sector. Even so, given the special circumstances of psychiatric hostels, it would be desirable for the proposed granting or renewal of licences for such hostels to occur only after consideration by the Commissioner of Health or his delegate of a written report by the Chief Psychiatrist.

161. This approach has a number of attractions. Apart from public improvement and clarity of standards, health care providers can integrate the professional services of assessment, monitoring and compliance into their own timetables for development of proposals, and can engage professionals of their choice. There is an incentive for process efficiencies being developed in private assessment and monitoring activity. Much of the customer service culture related to activity in licensing lies within the influence of the private providers or proponents. The 'turnaround' time for licensing would rest mostly in the proponents' area of influence.

162. Performance risk of compliance with given standards would rest clearly with the provider, an appropriate risk allocation would be achieved, and costs generated by private sector activities would be met by the private sector. Public costs would be reduced to include only those associated with the standards setting and licensing administrative function.

163. The overall proposal is considered acceptable from private, public and political viewpoints, and requires no immediate legislative change, and minimal regulatory change.

Preferred Licensing Framework

164. A private health care licensing framework exists to ensure the achievement of established health care standards by those private providers who wish to participate in that field. To be credible, the framework must not only be straightforward, understandable and equitable, but it must also operate with effective sanctions in withdrawal of licence or the imposition of an appropriate penalty for non-compliance with those established standards. Further, any system in which each party is accountable for and meets the costs most directly incurred by its own activity is more likely to be supported and less open to challenge.

Recommendation 35: Sanctions

165. *We recommend that the relevant legislation be amended to ensure that the Western Australian licensing framework is supplemented with effective sanctions by way of withdrawal of licence or the imposition of an appropriate penalty for non-compliance with established standards, including specific sanctions, both remedial and punitive, against breaches of duty of care by Accredited Certifiers.*

166. It is clear to this Review that the present licensing framework is under pressure, a result of the combination of current processes, restrained public resource availability and a degree of absoluteness in documented standards. There needs to be a shift in process to improve the outcomes. Further, it is seen that the current licensing arrangements so intermingle licensor and licensee activity that clear and unequivocal shouldering of relative responsibilities arising from the licensing process is neither likely nor achieved.

167. Fundamental to all methods of licensing is an established set of standards of care, services and facilities, pitched at an appropriate level of community needs and expectations, and which lends itself to the concept of progressive improvement of services at the lower end of the acceptable spectrum. The current standards, for pragmatic and sensible reasons, from time to time require reluctant acceptance and licensing of services and facilities that are clearly non-compliant with standards. This undercuts the credibility of the process. While pragmatic and sensible reasons usually spring from the lack of alternate care and accommodation for the users of the service in question, the licensing of such non-compliant services generates intra-industry difficulty and potential public accountability for what is a private responsibility. Hence the Review has proposed a system of conditional licensing in these circumstances.

168. A fact not widely recognised is that the current licensing methodology so intermingles public and private responsibilities that it is difficult to identify clear private accountability for services provided under licence. The overall framework and its method of operation must avoid this blurring of accountability while ensuring the provision of services to the requisite standards.

169. It is for these reasons, and others mentioned earlier, that significant changes to the processes, as distinct from the concept, of the current licensing arrangements are recommended by this Review.

170. These changes are based on:

- HDWA to concentrate its resource on refinement of standards for proprietors, care, services and facilities in consultative co-operation with the industry, but with sole authority for the standards vested in HDWA. The consultative arrangements for further

development of standards would be supplemented by the issue of draft standards to all licensed providers, applicants, and industry representatives for consideration over a 60 day period, with the consultative committee having a further 30 days for consideration of comments received and any amendments judged desirable by HDWA before formal adoption of those standards by the Commissioner of Health for the purpose of licensing;

- HDWA to continue to license all aged care services, nursing homes and aged hostels, with a staged transition with respect to aged care from HDWA assessment, inspection and monitoring to reliance on the developing Commonwealth system of proprietor approval with certification and subsequent accreditation as the pre-requisite for state licensing; no change in the statutory requirement for Western Australian licensing is envisaged;

- the current arrangements under which HDWA personnel assess and clear private provider proposals for services and facilities to be replaced by a reliance, wherever the equivalent private sector professional service exists, upon private professional services for this assessment and clearance of compliance with HDWA standards;

- those private professional services to be engaged and remunerated by the proprietors seeking approval, and only professional services accredited by HDWA and carrying full professional indemnity insurance for the services to be eligible to provide licensing inputs;

- better identification of proposed provider suitability through provider-funded submission to HDWA of information required by HDWA about the provider. This would canvas such issues as personal or corporation community repute, financial capacity for the services contemplated, industrial relations history, prudential arrangements for receipt of public funding, any civil/criminal legal complaints or judgments, and previous history in provision of health care in the field under consideration. Providers or proponents would authorise and fund such reporting from HDWA-nominated commercial reporting agencies, relevant accountants, the Police, and from nominated senior representatives of the relevant health industry. In this way the legislative requirements of proprietor character and capacity are more likely to be fully met;

- for the more competent suppliers of private health care services, the issue of licences effective for appropriate longer periods (such as 3 years), including formal advice of HDWA intention, as a matter of course, to renew the licence annually as is required by current legislation. The usual sanctions available under the legislation, such as cancellation, to remain available if needed. Reduction in unwarranted administrative workload to be the aim;

- change in legislative authorities, and inclusion in the *Health and Hospital Services Act 1927* of more realistic penalties for non compliance with published standards.

171. The adoption of this framework for licensing of private health care services would see maintenance of existing quality standards of health care and facilities, improvements in the efficiency of licensing, cost reduction in the public sector and risk carriage appropriately met by the directly responsible party.

Other Issues Arising

172. This detailed Review of HDWA licensing processes for private sector health care inevitably confronted other issues outside the specific brief of the Review. As several significant matters in public health care came to attention, comment is warranted.

173. By way of background, the last decade has seen steady devolution of management of public health care institutions from centralised bureaucracies to decentralised management in the pursuit of direct performance accountability and under relentless pressure on available public resources. As part of a broad-based drive for efficiency, this is a recognised management reform that clearly brings results in responsiveness, efficiency and accountability. The reform thrust invariably includes provision for more developed management reporting, decentralised funding and purchasing, increased delegation of authority, and more local autonomy. Less in evidence is the provision of compensatory structural mechanisms in organisations to institutionalise efficient quality support functions and which do not demand attention in the face of the attractions of increased autonomy.

174. The Review encountered consistent comment that reform of the managerial arrangements affecting Western Australian public sector health services and associated facilities had seen devolution of once centralised authority in management being accompanied by significant reduction in centralised support functions. The theme of this widely held view is that devolved management with a focus on operations was not provided with the necessary capacity nor the requisite staff skills to ensure that facilities remained at the standards necessary for adequate public health care delivery. Furthermore, localised trade-offs permitted solution of short term operational issues at the expense of longer term needs.

175. Health care is wide-ranging and increasingly technological, equally dependent upon both providers and facilities for the adequacy of the service. It is apparent in the case of Western Australian public sector health services that the lost strength of centralised facility (and equipment) support programs has not been offset during managerial devolution by a sufficient quality assurance mechanism to ensure that the condition and operation of facilities and equipment is without risk to both health care and personnel. Examples of boiler failure, inappropriate systems choice, and hazardous and dangerous alteration of installations are indicative of systemic inadequacy in service support.

176. The TSU and the F&A Branch both impact upon the maintenance of the physical plant and equipment of public sector health care facilities, but both of these units are in the unfortunate juxtaposition of having possession of requisite knowledge and skills with little involvement in relevant decisions, other than as a point of technical reference by some other operational area.

177. While upgrade programs for imaging equipment and sterilisation capability are established on a coordinated basis, there is minimal specialist involvement in operational and preventative maintenance for facilities. A recent Commonwealth funded independent study of the maintenance backlog in Western Australian public sector health care facilities identified a 10-year forward maintenance backlog that consisted of some $280M of deferred and/or projected essential work.

178. The net effect of this gap between managerial systems and facility support is that appropriate management of the risks involved does not occur. There is neither formal nor audited risk

management in this area, and few if any consistent standards. It can only be that facility risk is at a major, and only currently latent, level.

179. This deficiency is well illustrated by the fact that a public health facility failed to meet the standards required for a HDWA licence when it moved into private proprietorship. That this risk needs to be addressed is undeniable, yet return to centralised management is neither desirable nor achievable in the current resource environment. Rather, a way needs to be found to ensure that decentralised management is aware of and addresses appropriate standards in all areas of health care delivery. Hence this Review's recommendation with respect to conditional licensing of and budgetary restrictions on public sector facilities which do not meet the prescribed standards.

180. Transparency, equity and national competition policy indicate that public and private service delivery should be on an equivalent footing. Accordingly, and for the reasons discussed above, the Review has proposed that the licensing regime developed for private sector health services in Western Australia also be applied to the Western Australian public sector health services. There are no grounds for accepting different standards from each sector, nor are there grounds for tolerating substantial decline in existing facilities in the public sector.

181. The licensing regime would contribute to health care in two ways. Apart from promoting essential system-wide recognition that similar standards need to be met by the public and private sectors, it would also redirect operational managerial attention to proper management of risk by harnessing support services expert in the facilities risk field, as well as the more usually addressed health care services field.

182. At the implementation level in HDWA, this would not involve additional resource input into meeting the standards adopted for health care delivery, as redeployment of existing resources has been recommended for the reinforcement of the standards developed for private sector licensing purposes.

183. It is in the monitoring and support area of compliance assessment and in the area of operational and preventative maintenance identification and implementation that the high level of non-managed risk in the Western Australian public health services field can be ameliorated. The resource impact could be accommodated by redeployment to this strategic task of some of the higher level resources currently deployed on detailed inspections, monitoring and assessment of private sector health facilities.

184. The proposal to deploy centrally-identified, tied-for-purpose funded programs in public facility preventative maintenance has a clear operational basis that parallels this Review’s recommendations about the management of private sector health care provision. Specifically, this involves clear standards setting, execution of the tied-for-purpose programs by the public sector's professional consultants, and an arms-length random inspection program by the standards group. Neither TSU nor F&A should be resourced or held responsible for preventative maintenance contract administration/acceptance, which would remain a local management matter.

HDWA Organisational Impact

185. This Review has recommended a number of changes to HDWA functions in private services licensing, public standards setting, private compliance certification, and centralised specialist support to devolved facility management (as tied-to-purpose maintenance programs).

186. Implementation of these recommendations would involve the following organisational changes to the PSLU, the F&A Branch, and the TSU within the Finance and Resource Management Division:

- abolition in their current form of these units;
- establishment of a *Health and Aged Services Licensing Unit* with a Standards Section of around five (5) personnel for development of formal standards on proprietors, services and facilities, and a License Administration Section of some four (4) personnel.

Recommendation 36: Establishment of a Health and Aged Services Licensing Unit

187. *We recommend that the PSLU, the F&A Branch and the TSU be abolished, and that there be established within the Finance and Resource Management Division of HDWA a Health and Aged Services Licensing Unit with a Standards Section of around five (5) personnel for development of formal standards on proprietors, services and facilities, and a License Administration Section of some four (4) personnel.*

188. The Unit would require close access to and cooperation from the other technical personnel of the current F&A Branch and the TSU so that the standards section does not become unduly isolated from technical practice. Innovative staffing practices should be adopted, including staffing some positions in the new Unit by way of short-term secondment from other parts of the state health system and from the private sector.

Recommendation 37: Staffing the Health and Aged Services Licensing Unit

189. *We recommend that all positions in the new Unit be filled after advertising within HDWA with careful attention being paid to the selection of the most appropriate person to manage the Unit, and that innovative staffing practices be adopted, including staffing some positions in the new Unit by way of short-term secondment from other parts of the state health system and from the private sector.*

190. The F&A Branch/TSU functions and staff not drawn into the new Health and Aged Services Licensing Unit should be considered for incorporation into the proposed shared services division or agency currently under consideration within HDWA.

Recommendation 38: Shared or Common Services Agency

191. *We recommend that F&A Branch/TSU functions and staff not drawn into the new Health and Aged Services Licensing Unit should be considered for incorporation into the proposed shared services division or agency currently under consideration within HDWA.*

Attachment 1:

Personnel Interviewed

BASHAM, Ray	Facilities and Assets Branch, HDWA	Consultant Health Architect
BASSETT, Bob	Facilities and Assets Branch, HDWA	Consultant
BUCKLEY, Alan	Facilities and Assets Branch, HDWA	Manager, Facilities and Assets Branch, HDWA
BURRELL, Geoff	Public Sector Licensing Unit, HDWA	Consultant
CARPENTER, Mike	Facilities and Assets Branch, HDWA	Asset Adviser
DEBOWSKI, John	Facilities and Assets Branch, HDWA	Principal Consultant, Health Engineering
FLETT, Penny	Brightwater Care Group	Executive Director
HALL, Bobby	Salisbury Homes	Proprietor
HEFFORD, Jenny	Aged and Community Care Unit, Department of Health and Aged Care	Director, Quality Assurance
HOOKWAY, Trevor	Facilities and Assets Branch, HDWA	Research Officer (CADD)
HORNE, Darrell	Facilities and Assets Branch, HDWA	Consultant, Health Facility Standards
KIRKWOOD, Alex	Financial and Resource Management Division, HDWA	General Manager, Finance & Resources
LE COULTRE, David	Belswan Group	General Manager
LIPSCOMBE, Penny	Mental Health Division, HDWA	Principal Policy Officer, Mental Health
LIPTON, George	Mental Health Division, HDWA	Chief Psychiatrist
LYONS, Helen	Western Australian Association for Mental Health	Executive Officer
MACKEY, Ruth	Public Sector Licensing Unit, HDWA	Manager, Public Sector Licensing Unit, HDWA
NOMINSKI, Teresa	Glyde Street Hostel	Manager
PALMER, James	Honeybrook Lodge	Proprietor
PICKWORTH, Jenny	Legal Unit, HDWA	Consultant, Legal Services
PSAILA-SAVONA, Paul	Public Health Division, HDWA	Executive Director, Public Health
RIDGE, Ken	Baptist Care	Chief Executive Officer
RIDGE, Noel	Technical Services Unit, HDWA	Building Inspector

ROBINS, Phil	Facilities and Assets Branch, HDWA	Consultant Sterilising Services
SORARU, Claude	Facilities and Assets Branch, HDWA	Consultant, Health Architecture
STELLING, Brian	Facilities and Assets Branch, HDWA	Commissioning Officer
STOKES, Bryant	HDWA	Chief Medical Officer
STUART, Andrew	Aged and Community Care Unit, Department of Health and Aged Care	Branch Head
TAYLOR, Graeme	Technical Services Unit, HDWA	Consultant, Maintenance Engineer
TAYLOR, Mitch	Public Sector Licensing Unit, HDWA	Liaison Officer
TUXWORTH, Ian	Belswan Group	
WATSON, Melissa	Public Sector Licensing Unit, HDWA	Liaison Officer
WILKINSON, Ross	Technical Services Unit, HDWA	Manager Technical Services

Attachment 2:

Extracts from the *Hospitals and Health Services Act 1927*

Interpretation

2 (1) … .

> "hospital" means an institution for the reception and treatment of persons suffering from illness or injury, or in need of medical, surgical or dental treatment or assistance, and includes a maternity home or maternity hospital, day hospital facility, nursing home or nursing post; …
>
> "private hospital" means a hospital that is not a public hospital; …

Application of Act

3 (1) This Act applies to any private hospital … .

Licence to conduct a private hospital

26B (1) Any natural person or body corporate who or which desires to conduct a private hospital may apply and obtain a licence to conduct a private hospital.

(2) Subject to this Act, a person not being a member of a firm or a body corporate who desires to obtain a licence to conduct a private hospital shall satisfy the Commissioner -

(a) that he or she has attained the age of 18 years;

(b) that he or she is a person of good character and repute and a fit and proper person to conduct a private hospital;

(c) that he or she has sufficient material and financial resources available to him or her to comply with the requirements of this Act; and

(d) that he or she understands fully the duties and obligations imposed on him or her in relation to the conduct of a private hospital under this Act and otherwise. …

Premises to be approved

26C The Commissioner shall not grant a licence to conduct a private hospital unless he is satisfied-

(a) that the proposed premises are suitable to be approved as a private hospital; and

(b) that arrangements for the management, equipment and staffing of the private hospital are satisfactory.

Grant of licence

26D. (1) Where the Commissioner is satisfied that an applicant complies with the requirements of section 26B and the premises at which the applicant proposes to conduct the private hospital are satisfactory for that purpose and that the arrangements for the management, equipment and staffing of the private hospital are satisfactory he may grant a licence to the applicant.

(2) The Commissioner may impose such terms and conditions, as he thinks fit in relation to any licence granted under this section.

(3) Without limiting the generality of subsection (2) conditions imposed in relation to a private hospital may specify –

(a) the maximum number of patients that may be treated at any one time at the private hospital and kinds or classes of patients that may be treated at the private hospital; and

(b) the number and the categories of nursing and other staff, the kinds of nursing and other care that shall be provided or available at the private hospital and the periods and times at which they shall be provided or available. …

Duration of licence

26E (1) Subject to this Act, every licence is valid from the date of its being granted but may be surrendered or cancelled pursuant to this Part.

(2) A licence may be renewed annually in accordance with the regulations.

(3) A licence is not transferable. …

Guidelines

26J (1) The Commissioner may issue guidelines with respect to the construction, establishment and maintenance of private hospitals.

(2) Guidelines issued under subsection (1) may –

(a) specify standards to be observed and procedures to be followed in relation to the construction, establishment and maintenance of private hospitals;

(b) adopt, either wholly or in part of with modifications and either specifically or by reference to any rules, regulations, codes, instructions or subsidiary legislation under any Act of the State or the Commonwealth or any standards, rules, codes or specifications of the bodies known as the Standards Association of Australia, the British Standards Institution or other body specified in the guidelines. …

Provisions of Part IIIA apply to private psychiatric hostels

26Q (1) Subject to this section, Part IIIA applies to and in relation to private psychiatric hostels as if references in that part to a private hospital were references to a private psychiatric hostel.

Attachment 3:

Extracts from the *Mental Health Act 1996*

Definitions

175. In this Part –

"private psychiatric hostel" means private premises in which 3 or more persons who:

(a) are socially dependent because of mental illness; and

(b) are not members of the family of the proprietor of the premises,

(c) reside and are treated or cared for.

Meaning of "mental illness"

4. (1) For the purposes of this Act a person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgment or behaviour to a significant extent.

(2) However a person does not have a mental illness by reason only of one of more of the following, that is, that the person:

(a) holds, or refuses to hold, a particular religious, philosophical, or political belief or opinion;

(b) is sexually promiscuous, or has a particular sexual preference;

(c) engages in immoral or indecent conduct;

(d) has an intellectual disability;

(e) takes drugs or alcohol;

(f) demonstrates anti-social behaviour.

Attachment 4:

Extracts from the *Health Act 1911*

Powers of Executive Director, Public Health and Officers

12. The Executive Director, Public Health and any medical officer or environmental health officer acting with his authority, shall have all the powers of a medical officer of health or environmental health officer of a local government, and may exercise such powers in any part of the State, and the Executive Director, Public Health shall have all such rights and powers as the local government would have in case its medical officer of health or environmental health officer exercised the power, or to enable such officer or environmental health officer to exercise the power. Any provision of this Act conferring any power on a medical officer of health or environmental health officer of a local government, or relating to or connected with the exercise of any power by him, shall be construed and have effect for the purposes of this section as if the references therein to a medical officer of health or environmental health officer of the local government extended to the Executive Director, Public Health or any medical officer or environmental health officer acting with this authority, and as if all references to a local government extended to the Executive Director, Public Health.

Executive Director, Public Health may act where no local government

16. The Executive Director, Public Health and all persons authorised by him may exercise and perform all or any of the powers and duties of a local government in any place which does not lie within the boundaries of a district, including the powers conferred by Part III.

Proceedings on default of local government

35. (1) Where in the opinion of the Executive Director, Public Health any local government has made default in enforcing or carrying out or complying with any provisions of or in the exercise of any power conferred by this Act, or any local law or regulation thereunder, or of any order of the Executive Director, Public Health, which it is the duty of such local government to enforce, carry out, comply with, or exercise, the Executive Director, Public Health may make an order limiting a time for the performance of the duty of the local government.

(2) If such duty is not performed within the time limited in such order, the performance of such duty may be enforced by writ of *mandamus*, or the Executive Director, Public Health may appoint some person perform such duty, and shall order that the expenses of performing the same, together with a reasonable remuneration tot he person appointed for superintending such performance, and amounting to a sum specified in the order, together with the costs of the proceedings, be paid out of the funds by the local government in default; and any order made for the payment of such expenses and costs may be removed in the same manner as if the same were an order of such Court.

Attachment 5:

Commonwealth Certification and Accreditation of Aged Care Facilities

1. A new accreditation-based quality assurance system for services providing residential aged care was introduced over three years from January 1998 as part of the Commonwealth Government's reforms to the quality of care for older Australians.

2. The new system will ensure that older people receive higher quality care and accommodation in aged care services. It will also recognise those providing high quality services and encourage the achievement of high quality care.

Requirement to be an Approved Provider

3. To receive Commonwealth funding or an allocation of places, a prospective provider must be an approved provider.

4. It is also a requirement that the applicant is a corporation.

5. It is a pre-requisite of approval that approved providers, including key personnel, are at least 18 years of age.

6. Only an approved provider is entitled to receive Commonwealth funding and allocations of places. In return, it is the approved provider who is responsible for meeting conditions of approval and the range of requirements and responsibilities relating to standards of care and protection for residents. An approved provider can contract with someone else to undertake some or many of the tasks required in operating the service. Even in this case it is still the approved provider who retains responsibility and funding entitlement.

Criteria for Approval

7. Applicants are assessed against a range of criteria set out in the Approved Provider Principles. In summary, in order to be approved the applicant, and each of his/her key personnel, must demonstrate satisfactory:

- ability and experience;
  - for example, the applicant's record, either in a paid or voluntary capacity in the provision of aged care services in residential or community environments; and
  - efficiency and experience in personnel management and practices.
- record of financial management;
  - the methods used or proposed to ensure sound financial management of the service, for example adherence to recognised accounting methods and maintenance of appropriate books of account. The applicant's financial liabilities including lease obligations may also be considered.
- conduct as a provider; and

- where an applicant has been a provider of aged care services his/her conduct in terms of meeting their obligations and responsibilities, particularly relating to Commonwealth payments and treatment of residents.

- conduct generally

  - the veracity of information supplied in respect of applications for approved provider status, the meeting of obligations to government authorities and whether the applicant has been convicted of an offence may all be considered.

8. The Secretary may seek further information to assist in the determination of an application for approved provider status – the applicant is required to comply with the request within 28 days or such other period as the Secretary decides.

9. Each one of the criteria above is applicable to both the provider as an entity and to each of the key personnel individually.

Applications for Certification

10. Under the *Aged Care Act 1997*, a service may apply for certification at any time. If a service applies after being refused certification or certification ceasing to have effect, the service needs to give details of any improvements to buildings and equipment as part of the application.

11. All approved residential aged care services which are funded under the *Aged Care Act 1997* (including those with adjusted subsidy places and extra service places) are eligible to apply for certification.

12. It is not mandatory to apply for certification. However, services must be certified to charge accommodation bonds or receive concessional resident supplements.

13. A service may apply for certification only for the entire approved facility. Certification will not apply to selective wings, rooms or only a part of an approved facility.

14. Co-located services will not be certified jointly. Each approved facility must apply for certification separately irrespective of whether they occupy the same site.

15. Services will only be certified where they meet specified standards. Until then providers will not be allowed to charge accommodation bonds, even if they are in the process of upgrading to meet acceptable standards, as it would be unfair to ask residents to pay accommodation bonds for poor quality services.

Inspection of Residential Care Services

16. The physical standard of a facility will be measured against a 'benchmark' set by an assessment instrument and methodology which has been developed for that purpose.

17. Inspections will focus on:

- safety – with an emphasis on fire safety;

- hazards;

- resident privacy;

- occupational health and safety;
- lighting and ventilation; and
- heating and cooling

Accreditation in Summary

18. Accreditation is the formal recognition provided to a residential aged care service by the Aged Care Standards and Accreditation Agency where that service is considered to be:

- operating in accordance with the legislative requirements of the *Aged Care Act 1997*;
- providing high quality care within a framework of continuous improvement.

19. Following the audit assessment, accreditation may be granted for either a one or three year period.

20. A facility may be eligible for accreditation for a period of up to three years depending on the overall assessment of its performance against the standards, provided it meets other key areas of the accreditation framework.

21. Where the overall assessment of the facility's performance against the standards is rated as 'marginal', a facility may only be eligible for accreditation for a period of one year.

22. A facility will not be granted accreditation where the overall assessment of the facility's performance against the standards is rated either 'unacceptable' or 'critical'.

The Accreditation Framework

23. In accordance with the requirements for approved providers outlined in the *Aged Care Act 1997*, accreditation is based on a framework of five key elements:

- accreditation standards
- building quality measured by the certification instrument
- prudential arrangements
- concessional resident ratios
- user rights

24. Every residential aged care service will need to be accredited by 1 January 2001 in order to continue to receive Commonwealth funding. Accreditation applies to an individual service, and if a service is sold, relocated or extended, its accreditation status may be reviewed by the Agency.

Accreditation Standards

25. All facilities must achieve accreditation against the Accreditation Standards during a three year transition period from January 1998. Facilities that apply for accreditation will be assessed against all four primary standards. Continuous improvement and education and staff development will be assessed comprehensively as a requirement for achieving accreditation across:

26. Management Systems, Staffing and Organisational Development (Standard 1);

- Health and Personal Care (Standard 2);
- Resident Lifestyle (Standard 3); and
- Physical Environment and Safe Systems (Standard 4)

27. Accreditation will also involve an assessment of building quality against the instrument used to determine certification. The level for accreditation has not yet been established.

28. One of the five key elements of the accreditation framework is the Accreditation Standards. Facilities that apply for accreditation will be assessed against all four primary standards as outlined below:

- Management Systems, Staffing and Organisational Development (Standard 1);
- Health and Personal Care (Standard 2);
- Resident Lifestyle (Standard 3); and
- Physical Environment and Safe Systems (Standard 4).

Accreditation in Detail

29. Accreditation is the evaluation process which residential aged care facilities must go through to be recognised as approved providers under the *Aged Care Act 1997*. The process starts with self assessment and concludes with a decision on the accreditation of a service by the Aged Care Standards and Accreditation Agency.

30. All services must be accredited with the Agency by 1 January 2001 in order to continue to receive residential care subsidies.

31. The framework is the five elements which are considered in the audit for accreditation. These elements are:

- the four accreditation standards
- user rights
- the quality of buildings
- concessional and assisted resident ratios
- prudential arrangements

32. This quality improvement and accreditation framework plays a key part in implementing the aged care reform objectives, which are;

- to improve the standard of care
- to improve the quality of facilities and
- to streamline funding and administrative arrangements between Government and the industry.

33. The accreditation system assesses the quality of the care and services provided to residents. Facilities which provide poor quality of care and service will not be accredited. If such facilities have not improved and achieved accreditation by 1 January 2001, they will no longer receive Commonwealth funding.

34. The Agency is an organisation established in early 1998. It is set up outside the Australian Public Service. It is responsible for the accreditation process for residential aged care facilities across Australia and for assisting providers to improve their services through education and information.

35. The Agency is also responsible for monitoring services not yet ready for accreditation. This will continue until all services are accredited, but no later than 1 January 2001.

36. The current standards monitoring will continue until all facilities have achieved accreditation. Standards monitoring covers three of the four accreditation standards, namely, health and personal care; resident lifestyle; and physical environment and safe systems. The focus will be on facilities in high risk situations.

37. Monitoring will be by staff of the Agency, who will be expected to achieve registration as quality assessors.

38. Certification is the end result of a program of inspection of aged care accommodation to ensure buildings comply with basic standards of safety and comfort. It is a response to long-standing concerns about the physical standards of some residential aged care buildings.

39. With its associated funding streams and links with accreditation, certification provides an effectively targeted capital funding base for the future development of quality residential aged care. It encourages and rewards continuous improvement in the physical quality of aged care facilities in a way that meets the increasing expectations of older Australians.

40. Certification involves a detailed inspection of a facility and results in an overall score being awarded. Independent consultants with expertise in the area of building quality carry out the inspections. The consultants consider a range of characteristics including fire safety, hazards, the provision of sleeping and common space, access to toilets and showers, and the provision of lighting, ventilation, heating and cooling. They use a rigorous assessment method which assigns weighted scores to the identified aspects of physical quality in a way which ensures accurate, fair and consistent appraisal across all assessed facilities.

41. If a facility fails to meet the standards, the building inspection report will show the service provider where to concentrate his or her efforts and resources. There are also adequate timeframes in which to make the required improvements.

42. There are strong financial incentives for services to invest in upgrading, rebuilding or other improvements so that their facilities meet the certification standards. Facilities which get a pass mark gain access to accommodation payments (bonds in the case of low care or hostel places, charges in the case of high care or nursing home places) and are eligible for Commonwealth funding supplements for concessional and assisted residents.

43. The views of consumers and providers play an important part in developing the certification process, particularly in setting certification benchmarks and timing their introduction.

The Review of the Building Code of Australia as it Relates to Aged Care

44. Funding for the review was approved in May this year. It will consider development of a single residential aged care classification which covers both hostels and nursing homes.

45. The review aims to simplify regulatory procedures and to facilitate greater flexibility in the provision of care and design of facilities. It is expected, for example, that buildings designed under a single classification will have increased scope for offering aging in place.

46. New privacy and space requirements have also been set for existing buildings. These requirements will have to be met from 2008.

47. All services which plan to upgrade between now and 2008 should aim to meet or exceed these new requirements.

48. All facilities must be accredited by 1 January 2001 and will resubmit for accreditation again either one or three years after their initial accreditation, depending on their performance in meeting or exceeding accreditation standards. All facilities therefore undergo assessment at some time during the period from 1998 to the end of 2000, and again (at least once) during the period from 1 January 2001 and 2003.

49. All facilities must be certified before they are assessed for accreditation. Since all facilities are required to be accredited by 1 January 2001, they must be certified by that date. In order to achieve the second accreditation which is during the period from the period from 1 January 2001 and 2003, all facilities must be reassessed for certification and pass a second time during that period.

Attachment 6:

Residential Aged Care Facilities –State and Territory Comparisons

Table 1. Maximum Number of Persons per Room

State/Territory	Maximum No./Room	Comments
NSW	6 (4 in new buildings)	Fire regulations specify maximum of 6 per room, but NSW Health has not enforced and some services have up to 9 residents in some rooms.
VIC	Nil	
QLD	4	State Health may vary in particular cases
WA	Maximum of 2	50% of rooms are to be singles and no rooms are to be more than 2 beds. Applies only to new facilities Applies only to nursing homes
SA	3-4	Single rooms preferred. In multiple rooms, dividers, furniture or partitions must be used to ensure privacy.
TAS	Nil	
ACT	Nil	
NT	Nil	
BCA	Nil	

Table 2. Minimum Space in Residents' Rooms

State/Territory	Single Rooms	Multiple Rooms	*Comments*
NSW	No legal requirements	No legal requirements	Earlier minimum 8 sq. m repealed
VIC	12 Sqn. m		Draft BCA requirements for Victoria
QLD	9.3 sq. m	8.3 sq. m	Nursing Home Regulations only
WA	12.9 sq. m (3.6m *3.6m)	20.16 sq. m for 2 beds (3.6m *5.6m)	New Nursing Homes only Max of 2 beds in multiple rooms
SA	8.1 sq. m	6.3 sq. m	
TAS	9 sq. m	7.5 sq. m	
ACT	Nil	Nil	
NT	9.5 sq. m N Homes 28.31 cu m Hostels* *Applies to single + double rooms	7.5 sq. m (N Homes) 42.47 cu m Hostels# #3 or more people	NH requirements are not legislated but are used in NT for licensing
BCA	Nil	Nil	

Table 3. Minimum Space Per Resident in Common Areas

State/Territory	**Minimum Space**	*Comments*
NSW	Nil	
VIC	3.5 sq. m for Cl 3 2.5 sq. m for Cl 9a	Draft BCA requirements for Victoria
QLD	1.5 sq. m per resident	
WA	Lounge: 16 sq. m minimum Family: 2.8 sq. m/r Dining: 1.5 sq. m/r	Applies to nursing homes only. No state requirements for hostels. Applies only to new facilities
SA	Nil	Requirements are determined by Local Government Councils. Some still use as a guide a discontinued State Health requirement of 12 sq. m/per resident for communal areas
TAS	Nil	
ACT	15 sq. m minimum	
NT	12 sq. m minimum	Applies to nursing homes only, up to 10 beds. Increases by 1 sq. m/bed for additional places.
BCA	Nil	The BCA specifies a maximum density of people for each floor of a building, however it applies only to egress for the floor as a whole. It is not a space requirement for common areas.

Table 4. Maximum Ratios of Residents to Showers & Toilets

State/Territory	*Toilets*	*Showers*	*Comments*
NSW	Nil	Nil	
VIC	1:10 for Cl 9a 1:8 for Cl 3	1:10 for Cl 9a 1:8 for Cl 3	These are draft BCA requirements for Victoria
QLD	1:6	1:10	
WA	1:4	1:4	Applies only to Nursing Homes. Applies only to new facilities. Actual average for new facilities is close to 1:1
SA	1:8	1:8	
TAS	1:6	Nil	
ACT	1:10	1:10	
NT	1:10	1:10	Applies to hostels. No legal limits for nursing homes. There must be at least one bathroom per floor
BCA (Hostels)	1:10 + 1:25 (male urinals)	1:8	
BCA (Nursing Homes)	1:16 (+ 1:8 additional people)	1:8	There must also be one island type bathroom per floor

Attachment 7:

Extracts from a Summary of *"Proposals for a Building Act for Western Australia"*

5.1 A person commissioning building works or their authorised agent must appoint an approving building surveyor.

An underpinning principle of the new legislation is that the person commissioning the building works has overall control of and responsibility for the building process. This person may authorise an agent to do this on his or her behalf.

A key responsibility is to appoint an approving building surveyor who will then have responsibility to undertake core elements of this process ie. approval of plans, inspection(s) as considered necessary and appropriate, enforcement action during construction if and when considered necessary, placing of conditions on the building works at any stage if considered necessary and giving occupancy approval.

5.2 The authorised agent must not be the architect, builder or any other person consulting to or contracting to the works.

This provision excludes those who might otherwise be seen to have or actually have a conflict of interest in acting on behalf of the person commissioning the building works.

5.3 An approving building surveyor must be registered

The registration of approving building surveyors is dealt with in some detail later in this Paper. However, for the purpose of this provision, the functions of an approving building surveyor are critical to the achievement of the objectives of this legislation, in particular the maintenance, enhancement and improvement of the safety and health of people using buildings in this State.

For this reason, the legislation will require a minimum level of qualifications for a building surveyor who is to undertake these functions and one way of ensuring this is to require such building surveyors to be registered in accordance with the requirements of the legislation. This requirement will act to protect the community and other involved in the building process.

5.5 An approving building surveyor may be privately employed, employed by a local government or employed in the State public service.

This provision is consistent with national competition policy in that it introduces competition in terms of who can undertake the functions of an approving building surveyor.

5.6 An approving building surveyor must not accept appointment or, having accepted appointment, exercise any of the functions of an approving building surveyor in relation to a building where:

- they have been involved in any aspect of the design or documentation of the building;
- they have a direct or indirect financial interest in the building or any body associated with the building;
- they are employed by an authority required to report to the approving building surveyor or by an authority required to give independent approval to the project; or

- they are employed by any person or body associated with any aspect of the building, unless that body is a public authority.

5.7 An authorised agent is to be subject to the same independence requirements as the approving building surveyor.

5.10 The relevant local government is to be notified once an approving building surveyor has been appointed.

5.11 Once appointed, an approving building surveyor is to be responsible for all stages of the building approval process, including inspections and occupancy approvals.

5.12 The role and functions of an approving building surveyor are to be as set out in the Act.

6.1 A registered building surveyor is the only authority that can approve building works in Western Australian.

6.2 An application for building approval may be made to any registered building surveyor whose services are available for hire. This includes a building surveyor who is:

- Employed or contracted by the local government for the area;
- Employed or contracted by another local government
- Privately employed; or
- In the State public service.

6.8 An approving building surveyor may accept a compliance certificate from a competent building practitioner.

6.10 A building permit cannot be issued with:

- Planning and other conditions unrelated to building control; and
- Conditions that require higher or lesser standards than those required by the BCA or Building Regulations.