REPORT

CENTRE FOR
INTERNATIONAL
ECONOMICS

NCP review of the Northern Territory Private Hospitals and Nursing Homes Act

Prepared for Territory Health Services

FINAL REPORT

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CANBERRA

Centre for International Economics
Ian Potter House, Cnr Marcus Clarke Street & Edinburgh Avenue
Canberra ACT

GPO Box 2203
Canberra ACT Australia 2601

Telephone +61 2 6248 6699 Facsimile +61 2 6247 7484
Email cie@intecon.com.au
Website www.intecon.com.au

SYDNEY

Centre for International Economics
Level 8, 50 Margaret Street
Sydney NSW

GPO Box 397
Sydney NSW Australia 1043

Telephone +61 2 9262 6655 Facsimile +61 2 9262 6651
Email ciesyd@intecon.com.au
Website www.intecon.com.au

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Executive summary

THE REVIEW OF THE *Private Hospitals and Nursing Homes Act* is one of twelve reviews being undertaken of the Northern Territory's health legislation under National Competition Policy (NCP) requirements. This report briefly describes NCP principles and procedures and provides some background information about the act and procedures adopted in its administration. Subsequent sections then follow the steps that must be taken in any NCP review, namely to:

- clarify the objectives of the legislation;
- identify the nature of every restriction on competition;
- analyse the likely effects of the restrictions on competition and on the economy generally;
- assess the balance between the costs and benefits of the restrictions; and
- consider alternative means of achieving the same results including nonlegislative approaches.

A final chapter makes recommendations from the above.

No explicit objectives are stated in the act. However, its implicit objective appears to be to protect the wellbeing of patients and the general public by ensuring that only those institutions and persons suitably qualified to operate a private hospital or nursing home are allowed to be licensed.

Features of the legislation that have been identified as potentially restricting competition include:

- the requirements that persons who conduct a nursing institution shall hold a licence in respect to that institution and will conduct its activities in accordance with conditions to which the licence is subject — the possibility being that standards and requirements may be set too high relative to requirements of users;
- discretion by the Minister to determine fees for application, renewal, transfer and issue of a duplicate licence;

- opportunities (not currently used) for the Northern Territory's administrator to make regulations about minimum qualifications of staff, duties of staff, staff–patient ratios and minimum standards of accommodation;
- requirements that each licensee keeps a register of patients containing specified information and that, following an inspection (which must occur not less than once a year), the Chief Health Officer may require a licensee to make repairs, alterations, additions or improvements to premises or equipment or a change in management;
- a body corporate must be incorporated or, if a foreign company, be registered under the law of the Northern Territory; and
- a manager or matron must be replaced by a person approved by the Chief Health Officer if he or she is away from duties for a period in excess of seven days.

It is stressed that this identification has been of *potentially* anticompetitive features of the legislation. Whether these or other features *actually* restrict competition, and what their effects might be, depend on how they are administered and other features of the competitive environment.

Chapter 6 makes an assessment of the balance between public benefits and public costs of these restrictions on competition. The following conclusions were reached.

- There are a number of differences in the way private hospitals and nursing homes are licensed and administered, suggesting that they should be administered by separate acts.
- The benefits to be gained from licensing appear to be substantive against negligible costs, notwithstanding the lack of enforcement of licence requirements. Guidelines for the renewal and transfer of licences are required.
- An anomaly exists where hostels are providing high level care but are not required to be licensed. Provision should be made to bring them under the act.
- Insofar as the ability to make regulations and impose conditions of licence provide a basis for the Northern Territory to determine appropriate standards of care, and provided they are not used to restrict the ability of private hospitals or nursing homes to meet demand, they provide a net public benefit.
- The maintenance of registers of patients does not appear to be anticompetitive nor does it impose significant costs. It provides beneficial

assistance to the Chief Health Officer in fulfilling his obligations. There appears to be no good reason that this should be rescinded.

- There appear to be no benefits in the requirement for the Chief Health Officer to approve temporary replacements for the manager or matron of a nursing institution.

Chapter 7 briefly lists some alternative means of achieving the objectives of the act, including nonlegislative approaches. It concludes that standards could be enforced through the imposition of quality assurance and accreditation programs (some standards are covered by Commonwealth accreditation) and through the inspection and direction provisions in the legislation. Such provisions could be a better alternative to the current regulatory approach to the legislation, but these issues need to resolved in consultation with key stakeholders.

In response to the guideline given to the review that a strong net benefit for retention must be demonstrated if no change to existing restrictions is to be recommended, a number of recommendations are made in chapter 9. These recommendations are that:

- consideration be given to separating the regulation of private hospitals and nursing homes, and of their complementary and/or competitive institutions, into separate acts;
- objectives be clearly stated in the act(s), for example:
  - 'to protect the social health, safety and wellbeing of patients–residents and the welfare of the Northern Territory community by ensuring that only those institutions and persons suitably qualified are licensed and permitted to operate a private hospital–nursing home';
- licensing of private hospitals and nursing homes be retained and extended to include all residential aged health care facilities — such as hostels;
- the requirement of the act that a body corporate must be incorporated or, if a foreign company, be registered under the law of the Northern Territory be rescinded; and
- the requirement of the act that a manager or matron must be replaced by a person approved by the Chief Health Officer if he or she is away from duties for a period in excess of seven days be rescinded.

Without leading to recommendations, since no restrictions in practice were concluded, a number of other conclusions have been noted:

- The conditions for licence renewal and transfer should be established and transparent.
- The power to make regulations and impose conditions of licence should be retained but used flexibly, having regard for the requirements of rural and remote communities. It should not be used to determine the number of private hospital or nursing home beds in the community. This should be left to market forces.
- The requirement for a register of patients should be maintained.
- The powers of the Chief Health Officer following inspections in relation to buildings, equipment and management should be maintained.

1 Introduction

THE CENTRE FOR INTERNATIONAL ECONOMICS (CIE), a private economic research consultancy, in conjunction with Desliens Business Consultants was commissioned by Territory Health Services (THS) to undertake an independent review of the *Private Hospitals and Nursing Homes Act* in accordance with the principles for legislation review set out in the National Competition Principles Agreement (CPA) entered into by all members (Commonwealth, states and territories) of the Council of Australian Governments in 1995. The review forms part of the Northern Territory government's obligation under the CPA to review and, where appropriate, reform all laws that restrict competition by the year 2000. Legislative reviews along National Competition Policy (NCP) lines are currently being undertaken of health and health related acts in other states. The Commonwealth is also conducting NCP reviews of its health legislation.

The *Private Hospitals and Nursing Homes Act* is one of 12 Northern Territory pieces of legislation being reviewed (box 1.1).

In undertaking this review we consulted with stakeholders and asked for submissions from any interested parties. An issues paper, designed to facilitate consultations and the preparation of submissions, was distributed in March this year. Only two submissions were received — from THS through its legal services unit and from Ms Jenny Mills (personal submission). Follow up consultations were held to discuss issues raised in submissions.

1.1 Acts to be reviewed

- ***Private Hospitals and Nursing Homes Act***
- *Dental Act*
- *Optometrists Act*
- *Radiographers Act*
- *Community Welfare Act*
  - Community Welfare Regulations
  - Community Welfare (Childcare) Regulations)
- *Health Practitioners and Allied Professionals Registration Act*
- *Nursing Act*
- *Mental Health and Related Services Act*
- *Public Health Act*
  - Public Health (Barber's Shops) Regulations
  - Public Health (Shops, Eating Houses, Boarding Houses, Hotels and Hostels) Regulations
- *Medical Act*
- *Medical Services Act*
- *Hospital Management Boards Act*

2 The 'industry' operating environment

THE *PRIVATE HOSPITALS AND NURSING HOMES ACT* in the Northern Territory applies currently to one private hospital and seven nursing homes. There are a number of low care facilities in operation such as hostels, day centres and supported accommodation, which are not covered under the act.

The *Private Hospitals and Nursing Homes Act* is not the sole statute under which private hospitals or nursing homes are required to operate. The act makes reference to the *Medical Act*, the *Nursing Act* and the *Pharmacy Act*. In other Australian jurisdictions the equivalent act also covers prescriptive requirements in the establishment and maintenance of appropriate building standards.

Consumers of private hospital and nursing home services fall into various categories. Northern Territory nursing home operators report that two thirds of their patients are indigenous Australians. In the context of this review, it is important to consider the current trend in old age care. It is now common practice for persons who in the past could be described as traditional nursing home patients to be cared for in hostel accommodation. Often the transition is from *home stay* to *residential aged health care* in hostels to *nursing homes*. Hostels are playing an increasingly important role in high quality care but are outside the provisions of the act.

The submission from THS commented that people from remote areas often do not have the support and infrastructure to provide appropriate levels of care in their own communities and that this may result in inappropriate residential placement. Government is cognisant of this and is developing innovative service models to promote coordinated care options in communities.

The private hospital system in the Northern Territory is small. The one private hospital has about 130 beds, which have an occupancy rate of around 30 per cent. By contrast, the five public hospitals have around 600

beds with an occupancy rate of around 90 per cent. There is not enough critical mass in the private hospital system to justify the purchase of high technology equipment. As a result, patients requiring such equipment are treated in the public hospital system even though they might have the status of private patients.

3 NCP principles

UNDER THE CPA, nearly 2000 pieces of Commonwealth, state and territory legislation are being reviewed over a six year period. The guiding principle behind these reviews and the reforms that follow them is that legislation (encompassing activities of authorities set up under that legislation and any regulations, rules, etc. authorised under it) should not restrict competition unless it can be demonstrated that the:

- benefits of the restriction to the community as a whole outweigh the costs; and
- objectives of the legislation can only be achieved by restricting competition.

It is significant to note that *both* of these criteria are required to be met if a restriction is to be retained. This means that even if a restriction passes a net public benefit test, it should not be retained if there are other less restrictive ways of achieving that outcome. Also, if a restriction is to be retained, it is necessary to demonstrate that to keep it will result in a public net benefit. It is not sufficient to demonstrate that its removal would result in no or little net benefit.

It is important when assessing the benefits and costs of a restriction that distinctions are made between private benefits and costs, industry benefits and costs and communitywide benefits and costs.

The CPA does not define how any piece of legislation should be reviewed. However, it does state that, without limiting the issues that can be addressed, it should:

- clarify the objectives of the legislation;
- identify the nature of every restriction on competition;
- analyse the likely effects of the restrictions on competition and on the economy generally;
- assess and balance the benefits and costs of the restrictions; and

- consider alternative means of achieving the same results including nonlegislative approaches.

The CPA lists a range of public interest issues that are to be taken into account where relevant in assessing the benefits and costs of any restrictions. These include:

- ecological sustainability;
- social welfare and equity;
- occupational health and safety;
- industrial relations and access and equity;
- economic and regional development including employment and investment growth;
- interests of consumers;
- competitiveness of Australian businesses; and
- efficient resource allocation.

Thus, NCP recognises that unrestricted competitive markets may not result in best community outcomes. However, the NCP and the legislative review process is underpinned by the view that free interactions between consumers and producers result in broadly based benefits throughout the community.

In this context, it is important to bear in mind that suppliers encompass a wide range of activities. A particular objective for introducing NCP was to extend competition laws to encompass the professions and services such as health services provided by both private and government agencies.

It is also important to bear in mind that NCP is not based on a view that fewer rules and restrictions would necessarily be better. Competition itself cannot operate outside a framework of trust which is underpinned by general commercial, industrial, health and safety, and environmental laws. Some features of these laws themselves restrict actions that are deemed to undermine the operations of an efficient competitive economy.

4 The legislation and its objectives

THE *PRIVATE HOSPITALS AND NURSING HOMES ACT* was introduced in 1981. It makes provision for the licensing and transfer of licences of private hospitals and nursing homes, the management of nursing institutions, the control of nursing institutions and in a miscellaneous section deals with fees, regulations and penalties for noncompliance. The act is currently being reviewed by THS.

There are some difficulties in dealing with issues relating to private hospitals and nursing homes in one act, for example:

- stand alone day-care hospitals, which although not yet present in the NT, are not covered under the act;
- currently facilities are referred to as low level and high level — however, both types of facilities may house residents that may be low care or high care; and
- there is an inconsistency in the timing of licensing in relation to the Commonwealth — private hospitals are first licenced by the Northern Territory and then declared by the Commonwealth, and the Commonwealth first approves nursing homes and subsequently the Northern Territory licenses them.

We recommend consideration be given to separating the legislation into two acts, with nursing homes and hostels being included in a new 'Residential Aged Care Facilities Act'.

Objectives

No explicit objectives are stated in the act.

The implicit objective appears to be 'to protect the wellbeing of patients and the general public by ensuring that only those institutions and persons suitably qualified to operate a private hospital or nursing home are allowed to be licensed'.

During the second reading speech of the Private Hospitals and Nursing Homes Bill in 1980, the then Health Minister said, '…it is important that the government ensure that any private hospital or nursing home meet proper standards that protect the wellbeing of patients and the general public'.

The THS submission supported the objectives of licensing being stated in the act if nursing homes are to remain licensed.

> If 'residential aged care' facilities are to continue to be licensed, the objectives of the act should be stated and need to be determined by key stakeholders (providers, government and consumers).

A further submission from Ms Mills suggested that the principles should be about 'social health and safety of the target group'.

What the act does

The act specifies the functions of the Chief Health Officer, who has the power to:

- grant a licence to a person to conduct a private hospital or a nursing home on premises specified by the licence;
- vary their conditions, including suspending or cancelling a licence;
- inspect institutions and take action if the institution is in breach of conduct as prescribed in the licence; and
- take legal action against persons for offences under the act.

The act defines who can hold a licence, the process of how to obtain a licence and the transfer of a licence. It also specifies the duties of the manager or matron and their power of delegation, including the maintenance of a patient register. One of the duties of the manager is to ensure that a nurse registered under the *Nursing Act* is on duty at all times. The process of inspection of nursing institutions is spelled out and the actions to be taken by the Chief Health Officer are defined.

The act specifies the handling of complaints and objections, defines the penalties for noncompliance, and delegates the determination of fees to the Minister. It also contains a section specifying the responsibility for the making of regulations in relation to the operation of a private hospital or nursing home with the Chief Health Officer.

Although hostels are not covered by the act, they are now taking high care patients. High care patients require qualified professional staff such as nurses. By contrast, low care patients require personal support, but not pro-

fessional support. Low care patients, through illness, accident and age, may in turn become high care patients.

In its submission, THS suggested that the debate as to whether the Northern Territory government should license nursing homes and hostels hinges on a number of issues.

- Government would argue that high level facilities should be licensed to guarantee quality of care. This is most appropriate when considering the recent events with respect to Victoria.
- Standards might have to be introduced to include some hostel facilities which have high level of care consumers — that is, a hostel that embraces residential aged health care — and have a number of high care patients. The problem with this is that a hostel might struggle to meet accreditation–certification requirements (that is, 24 hour qualified nursing care, occupational health and safety, or fire safety).
- Extensive consultations need to occur regarding amending the act to remove the term nursing home and replace it with residential aged care facilities.
- If hostels were to be included under the act, the minimum requirement of having a registered nurse on duty at all times would need to be addressed, as it would be potentially cost restrictive for current operators of low level facilities.
- Prior to an amendment to the Commonwealth's *Quality of Care Principles 1997*, the Commonwealth established patient–nurse ratios depending on the number of people in high level care. These might be a preferred option in the NT legislation.

The Mills submission also suggested that there were no good reasons for excluding hostels from the act, citing the risks to the frail, aged and elderly. The submission went on to say that hostels should be included because of the number of high support care needs hostels currently take and the projection that numbers will increase.

Links with other jurisdictions

Different states have their own private hospitals and nursing homes acts and different procedures and approaches towards licensing and regulating the scope of their activities. An issue for consideration concerns the statutory requirements (if any) that should be imposed on their activities. The list might include all or some of:

- specified duties and responsibilities of the manager

- reporting requirements and provisions for inspection
- inquiry and complaints procedures
- registers and records that need to be kept
- provisions for staff of specified qualifications to be in attendance
- construction and performance of facilities
- standards of health and patient care.

There are significant differences across jurisdictions in the detail of what each act covers. However, there is a common requirement under Commonwealth legislation for nursing homes to be aged care accredited to continue to receive Commonwealth funding. A similar initiative for hospitals, though industry governed, is the Australian Council on Hospital Standards (ACHS) accreditation program, which has been operating since 1973.

The THS submission suggests that, given the recent criticism of Commonwealth accreditation processes, it might be preferable that each jurisdiction decides on the appropriateness of legislation.

> More importantly, if the Commonwealth is to maintain responsibility for residential care, there should be legislative requirements (which include sanctions) that guarantee quality of care.

Underlying the question of whether there are good reasons for continuing the lack of uniformity across jurisdictions is the need to identify the responsibilities of the Commonwealth and the states and territories in guaranteeing specific provisions for quality nursing care for recipients of high level care in residential aged care facilities. The conditions of operation of residential care facilities are different across jurisdictions and THS suggest that there may be an argument for flexibility in the regulation of facilities. However, they believe the responsibilities of the Commonwealth and states–territories need to be established in order to determine the level of flexibility required.

The Mills submission notes that standards and accreditation that specify qualifications may disadvantage rural and remote operators due to present difficulties with recruitment and retention of staff.

5 *Nature of restrictions on competition*

ALL LEGISLATION REGULATES BEHAVIOUR in some way, but not all regulation necessarily restricts competition. The National Competition Council (NCC), the Commonwealth body set up to advise on progress in meeting NCP obligations, has suggested seven ways in which regulation might restrict competition (NCC, *Legislation Review Compendium*, April 1997, p. 4). According to the NCC, legislation could restrict competition if it:

- governs the entry and exit of firms or individuals into or out of markets;
- controls prices or production levels;
- restricts the quality, level or location of goods and services available;
- restricts advertising and promotional activities;
- restricts price or type of input used in the production process;
- is likely to confer significant costs on business; or
- provides advantages to some firms over others by, for example, sheltering some activities from pressures of competition.

The review is required to identify the *nature* of restrictions in the act that limit competition. Some of these may be more *potential* than *real*. For example, registration potentially limits market entry, but if it is used solely to require certain standards for market participants and is not used to limit their size or numbers, it should not be considered to have any actual impact on market entry.

The actual impact of each restriction on competition or potential restriction on competition needs to be assessed prior to any evaluation of the balance between benefits and costs to the community.

As noted in chapter 3 of this report, efficient competition cannot take place in a totally unrestricted way but requires a body of laws which set the rules

in terms of property rights, the types of commercial and industrial relationships permitted, and obligations within commercial relationships for health and safety and for the environment. Indeed, part IV of the *Trade Practices Act 1974* (which is an integral part of NCP) prohibits a range of actions which, while they might otherwise be used by individual market players to promote their competitiveness, are considered anticompetitive in an economy-wide context.

A competitive industry is generally considered to be one in which:

- there are no restraints on firms or consumers entering or leaving the industry;
- there are no constraints on the free flow of information between suppliers and consumers; and
- prices paid and received for the industry's outputs and inputs are determined by the independent actions of many suppliers and consumers in the markets for those services.

The act contains a number of regulations that could be classified as restricting or potentially restricting competition under several of the headings used by the NCC as follows.

Restrictions on entry and exit

Section 5 of the act specifies that the Chief Health Officer may grant a licence to conduct a private hospital or nursing home on premises specified in the licence, with section 6 of the act specifying that a person shall not conduct a nursing institution unless he or she holds:

- a licence in respect of the nursing institution (defined in the act to include private hospitals and nursing homes); and
- conducts that institution in accordance with the conditions to which that licence is subject.

Section 13 specifies that the duration of the licence is for a period specified in the licence. Licences are for 12 months and are renewed annually. Under section 16 an approval is required by the Chief Health Officer to transfer a licence. Any conditions placed on the original licence may or may not be lifted when the transfer occurs. Each of these requirements, in principle, restricts entry and hence weakens competition.

The benefits of licences are premised on judgements that market forces may not work efficiently in the provision of private hospital and nursing home

facilities and that it is better for users of their services to exclude incompetent (or unfit) operators at the outset rather than deal with the consequences of their actions later if the implicit objectives of the act are to be met. But, if standards and requirements for operating certain nursing home facilities are set too high relative to the standards needed to meet requirements of users for the facility they wish to utilise, then the licensing process will exclude suitable operators and restrict competition to the detriment of users.

THS submitted the following.

- There are financial constraints placed upon facilities as a result of the aged care reforms that could impact on standards of facilities if legislative requirements were removed.
- It is unclear whether it is essential that Chief Health Officer approval be granted to transfer a licence. At the moment the Northern Territory relies on Commonwealth legislation to revoke a service as an approved provider.
- A nursing home must be inspected and a report provided to the Chief Health Officer before a licence is renewed. This mechanism guarantees the inspection of the premises. However, it could be possible to grant an ongoing licence and the legislation could require an annual inspection and report provided to the Chief Health Officer. The act has provision for a licence to be revoked.
- There is no evidence that the current fixed term licence arrangements impose uncertainty on business and business behaviour.

In her submission Ms Mills suggested that, while the effect on competition of being licensed and having to operate in accordance with the licence is not clear, meeting standards in a remote area context is almost impossible. The requirement for approval for transfer of a licence was supported with the period being required to ensure there is continued quality assurance in client care provision.

Section 31 of the act specifies that the Minister determines the fees for application, renewal, transfer and issue of a duplicate licence. Fees are based on the number of beds, with the same fee structure for private hospitals and nursing homes, and are gazetted. However, as fees have not been changed for 15 years, there are no restrictions on competition from this source. It would seem appropriate that the fee structure be reviewed with a view to achieving recovery of the costs of administering licenses.

In her submission, Ms Mills suggested that a rational criterion for the application, renewal, transfer and issue of a duplicate licence be developed if this requirement is to stay in place.

Controls price or production levels

Section 36 of the act allows the administrator to make regulations about:

- minimum qualifications of staff
- duties of staff
- ratio of staff to patients
- minimum standards of accommodation.

No regulations are currently in force. However, the Licence to Conduct a Private Hospital and attached Conditions of Licence do impose some requirements in these areas (boxes 5.1 and 5.2).

No such conditions are imposed on the licences for nursing homes, although responsibility for quality of care lies with the Northern Territory. Thus, no restriction on competition arises from the imposition of standards of care.

The THS submission pointed out that Commonwealth accreditation does cover provisions for minimum standards of accommodation. It also addressed the extent to which the *Aged Care Act 1997* assists in the following

5.1 Licence to conduct a private hospital

I, Shirley Hendy, the Chief Health Officer, in pursuance of sections 5 and 10 of the *Private Hospitals and Nursing Homes Act*, grant a licence to Healthscope Limited, ACN 006 405 152 an incorporated company operating in the Northern Territory (the 'Company'), to conduct a private hospital to be known as the Darwin Private Hospital (the 'Hospital') on the land comprised in Lot 9269 Town of Nightcliff entered in the Register Book of Titles Volume200 Folio 144 to be managed on behalf of the Company by Ann Cassidy.

This licence is granted to the condition that:

- the number of beds in the Hospital shall not at any one time exceed 150 general beds; for the provision of surgical, medical, psychiatric, obstetric, special care nursery (level 2), emergency and rehabilitation services; and
- the further conditions specified in the schedule.

This licence shall, unless it is sooner revoked or surrendered in accordance with the Act, continue in force up to and including 3 December, 1999.

areas.

- *Aged Care Act* and associated principles previously specified that an approved provider must make provisions for appropriate nursing care. Recent amendments to the *Aged Care Act* have dramatically reduced the essential requirements in relation to nursing care.
- *The Aged Care Act* does not specify ratios of staff to residents or minimum qualification requirements of staff.

Restrictions on the quality, level or location of goods and services available

Sections 21 and 24 come under the management of nursing institutions section of the act. Section 21 requires every licensee to keep a register of

5.2 **Private hospital licence — schedule**

Conditions of licence

The Chief Health Officer shall be satisfied that:

1. there is adequate and appropriate medical staff coverage 24 hours a day;
2. there are adequate emergency medical procedures to maintain patient safety;
3. there are adequate emergency non-medical procedures to maintain patient safety e.g. fire, cyclone;
4. an acceptable system for the delineation of clinical privileges is maintained;
5. adequate clinical standards are maintained;
6. subject to the direction of the manager, the registered nurse in charge of nursing services is responsible for nursing standards, quality assurance and deployment of nursing staff;
7. a minimum of two nurses (at least one of whom shall be a registered nurse) shall be on duty at all times in each ward area, theatre or midwifery unit when occupied by patients;
8. the ratio of registered nurses to enrolled nurses is determined by patient dependency;
9. adequate medical records are maintained;
10. data on patient morbidity and related statistical data are supplied as required to the Chief Health Officer;
11. the Darwin Private Hospital staff liaises with the Combined Ethics Committee established by the Royal Darwin Hospital and the Menzies School of Health on all matters of research; and
12. the Darwin Private Hospital complies with all requirements of the laws of the Northern Territory which apply to the operation of a private hospital.

patients, which shall contain particular information about the patient's stay at the nursing institution. Section 24 specifies that following an inspection, the Chief Health Officer may require the licensee to make repairs, alterations, additions or improvements to the premises or equipment or a change in management within a specified time.

The THS submission suggests that it could be unnecessary for the Northern Territory to make regulatory provisions in this regard because these provisions are covered by Commonwealth accreditation.

Restrictions on price or type of input used in the production process

Section 7 of the act specifies that a body corporate shall not hold a licence unless it is incorporated or registered as a foreign company under the law of the Northern Territory.

There appears no compelling reason for this requirement. While neither submission addressed this issue, discussions with interested parties suggested that religious bodies, which run the majority of nursing homes in the Northern Territory, would have trouble in complying with the requirement. It is observed in the breach and hence does not restrict competition.

Section 9 requires the Chief Health Officer to approve the manager and matron. Similarly, section 19.1(b) specifies that an approved person must replace a manager or matron of a nursing institution if away from duties for a period in excess of seven days. This provision is not enforced and there appears no good reason to do so.

Ms Mills suggested in her submission that the approval process does not add to nursing home costs, except in cases of 'higher duties' payments being required. She suggested that removal of this restriction might compromise administrative and decision making power.

From consultations it is apparent that approval is not sought from the Chief Health Officer for the replacement where the manager or matron of a nursing home is away from duties for a period in excess of seven days, nor has THS sought to enforce the requirement.

Restrictions which confer significant costs on business

The issues raised in relation to section 36 above (the power to make regulations) must also be considered in the context of raising business costs insofar as imposing standards through:

- minimum qualifications of staff
- duties of staff
- ratios of staff to patients
- minimum standards of accommodation

may impose additional costs on institutions. In her submission, Ms Mills suggested that standards and accreditation that specify qualifications might exacerbate the current difficulties of rural and remote operators in recruiting and retaining staff. A high proportion of the costs of service provision are associated with the recruitment and retention of staff.

THS suggested that, if low level facilities are to be required to be licensed and have a registered nurse on duty at all times, the cost impositions are potentially prohibitive.

Practicality and costs are important issues to be resolved in the imposition of standards of care and the extension of licensing to hostels.

Likely effects

It can be argued that the actual and potential restrictions on competition outlined above are having only a minimal impact on private hospital and nursing home providers and on standards of care provided to patients. This is because nursing institutions in the Northern Territory must undergo aged care accreditation as a requirement under Commonwealth legislation. As from January 2001, accreditation will be compulsory for institutions to retain their funding allocation.

Accreditation programs are now widespread. The ACHS conducts an accreditation program in which hospitals must achieve a high standard to become accredited. Hospitals and health care facilities are surveyed to determine whether equipment, facilities, procedures and staffing meet with ACHS standards. The private health insurance industry is also a significant player in the definition of standards in the private hospital and nursing home accreditation process.

It can also be argued that, in a deregulated private hospital and nursing home environment, consumers would utilise facilities with a good reputation. Facilities with a less than exemplary record would be avoided by consumers and subsequently would be forced to exit the market.

The same market based arguments might be applied to the supply of professionals required to operate these facilities. Health professionals and administrators would be reluctant to offer their services to a substandard institution.

THS point out that, while consumers may utilise facilities with a good reputation in a deregulated environment, unlike the plethora of facilities in other states–territories, Northern Territorians are restricted with regard to the choices they can make.

Similarly, THS suggest that it cannot be argued that health professionals and administrators would not offer their services to lower standard institutions. All facilities already have enormous difficulty in attracting quality staff, as there is a shortage of qualified people in many health and aged care areas.

Ms Mills questioned whether, in a deregulated market, potential users would have the knowledge of which facilities have good and bad reputations. She pointed out there are situations, such as emergency or crisis admissions, in which rational choice is impeded or restricted. Similarly, she considered that the removal of the restrictions would have little effect on costs.

- A high proportion of the costs of service provision are associated with recruitment and retention of staff. Removal of the restrictions would not change these costs, as they are determined through the award system.
- The cost of capital equipment is heavily subsidised by the Commonwealth government.

6 *Assess balance between benefits and costs of each restriction*

THE FOURTH REQUIREMENT OF THE NCP review process is to assess the balance between the costs and benefits of any potential restrictions on competition. That is, there is a requirement to consider whether restrictions on competition are in the public interest. The guiding principle of NCP requires the onus of proof in this regard to be with those who argue for the maintenance of any restrictions.

The case for restrictions on competition being in the public interest (that is, their social benefits exceed their social costs) is usually made on the grounds that 'market failures' in the provision of goods or services justify the various restrictions. Unrestricted markets might fail to deliver best community outcomes if:

- benefits flow to sectors of the community which do not contribute to costs or costs are imposed on those who do not receive benefits (externalities);
- information available to one group is not available to others with whom they do business (information asymmetry);
- economies of scale are so large that only one provider would survive in the market (natural monopoly); or
- goods and services are provided in ways from which no potential user can be excluded (public goods).

One of the traditional 'market failure' arguments listed above, that information available to one group is not available to others with whom they do business (information asymmetry), is of particular relevance in the evaluation of the public interest of any potentially anticompetitive features of the *Private Hospitals and Nursing Homes Act*. A basic premise of an efficient competitive market is that people are capable of making informed choices. A major argument for restrictive provisions in many health related acts is that users of health care services do not have sufficient information to be able to make informed choices. Not only can this lead to unsatisfactory 'market driven' outcomes for individuals, but there is a contingent

liability on the community in cases where treatment is not of an appropriate standard.

The registration of private hospitals and nursing homes can be viewed as providing valuable information to consumers on the capabilities of the service provider. Conditions of licence specifying the standard of services an institution can deliver can be viewed as providing assurance to users that the services they purchase will be carried out professionally, minimising the risk to their health, which in turn is of benefit to society as a whole.

Benefits

The benefits of any restrictions on competition in the Northern Territory's private hospital and nursing homes industry need to be assessed with respect to the stated or implied objectives of the legislation. With no stated objectives, the implied objective — that the government ensures that any private hospital or nursing home meets standards that protect the well-being of patients, residents and the general public — become the benchmark against which the legislation should be assessed. In addition, the overriding objective of NCP itself, which is to encourage efficiency by means of a more competitive economy, must be considered, as should the public interest issues nominated in the NCP agreements — namely, the environment, employment, regional effects, consumer interests as well as the competitiveness of business.

Notwithstanding any conclusions drawn about the role of restrictions in achieving the objectives of the legislation, the nature of any community benefits that flow from the objectives needs to be assessed. High health care standards in private (and public) hospitals and nursing homes contribute to improved health outcomes for citizens. And it is widely accepted that the community as a whole benefits from improvements in the health of its citizens.

It is not unreasonable for the community to require assurance that services are being provided effectively and that there is continuing improvement in their delivery. Governments too, as funders of many health care services, need assurance that individuals and organisations which provide services on their behalf are both effective and efficient. The achievement of certain standards is, therefore, of core importance in health care legislation.

A concern about standards in an NCP legislative review is therefore not to question the need for them as such, but rather to ensure that any standards

established or underwritten by legislation do not needlessly restrict competition. They could restrict competition if they introduce inflexibilities that stifle innovation in service provision or exclude service providers who could effectively service specified needs at low cost. In these regards, a preference might be, wherever possible, to specify standards as *performance based rules* that focus on outcomes rather than as *prescriptive rules* that focus on technical or qualification requirements. Specifying outcome requirements allows leeway in how they are to be achieved at least social cost and encourages innovation in their achievement.

A concern of NCP reviews is also that standards not be used to exclude entry of operators who can achieve outcomes of a required standard for limited tasks, but may not have the qualifications or facilities to achieve a wider spectrum of outcomes which are not required in particular circumstances. In this regard, the THS submission stated that specifying outcomes to be achieved allows leeway in how they are to be achieved at least social cost and encourages innovation in their achievement. This is appropriate to conditions in the Territory as it allows flexibility of service that is relevant to the specific regional, cultural and environmental factors that influence appropriate care outcomes.

Costs

Costs of the restrictions to the private hospitals and nursing homes industry and to the community can be of several types:

- administrative, enforcement and compliance costs;
- efficiency losses; and
- imposts on service users.

The community as a whole, through the budgetary process, picks up the bill for administrative and enforcement costs. Licensing fees, if charged to institutions, are likely to be passed on to patients and residents in fees charged. This is also likely to be the case with compliance costs. The regulations and conditions of licence are also likely to involve some efficiency losses in the way services are provided.

Balance between benefits and costs

The following assessment of the balance between benefits and costs of potential restrictions on competition groups those restrictions identified in the preceding chapter into whether the restrictions:

- limit the entry and exit of firms or individuals into or out of markets;
- control prices or production levels;
- restrict the quality, level or location of goods and services available;
- restrict price or type of input used in the production process; or
- are likely to confer significant costs on business;

The discussion first lists potential benefits and then potential costs, both in dot point form. Then a general conclusion is drawn about the net public benefit or cost of those restrictions. Many of the issues cross a number of these categories.

Entry and exit of firms or individuals into or out of markets

The act specifies that a person must be licensed to operate a private hospital or nursing home and provides for the renewal and transfer of licences. The licence applies to the premises specified on the licence. The Chief Health Officer has the power to revoke or vary a licence.

A nursing home must be conducted in accordance with the conditions of the licence, but no conditions have been imposed on nursing home licences. However, conditions of licence are imposed on the one private hospital in the Northern Territory.

A body corporate cannot hold a licence unless it is incorporated or registered as a foreign company in the Northern Territory, although this requirement does not appear to be enforced.

Licence renewal is at the discretion of the Chief Health Officer, with no guidelines for the requirements to be met by the licensee.

In applying for a licence the applicant must submit details of the proposed building and facilities, manager, matron, qualifications of staff and maximum number of patients to be accommodated. No such requirements are laid down for the transfer of the licence.

In relation to nursing homes, the Northern Territory makes provisions with regards to minimum qualifications of staff to be on duty 24 hours per day. This provision will be amended to take into consideration the licensing of facilities with higher low level resident numbers. Other requirements that are grounds for revoking a licence (for example, body corporate requirements, approval for absence of managers and matrons) are not enforced.

There is a trend for hostels increasing to provide high level care to patients. This trend is expected to continue. However, hostels are not required to be licensed under the act. While they could be held to be competing with licensed nursing homes, it is more likely that they are filling a gap in the market place.

The basic features of the licensing procedure are considered potentially to restrict competition in that approval is completely at the discretion of the Chief Health Officer.

Benefits

- Licensing allows the Northern Territory to determine the appropriate standard of care.
- Licensing provides a basis for traceability and transparency of performance.
- Licensing allows THS to monitor the performance of the institutions.
- Licencing, and its attendant record keeping, provides the Chief Health Officer with a source of information to determine the level of demand and service.
- The public is provided with a degree of confidence about the quality of care.

Costs

- Costs are negligible, licence fees not having been varied for the last 15 years.
- There are no fees for renewing or transferring a licence.
- There are few costs associated with keeping the requisite records.
- If the body corporate requirements restricted ownership or impeded access to capital there would be a cost to the community. This does not appear to be the case.

Assessment of balance

The benefits to be gained from licensing appear to be substantive against negligible costs, notwithstanding the lack of enforcement of licence requirements.

Conclusion

- Private hospitals and nursing homes should continue to be licensed.

- Hostels (and all residential care facilities) provide high level care should be brought into the licensing regime.
- The conditions for licence renewal should be transparent from the outset, with minimum discretion for refusal to renew provided the licence conditions have been met.
- Transferability of licences is a benefit and provides prospects for allocative efficiency. Guidelines for transfer of licences are required.
- The requirement that a body corporate not hold a licence unless it is incorporated or registered as a foreign company in the Northern Territory should be rescinded.

Controls on prices or production levels

An applicant for a licence is required to specify the maximum number of people proposed to be accommodated in the private hospital or nursing home.

The Northern Territory's administrator may make regulations about the minimum qualifications of staff, ratio of staff to patients and minimum standards of accommodation, all of which have the potential to control the number of patients the institution may service at any one time.

Approval must be obtained from the Chief Health Officer to vary the conditions of the licence, giving the Chief Health Officer ultimate control over the number of patients accommodated.

The needs of rural and remote operators must be taken into account. Strict enforcement of ratios or standards may preclude operators from providing effective service to their community, particularly given the difficulties of recruitment and retention of staff.

No regulations in respect of these matters have been made by the administrator. The Chief Health Officer has determined Conditions of Licence for the one private hospital but, apart from specifying the number of beds, does not appear to have established other limits to the accommodation provided to patients. In any case, the conditions specify 150 beds compared with the 130 actually provided, and the level of occupancy at 30 per cent is well short of these limits.

This said, the imposition of limits on the number of beds gives the Chief Health Officer the ability to control the supply side of the market. This may best be left to market forces.

As well as the ability to control prices or production levels, section 36 (the power to make regulations) has the potential to confer significant costs on a business. These issues are considered separately.

Benefits

- The regulations or conditions of licence allow the Northern Territory to determine the minimum standard of care.
- Should the need arise, the Chief Health Officer has the power to vary the conditions of licence, which allows accommodation levels to be varied and flexibility in level of service provided to meet the requirements of particular communities.

Costs

- A cost would be imposed on the community if use of these provisions were to restrict the ability of private hospitals or nursing homes to meet demand and ultimately force up prices.

Assessment of balance

Insofar as the ability to make regulations and impose conditions of licence provide a basis for the Northern Territory to determine appropriate standards of care, and provided they are not used to restrict the ability of private hospitals or nursing homes to meet demand, they provide a net public benefit.

Conclusion

- The power to make regulations and impose conditions of licence should be retained but used flexibly, having regard for the requirements of rural and remote communities. It should not be used to determine the number of private hospital or nursing home beds in the community. This should be left to market forces.

Restrictions on the quality, level or location of services

Nursing institutions are required to keep a register of patients, which includes particulars of the patient and when they were received into the institution, the name of their medical practitioner, the drugs being administered and the date they left the institution.

The Chief Health Officer has the authority to enter a nursing institution at least once per year to inspect the register, premises and equipment. Follow-

ing an inspection, the Chief Health Officer may require the licensee to make repairs, alterations, additions or improvements to the premises or equipment or a change in management within a specified time.

Commonwealth accreditation requires the achievement of minimum standards of accommodation and the provision of a register.

The Northern Territory's *Public Health Act* also provides for standards for the preparation of food.

Benefits

- Maintenance of registers assists in providing transparency of operations.
- It also provides the Chief Health Officer with information regarding demand and the level of service.
- Notwithstanding alternate avenues for standards such as Commonwealth accreditation and the Northern Territory's *Public Health Act*, ultimate responsibility for quality of care lies with standards established under the Northern Territory's *Private Hospitals and Nursing Homes Act*.

Costs

- Costs of maintaining registers appear to be trivial.
- The cost of remedying defects following inspection could be significant. However, institutions would need to incur such costs to maintain their Commonwealth accreditation.

Assessment of balance

Maintenance of registers of patients does not appear to be anticompetitive nor does it impose significant costs. It assists the Chief Health Officer to fulfill his or her obligations. There appears to be no good reason that this should be rescinded.

While it could be argued that market forces would ensure that nursing institutions maintain an adequate standard of building, equipment and management, residents and their families have a restricted choice of high and low care facilities in the Northern Territory. While there are supporting mechanisms including the Australian building code and the Northern Territory's *Public Health Act*, the need to assure the public of the standards

of nursing institutions suggests there is a net public benefit in the requirement.

Conclusions

- The requirement for a register of patients should be maintained.
- The powers of the Chief Health Officer following inspections in relation to buildings, equipment and management should be maintained.

Restrictions on price or type of input used in the production process

The Chief Health Officer is required to approve the person replacing the manager or matron of a nursing institution should they be away from the premises for more than seven days.

This presumes the government has greater skills or more information than the institution in selection and appointment of appropriate personnel, and knowledge of the operations of the institution. In addition, the ability to investigate the proposed appointee in a reasonable timescale must be questioned. The provision is not being used and it is doubtful whether it is enforceable.

Benefits

- The benefits of this provision are hard to discern.

Costs

- While there are potential costs if the Chief Health Officer chooses to override a nominee, in practice there are no costs as the provision is not enforced.

Assessment of balance

There appears to be no good reason to retain this provision of the act.

Conclusion

- Section 19.1(b) should be rescinded.

Restrictions conferring significant costs on business

The Northern Territory's administrator may make regulations about the minimum qualifications of staff, ratio of staff to patients and minimum

standards of accommodation, all of which have the potential to impose significant costs on an institution.

Approval must be obtained from the Chief Health Officer to vary conditions of licence, giving the Chief Health Officer ultimate control over the way care is delivered.

The needs of rural and remote operators must be taken into account. Strict enforcement of ratios or standards may preclude operators from providing any service to their community, particularly given the difficulties of recruitment and retention of staff.

If the regulation of hostels were included within the act, the minimum requirement of having a registered nurse on duty at all times would need to be addressed as it would potentially restrict the provision of low level care by raising costs of operators.

The administrator has made no regulations in respect of these matters. The Chief Health Officer has determined Conditions of Licence for the one private hospital which specify that a number of criteria (appropriate medical staff, emergency medical procedures, non-medical procedures, clinical standards, etc.) are 'adequate'. The conditions also specify the number of nurses in each ward area and the ratio of registered nurses to enrolled nurses.

No such conditions have been imposed on nursing homes.

Benefits

- The regulations or Conditions of Licence allow the Northern Territory to determine the minimum standard of care.
- Should the need arise, the Chief Health Officer has the power to vary the Conditions of Licence, which would allow flexibility in level of service specified to meet the requirements of particular communities.

Costs

- Imposition of these requirements confers a direct cost on inputs and must ultimately be passed on to patients and residents through prices.

Assessment of balance

Insofar as the ability to make regulations and impose conditions of licence provide a basis for the Northern Territory to determine appropriate

standards of care, they give potential users some reassurance of the standards they are purchasing and provide a net public benefit.

Conclusion

- The ability to make regulations and impose conditions of licence should be retained but used flexibly, having regard for the requirements of rural and remote communities.

7 *Alternative ways of achieving objectives*

NCP REVIEWS ARE REQUIRED to consider whether there are alternative means for achieving the same results as those which restrict competition, including nonlegislative approaches. The key question is whether the implicit objective of the act — that the government ensures that any private hospital or nursing home meets standards that protect the wellbeing of patients, residents and the general public — can be achieved efficiently and effectively, but in less regulatory ways than at present.

The issues paper for this review invited interested parties to comment on this proposition and to suggest less regulatory ways of delivering safe and high quality private hospital and nursing home care services to Northern Territorians. Higher standards generally result in higher quality and higher costs and, if standards to obtain entry are not necessary to carry out the functions at the level of quality desired by consumers or if operators with adequate standards are prevented from carrying out these services, inefficiencies may result.

Specific legislative provision for standards of accommodation, staff qualifications, staff duties and staff to patient ratios is not the only way to ensure that appropriate standards of care are maintained in private hospitals and nursing homes. Standards can and are being achieved in a number of other ways including through quality assurance and accreditation programs, and through inspection and direction provisions in the legislation. An alternative (perhaps less costly) approach would be to provide enhanced information to potential users and their families and communities, including official warnings, advertising campaigns and publications about particular institutions to enable informed decisions about purchasing the services to be made. This alternative has traditionally been rejected in the case of providers of health services.

THS submitted that standards could be enforced through quality assurance and accreditation programs (some standards are covered by Commonwealth accreditation) and through the inspection and direction provisions

in the legislation. It was said that such provisions could be a better alternative than the current regulatory approach in the legislation, but that these issues need to resolved in consultation with key stakeholders.

The two most applicable health quality assurance and accreditation programs appear to be those provided by:

- the Australian Council on Healthcare Standards
- the Quality Improvement Council Ltd.

Australian Council on Healthcare Standards

ACHS is an independent, not-for-profit organisation representing 22 member organisations, which in turn represent key stakeholders in health care, including consumers. The uniqueness of the ACHS is its broad health industry representation.

Its mission is: 'To promote continuing improvement in the quality of care delivered by health care organisations'. This is achieved through its Quality Improvement Program (QuIP) by:

- developing standards and clinical indicators in consultation with consumers and the health industry;
- providing a comprehensive education program;
- publishing standards, guidelines and serials; and
- access to a national aggregate database of clinical indicators for reviewing performance.

Quality Improvement Council

The Quality Improvement Council Ltd (QIC) was formed in 1997 from a prior Australian Community Health Association. The council, though its Australian Health and Community Services Standards (AHCSS), has a vision to be at the cutting edge of continuous improvement and evaluation, promoting productive partnerships between service providers, the community and consumers by strengthening the capacity of health and human services to achieve quality outcomes.

A comparison of the two schemes is given in table 7.1.

7.1 Comparison between ACHS–EquIP and QIC–AHCSS

Underlying principles	*ACHS–EquIP*	*QIC–AHCSS*
Emphasis on continuous improvement	Continuous improvement to best practice in health care is a core component	Strong emphasis on internal service development and assessment, using the standards and review tools
Scope of the program	The program provides a broad framework to improve performance, specifically developed for the health care industry.	Broad application, although targetted at health, community and human service sectors.
Nature of the criteria	Generally a non-prescriptive approach is taken, although elements of health care delivery that must be addressed are prescribed.	Generic manual of standards with sector specific 'modules' and detailed notes and examples.
Customer focus	The standards focus on patients, clients, residents, carers, their families, the community and funders as appropriate. There is also a focus on internal customers.	Strong and recognised consumer focus including involvement in service planning: strong emphasis on community participation; focus on internal customers.
Results/outcomes focus	There is an emphasis on demonstrating appropriate outcomes for all care and service. The program stresses the use of data. Suggested indicators of quality for clinical care are provided through the Care Evaluation Program.	Services required to demonstrate outcomes, both quality process outcomes and impact outcomes in interviews, documentation review and consumer/community input.
Focus on accreditation or certification	EquIP is an accreditation process, conducted by external, volunteer peer surveyors. Accreditation status is determined following the organisation-wide survey, every 3 years, subject to evidence of continuing improvement. Accreditation status can be withdrawn if serious issues of safety and quality care are identified at periodic review, midway between organisation-wide surveys.	National accreditation is available following preliminary state-based review, which is undertaken by external peer review. Service contract to a three year review cycle.

Of hospitals and nursing homes in the Northern Territory, only Royal Darwin Hospital, which is accredited by ACHS–EquIP, has followed this path.

The submission by THS in this respect provides a useful alternative to the legislative approach. It must be recognised, however, that achieving accreditation can impose significant, albeit worthwhile, costs.

8 *Other matters*

THIS NCP REVIEW represented a timely opportunity for interested parties to respond to any other issues in the act or the way it operates, or any other matters affecting the performance of private hospitals and nursing homes in the Northern Territory. They were invited to do so in the issues paper prepared for the review.

One issue raised by hospital administrators concerns ways of achieving a greater degree of cooperation between private and public hospitals in their use of facilities and services. Improved cooperation was seen as delivering advantages to both government and private operators and service users.

An example concerns the utilisation of laundry facilities. Royal Darwin Hospital has its own laundry facilities. But, because these facilities are government owned, the laundry service is unable, under current policy, to tender to undertake laundry services for the adjoining private hospital. As a result, competition in the Darwin market for the provision of laundry services is reduced. A preferable situation would be for public service providers to be allowed to compete, under conditions of competitive neutrality, with private service providers to supply these services.

9 *Recommendations*

THE FINAL TASK FOR THIS REVIEW is to make clear recommendations that flow from the foregoing analysis. A requirement of the terms of reference is that if change is not recommended and restrictions on competition are to be retained, a strong net benefit for their retention must be demonstrated.

An strong net benefit can be concluded for the current licensing system for private hospitals and nursing homes. Therefore it should be retained. However, many features associated with this system are either not in the net public interest, or are not strongly so, and for these the status quo is not being recommended.

Scope of the act

There are some difficulties in dealing with all issues relating to private hospitals and nursing home in one act. The range of issues dealt with in any one piece of legislation is not of itself an NCP issue. However, with a view to establishing more neutral regulatory structures for complementary and/or competitive activities, it is recommended that:

- consideration be given to separating the regulation of private hospitals and nursing homes, and of their complementary and/or competitive institutions, into separate acts; and
- objectives be clearly stated in the act(s), for example:
  - 'to protect the social health, safety and wellbeing of patients–residents and the welfare of the Northern Territory community by ensuring that only those institutions and persons suitably qualified are licensed and permitted to operate a private hospital–nursing home.'

Licensing

There is a strong net benefit in continuing the licensing of private hospitals and nursing homes. To achieve a more neutral competitive environment it

is recommended that licensing of private hospitals and nursing homes be retained and extended to include facilities classed as hostels. All residential aged care service providers should be licenced.

Such an extension may require changing terms used in the act, such as 'nursing homes' to 'residential aged care facilities'. No recommendations are made about licence renewal or transfer, or about particular conditions of licence, since these have been assessed not to restrict competition.

Provisions not used that potentially restrict competition

It is recommended that:

- the requirement of the act that a body corporate must be incorporated or, if a foreign company, be registered under the law of the Northern Territory be rescinded; and
- the requirement of the act that a manager or matron must be replaced by a person approved by the Chief Health Officer if he or she is away from duties for a period in excess of seven days be rescinded.

Some other conclusions

Without leading to recommendations, since no restrictions in practice were concluded, a number of other conclusions have been noted.

- The conditions for licence renewal and transfer should be established and transparent.
- The power to make regulations and impose conditions of licence should be retained but used flexibly, having regard for the requirements of rural and remote communities. It should not be used to determine the number of private hospital or nursing home beds in the community. This should be left to market forces.
- The requirement for a register of patients should be maintained.
- The powers of the Chief Health Officer following inspections in relation to buildings, equipment and management should be maintained.

Appendix

Terms of reference

THE REVIEW OF THE LEGISLATION shall be conducted in accordance with the principles for legislation review set out in the Competition Principles Agreement. The underlying principle for the review is that legislation should not restrict competition unless it can be demonstrated that:

- the benefits of the restriction to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition.

Without limiting the scope of the review, the review is to:

- clarify the objectives of the legislation, clearly identifying the intent of the legislation in terms of the problems it is intended to address, its relevance to the economy and contemporary issues and whether or not the legislation remains an appropriate vehicle to achieve those objectives;
- identify the nature of the restrictions to competition for all relevant provisions of the specified legislation. This analysis should draw on the seven ways identified by the National Competition Council in which legislation could restrict competition, which include:
  - governs the entry or exit of firms or individuals into or out of markets,
  - controls prices or production levels,
  - restricts the quality, level or location of goods or services available,
  - restricts advertising and promotional activities,
  - restricts price or type of input used in the production process,
  - is likely to confer significant costs on business, or
  - provides some advantages to some firms over others by, for example, shielding some activities from the pressure of competition;
- analyse the likely effect of any restriction on competition and on the economy generally;

- assess and balance the costs and benefits of the restrictions for each anticompetitive provision identified;
- consider alternative means for achieving the same result and make recommendations including nonlegislative approaches; and
- clearly make recommendations. These should flow clearly from the analysis conducted in the review. If change is not recommended and restrictions to competition are to be retained, a strong net benefit for retention must be demonstrated.

When considering the matters referred to above, the review should, where relevant, consider:

- government legislation and policies relating to ecologically sustainable development;
- social welfare and equity considerations, including community service obligations;
- government legislation and policies relating to matters such as occupational health and safety, industrial relations and equity;
- interests of consumers generally or of a class of consumers;
- government legislation and policies relating to ecologically sustainable development;
- economic and regional development including employment and investment growth;
- the competitiveness of Australian business; and
- the efficient allocation of resources.

The review shall consider and take account of relevant legislation in other Australian jurisdictions and any recent reforms or reform proposals including those relating to competition policy in other jurisdictions.

The review shall consult with and take submissions from those organisations currently involved with the provision of health services, other interested territory and Commonwealth government organisations, other state and territory regulatory and competition review authorities, affected members of the medical profession and their organisations and members of the public.