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Abstract: This article provides an explanation of why consideration is needed of historical practice issues when designing new regulatory regimes. It also suggests some practice techniques that can be applied both to existing and new regulatory regimes to enhance the effectiveness of the regulation. It does so by exploring the problems faced by existing service providers and regulators following the introduction of a new regulatory regime intended to raise the standard of out-of-home care services in NSW. This involved agencies making the transition from a licensing regime based on minimum standards under the Children (Care and Protection) Act 1987 to accreditation, employing optimum practice standards, under the Children and Young Persons (Care and Protection) Act 1998.

LICENSING, ACCREDITATION AND QUALITY IMPROVEMENT

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This paper provides an explanation of why consideration is needed of historical practice issues when designing new regulatory regimes. It also suggests some practice techniques that can be applied both to existing and new regulatory regimes to enhance the effectiveness of the regulation.

It does so by exploring the problems faced by existing service providers and regulators following the introduction of a new regulatory regime intended to raise the standard of out-of-home care services in NSW. This involved agencies making the transition from a licensing regime based on minimum standards under the Children (Care and Protection) Act 1987 to accreditation, employing optimum practice standards, under the Children and Young Persons (Care and Protection) Act 1998.

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Introduction

This paper draws upon the experiences of the author who has extensive experience in out-of-home care in New South Wales (NSW) and was involved in managing the implementation of the *Children and Young Persons (Care and Protection) Act 1998 (NSW)*, the preparation of the drafting instructions for the associated regulations and the design and implementation of the accreditation and quality improvement programs.

In 2003 the provisions under the *Children and Young Persons (Care and Protection) Act 1998* (the Act), specifically Chapters 8 and 10, requiring all out-of-home careⁱ service providers to seek accreditation if they wished to continue operating beyond 2005, were commenced.

These requirements are the current iteration of a long line of regulatory regimes in regard to out-of-home care services. Historically, all Australian jurisdictions, at least since Federation, and some prior to 1901, have sought to regulate the provision of services for children unable to remain in the care of their families. However, as 'popular' as the regulation of these services has been the notion of regulatory practice has not been theorised, beyond addressing the best approaches to adopt. By way of example, the Hilmer (1993) report, which set out the framework for a national competition policy, led to the formulation of the Competition Principles Agreement (COAG 1995b). Similarly, in NSW the report by Sturgess (1994), led to the development of a range of regulatory revisions set out in 'From Red Tape to Results' (NSW Government 1995). While both of these reports resulted in much being written about the different regulatory strategies available and best regulatory practice little was, and since has been, written about the theories that inform the different regulatory strategies, how they are applied, regulatory practice and some of the problems posed when a regulatory regime changes from one approach to another.

Historical context

In NSW the regulation of out-of-home care services was initially limited to residential services in the form of institutional care and group home care in respect of children subject to voluntary and court ordered care arrangements. It was not until 1966 that any attempt was made to regulate foster care, but limited to individual carers. The regulation of foster care services run by non-government organisations (NGOs), first mooted in the unproclaimed *Community Welfare Act 1982*, did not occur until the proclamation of the *Children (Care and Protection) Act 1987*. At the same time the out-of-home care regulatory framework was expanded beyond physical standards of care to address the emotional development of children and the provision of casework services (NSW Government 1989a and 1989b).

While meant to capture all out-of-home care service providers, being those providing care for children subject to voluntary and court ordered care, the regulatory focus was limited to those services that government funded and those caring for the children in respect of whom the State had a legal interest. While the legislation required the licensing of voluntary foster care services, the provisions were not applied. Subsequently the government progressively withdrew from the licensing of funded services on the basis that such services were subject to the standards referred to in their funding agreements (NSW Government 1996). The difficulty was that no standards were referred to, or incorporated in the funding agreements.

The net result of these policy changes was that in the responsible Department, the NSW Department of Community Services (DoCS), the need for, and understanding of, licensing passed from common understanding. This occurred in tandem with the closure of most State run residential care units which caused a crisis in locating placements for some children unable to remain with their families, particularly adolescents with behaviour problems. In addition many established non-government services, which were also coming under pressure from the State, through

the reallocation of funding, to close their residential units, were reluctant to care for these children. This led to the creation of a niche market to care for hard to place children. This in combination with the collapse of the licensing system enabled the introduction of unlicensed fee-for-service agencies, many of which operated at less than minimum standards.

While slow coming, concerns were increasingly expressed about the quality of care being provided, the failure of the State to properly regulate the sector (Usher 1992) and its role in promoting substandard care through placing children in dubious care situations. To this was added concerns about the State being perceived to provide substandard out-of-home care (DoCS 1997). In part this was attributed to the unique position of DoCS, relative to other out-of-home care service providers. In keeping with the majority of regulatory approaches, State run out-of-home care programs were not subject to regulatory controls. It was considered that such services were sufficiently regulated through the responsible department being answerable to the parliament.

This led to criticisms that DoCS, which as the regulator, funder and purchaser of services and the principle service provider, had a significant conflict of interest (DoCS 1997; Usher 1992). This in association with concerns about the *Children (Care and Protection) Act 1987* led to the Premier and Minister for Community Services announcing in 1994 a review of the 1987 Act (DoCS 1997).

The Children and Young Persons (Care and Protection) Act 1998

Following a four-year review of the *Children (Care and Protection) Act 1987* the government drafted, and in 2000 commenced the progressive introduction of the *Children and Young Persons (Care and Protection) Act 1998*. One of the features of the Act is the requirement for all out-of-home care service providers, including government departments, to be accredited by the Office of the Children's Guardian (OCG), a new government department established in December 2000. The objectives of

this new regime, as reported in Hansard (1998:9766) are to 'promot[e] the best interests of children and young people in out-of-home care; [to] ensur[e] the rights of children and young people in out-of-home care are safeguarded and protected'

This accords with the views of Rimmer (2006) and Walshe (2002) that the purpose of regulation is to exercise control over the conduct of certain activities to ensure the wellbeing of society. While there are a number of ways this can be achieved, such strategies fall into two categories of regulation: statutory and non-statutory mechanisms. The choice of the most appropriate regulatory category and mechanism involves two principle tests. Firstly the form of regulation adopted has to be the one that best achieves the regulatory objectives. That is, it has to be the most effective option in modifying behaviour. Secondly, it has to be the most efficient mechanism, meaning that it achieves the regulatory objectives at the least cost to society (Rimmer 2006). These two tests underpin the requirement in NSW to prepare a Regulatory Impact Statement (RIS) on all new statutory regulations (NSW Government 1989).

Statutory regulation is employed when it is considered that those working in a particular field of practice are, or are perceived to be, unable to self-regulate their behaviour (Breyer 1998) Other factors include the nature of the field of practice in need of regulation, the public's perception of risk and the consequences of failure to adhere to the regulatory regime (Baldwin et al 1998). In respect of the regulation of out-of-home care agencies, in the RIS it was concluded that in 'the absence of a statutory regulatory regime [there would be] insufficient safeguards and quality outcomes for children, young people and their families'. Further, and reflecting Braithwaite's (1981-82) views regarding the limitations of economism as a regulatory mechanism, in the RIS the view was also expressed that the 'funding regime is unable to provide the enforcement mechanisms..... to ensure the care and protection of children and young people (DoCS 2000:39 and 42).

However, questions arose as the nature of the prescribed regulatory model inherent in the Act. While the Act requires service providers to obtain 'accreditation', the regulatory processes set out in it rest on a pass/fail approach, as provided for in section 139, rather than continuous quality improvement, as is usually associated with accreditation. (Rooney and van Ostenberg 1999). This suggests it really is a licensing model. This uncertainty is exacerbated through the use of optimum standards in the regulation, as these are usually associated with accreditation and quality assurance programs (Rooney and van Ostenberg 1999).

Determining just what model of regulation is in the Act can be achieved by exploring some of the concepts informing regulation and, in particular, by reviewing the differences between licensing, accreditation and quality assurance and then apply them to the regulatory model in the Act and associated Regulation.

Licensing as an activity, is located in a statutory framework, is undertaken by the state, and in the absence of which a person or organisation is precluded from operating. Licensing is based on minimum standards, involves the capacity to prosecute, impose and vary licensing conditions and the imposition of monetary penalties. Licensing models also provides for the capacity to cancel a licence and so prevent the person or organisation from continuing to operate (Le Brasseur et al 2002)

Licensing is also subject to a number of limitations. It can inhibit the development of new services if they are unable to be accommodated within the regulatory framework and prescribed requirements (Walshe 2002). Licensing reviews tend to be backward looking in as much as they seek to determine the extent to which services have or have not complied with the licensing standards (Rooney and van Ostenberg 1999). In being based on minimum standards, once this standard has been achieved, there is little or no incentive on the part of the licensee or regulator to try and further improve the quality of care provided. As a consequence licensing does little to contribute to the building of capacity or improving

the quality of care beyond the minimum standards. Within out-of-home care, because licensing was seen by many licensees to make only a minimal contribution to improving the quality of care, it tended to be regarded as demanding of an agency's time and resources while providing little in return.

In comparison, accreditation, while employing some of the same mechanism as licensing, such as audits, assessments and external reviews, is an activity which people and organisations have the option of voluntarily participating in, that is, it not a pre-requisite to practicing (Harvey 2004). Unlike the use of minimum standards for licensing, accreditation employs a quality assurance model which Hindel and Natsagdorj (2002) notes involves the setting of optimal standards and rating a person or organisation's performance in terms of the extent to which the standards have been met. For its part, accreditation combines quality assurance with a quality improvement framework that promotes self-assessment, action plans to address gaps and ongoing and progressive improvements in service delivery (Fairbrother and Gleeson 2000: Le Brasseur et al 2002).

Being based on the concept of continuous quality improvement, accreditation standards are usually graded into a series of levels with the participating agencies being encouraged through the use of various incentives, including financial, such as higher levels of funding, to progressively improve their services (Rooney and van Ostenberg 1999). For example, the participation of private hospitals in the accreditation program run by the Australian Council on Health Standards, while an expensive exercise for each facility, and even though in NSW they have to be licensed under the *Private Hospitals and Day Procedure Centres Act 1988*, is a prerequisite to securing a contract with the health funds (Productivity Commission 1999) with different levels of attainment attracting differing levels of remuneration.

Given the forgoing, the model in the Act is more of a hybrid as it compels agencies that want to provide out-of-home care services to undergo what is referred to as accreditation (for one, three or five years), but based on a pass/fail model. In addition the Act provides for the imposition of conditions, prosecution and cancellation of the authority to provide services. If this is all there was to the regulatory model, it would be easily defined as a licensing regime, despite the references to accreditation.

However, while the Regulation (NSW Government 2000) provides for the Children's Guardian to develop appropriate standards for the accreditation program the Minister of the day 'suggested' that the OCG employ standards previously developed by a joint DoCS/NGO working party. Based on best practice, the standards were originally developed for use with a voluntary accreditation program (DoCS 1998) that never got off the ground. Significantly, and in keeping with the philosophy of accreditation, it was never intend that these standards would be applied as benchmark measures, but rather as practice ideals to be achieved over time (DoCS 1998:6).

By using them as optimal standards, a significant element of quality assurance was introduced which in turn blurred the nature of the model employed. The model was further blurred through the incorporation of self-assessments and quality improvement plans, as they are features of accreditation programs (OCG 2003).

Significantly, between the establishment of the OCG in December 2000 and the proclamation of the out-of-home care provisions in June 2003 the OCG not only developed the accreditation program, but also had the opportunity to trial it on a voluntary basis. It was soon established that the combination of the loss of licensing knowledge and the exemption of funded services from licensing; the absence of any standards associated with funding and the under-resourcing of agencies which limited the capacity of some services, which relied solely upon government funding,

to improve the quality of their services; and the application of optimum standards for the new regulatory regime in association with a pass/fail model resulted in the majority of agencies being unable to meet the standards required for accreditation.

However, as the government remained committed to introducing the accreditation requirements without any amendment to the Act, it was necessary to find a way through the political and regulatory maze. The solution had to satisfy all stakeholders and where possible avoid the closure of agencies as this would destabilise existing placements of children, but without compromising the quality of care provided to them. This was achieved through the use of some creative drafting in the transitional regulation which provided existing agencies with the option of either seeking accreditation or, subject to their demonstrating that the children in their care were not at risk of harm (being the grounds on which a child could be removed from his or her carers), participating in a quality improvement programme (OCG 2003). Sixty-five percent of agencies opted to participate in the quality improvement program (OCG 2005). While not voluntary, the quality improvement program is a blend of quality assurance, accreditation and licensing. This is reflected in the lack of choice agencies have in participating, unless they opt for accreditation, and the use of optimal standards, action plans, audits and the requirement to for each agency to benchmark themselves, in consultation with the regulator, against the accreditation standards.

While this strategy preserved the placements of the majority of children in out-of-home care, in comparison, new service providers have to be accredited and meet the minimum requirements prior to being allowed to practice. These consist of having in place policies and procedures of sufficient quality to ensure that when operationalised, the standard of care provided will meet the accreditation standards.

Adopting a different approach to new and existing service providers preserved and supported existing placements, where there were no

observable risk-of-harm factors. At the same time it ensured that future service providers, prior to their being able to seek funding from DoCS to provide services, could operate at a satisfactory standard.

Design of the Accreditation and Quality Improvement Programs

During the design phase of the accreditation and quality improvement programs the OCG executive identified a number of guiding principles to inform the development and implementation of the programs. The first was that all activities, and so the design of the accreditation and quality improvement programs, had to not only add value to the quality of care provided to children in out-of-home care, but had to be seen to do so. It was considered that unless the OCG could be seen to be making a positive contribution to the quality of care provided, agency staff would regard the OCG as just another regulatory black hole which consumed increasing amounts of agency resources and staff time for little benefit. As it was, until an agency immersed itself in the process, the benefits of either program were not readily apparent, they being initially perceived as demanding and excessive (OCG 2003).

Adopting a value adding position meant the OCG also taking responsibility for a significant educational role to both explain the new programs and to promote and gain acceptance for what constitutes an acceptable level of care (OCG 2003). In doing so the OCG clearly differentiated between facilitating improvements to the quality of care provided by the sector and working with individual agencies as a consultant to improve the quality of care which, as Walshe (2002) notes, would pose a conflict of interest for OCG staff. By adopting an 'arms length' approach when working directly with agency staff advice can be provided regarding the extent to which policies, procedures and practices meet the standards without specifying how any deficiencies should be addressed. In practice OCG staff limit their involvement to assisting individual agencies develop quality improvement plans and timetables. No

assistance is given to the development of policies and procedures, or the provision of advice on how to improve practice that had been found lacking.

The first principle informed the second principle adopted which was to respond to each agency employing a strengths-based perspective (OCG 2003). As described by Healy (2005:151) a strengths perspective is practice based and 'emphasises optimism and creativity'. In application, while not denying the significance of the past, a strengths perspective is forward looking and solution orientated, focussing on the capacity and potential of each agency to achieve change. This is realised through mobilising the talent, knowledge and capacities inherent in each agency.

Complementing the strengths perspective the OCG employed a task centred model that can be described as 'structured, focussed and time limited' (Healy 2005:112). Drawing on Reid (1996) the task centred model utilised by the OCG emphasises:

- the use of clearly defined time frames to achieve progressive and incremental changes,
- the agency taking responsibility for identifying what matters need to be addressed, the changes to be achieved and negotiating with the OCG when the changes would be in place,
- a collaborative approach in which the OCG's role is to facilitate change without being consultative,
- encouraging the agency to integrate quality improvement tasks into their strategic planning and annual review processes, and
- the agency taking responsibility for the standard of care provided, notwithstanding any perceived deficiencies in government funding.

Using these two strategies, participation in either program involves a two-stage process. An agency initially undertakes an audit of its policies, procedures and practices by benchmarking them against the shared standards used in the accreditation and quality improvement programs.

This enables the identification of each agency's strengths and weakness,

in both functional areas that need further attention and individual policies, procedures or practices that need developing or revising. Having identified their strengths, each agency then proceeds to develop a quality improvement plan and timetable for improving the identified areas of weakness. The identification of existing strengths provides a reference point, and a model for use as a template, to address other areas in need of attention. If an agency elected to seek accreditation, the application had to be lodged within the two-year period provided for in the transitional regulation (that is by June 2005). In comparison, those agencies participating in the quality improvement program were required to develop a quality improvement plan based on a three-year cycle. At the end of each cycle the agency is required to re-evaluate itself by undertaking a further audit, which is then used to develop a new quality improvement plan for the next three-year period. Depending on the number and significance of the matters to be attended to, an agency could prepare a master plan which spanned more than one three year cycle and, with the agreement of the OCG, prioritise which matters would be attended to when. Some very large agencies developed projected quality improvement plan timetables that spanned nine years, however, three to six years was more common. Regardless of the strategy adopted, the objective is for each agency to achieve a standard that enables them to exit the quality improvement program and achieve accreditation.

The third principle adopted was to promote the idea of 'good practice' as opposed to 'best practice'. While good practice was seen to be reasonably achievable, best practice was considered by a significant number of agencies to be an almost unachievable mythical standard. This is particularly significant for smaller agencies. They cannot be expected to have the same degree of sophistication in their policies and procedures as larger ones that have greater access to resources and more staff to call upon. Some larger agencies have evolved to the extent that they have dedicated staff to develop policies and procedures, as opposed to smaller

services which rely solely upon government funding, the provision of which is limited to direct services.

The fourth principle was that both programs had to be culturally appropriate, with particular regard for Indigenous agencies. Little is achieved by expecting Indigenous agencies to uncritically accept non-Indigenous practices. Such a position amounts to what Young (1990) refers to as cultural oppression. As Lynn et al (1998) observe there is a need to question the application of western values that are inherent in legislation and government policy, such as individualism and the nuclear family, to Indigenous agencies and communities because Indigenous professional (and personal) activities and perceptions are often structured around and by extended family connections.

Accordingly, the OCG had to do more than just acknowledge cultural differences. Because the accreditation and quality improvement requirements also structure relationships and influence practice, it was necessary to recognise the OCG - Indigenous agency relationship extended to informing Indigenous worker-client relationships. Accordingly, the OCG sought to create a framework that acknowledged Indigenous relationships based on Indigenous values and mores, or what Lynn et al (1998:3) refer to as 'private ethnicity'.

In some ways this was the most difficult principle to apply as the framework, the process and the standards, being informed by legislation, are based on western values. This is particularly significant for Indigenous services as Indigenous children are over represented in out-of-home care, constituting twenty six percent of the care population even though Indigenous people constitute only two percent of the NSW population (DoCS 2005). In addition, Indigenous out-of-home care service providers have different priorities when it comes to determining what is important, and not important. For example, when recruiting foster carers, the paramount consideration is placement with family, not only to maintain family links, but the child's place in their community, culture and politics.

Again, some creative interpretations and work practices were called for, if one of the objectives of the Act, Indigenous self-determination, was to be realised. In recognition of these differences discussions were held with each Indigenous agency providing out-of-home care services and AbSec (Aboriginal Child, Family and Community Care Secretariat, being the peak organization that represents all Indigenous out-of-home care services). Arising out of these discussion expressions of interest were sought from a number of universities to work with the Indigenous agencies to culturally reframe the accreditation and quality improvement standards and OCG practices. From the expressions of interest received the University of Newcastle was selected to undertake this task.

Discussion

Managing the transition from an inactive regulatory regime to a dynamic and active one has been an exercise in legislative and political management. The initial trials of the accreditation program had unforeseen benefits, despite the problematic findings. Firstly, it enabled the design of the regulatory regime to be revisited and, to the extent possible, without amending the Act, for corrective action to be taken. Secondly, through involving a number of agencies in the trials and actively pursuing their feedback they became valued participants in the further development of the regulatory regime to the point that some acquired a sense of ownership. In consequence they assisted in advocating the participation of other agencies to the point that when the legislation actually commenced, in excess of fifty percent of them were voluntarily engaged in one of the two programs. The participation of the Indigenous agencies in the reframing of the standards had a similar impact.

The future success of the programs will in part be dependent upon the extent to which agencies adopt a quality improvement approach to the management of standards of care. If agencies are able to integrate this into their strategic planning and reviews of their service delivery further improvements will become an intrinsic part of practice.

However, measuring the impact and effectiveness of any regulatory regime can be problematic as there are direct and indirect costs and benefits that hard to assess (Rimmer 2006). In addition, measuring outcomes such as children in care developing into healthy adults have such long lead times, that more short term measures have to be adopted. In addition, political perceptions may outweigh the value of any empirical process of review.

While the requirement for new service providers to achieve accreditation prior to their providing care should have some immediate and measurable impact, one of the more significant criticisms that has to be justified is the time it takes and the resources required for an existing agency to meet the accreditation and quality improvement requirements. Similar mandatory programs such as the Commonwealth's Aged Care and Child Care Accreditation Programs (which given the forgoing discussion are really licensing systems) because they are not as onerous, reinforce such a view. From this perspective all the ingredients are present with which to challenge the OCG methodology. However, this is not to say that such a challenge would be valid as non-statutory accreditation programs such as those run by Australian Council on Health Care Standards for health services and Standards Australia, are not only expensive to participate in, in terms of staff time, but are far more demanding, highly sought and prized, even within the government and non-government spheres (Fairbrother and Gleeson 2000). It is more the case of how to determine the actual and perceived benefits. However, anecdotal feedback suggests a high level of support for the accreditation and quality improvement programs.

This, however, is not to imply that all suggestions for change should be resisted. The time and resources required need to be addressed and research undertaken to see if there are alternative ways of achieving the same outcomes. Working within the existing legislative framework, and without compromising the programs, a number of variations that would

effectively diminish their impact on both agencies and the OCG seem possible. Consideration could be given to reducing the areas addressed by the standards and so the number of standards. Presently they address all aspects of an agency's functioning, from the delivery of services, to the agency's administration and management, including boards of management, where applicable. It would be of benefit to explore whether the standards need to be so extensive, or whether the same outcome can be realised by concentrating on service delivery and related activities. This could be achieved by setting up a control group that would be subject to all the standards, and an experimental group subject to standards only associated with service delivery and any variations in the expected outcomes assessed.

Consideration could also be given to introducing some form of self-certification for subsequent periods of accreditation and quality improvement cycles. Self-certification rests on a person certifying that they, or the organisation they represent has the capacity to and will meet all specified requirements (NHMRC 2002). However, if applied, it would need to be in combination with the use of random sampling to ensure that the policies and procedures associated with the standards self-certified have been kept up to date as self-certification can mask poor practice (Fairbrother and Gleeson 2000). This would dovetail in with the monitoring program, which is based on random audits, reviews of case files and encouraging agencies to seek client and stakeholder feedback. While not been addressed in this paper, the monitoring program embodies the same principles outlined earlier.

A further option would be to seek the Minister's approval, as required under clause 36 of the *Children and Young Persons (Care and Protection) Regulation 2000*, to vary the language introducing the Standards and move away from the pass/fail notion to that of a graduated approach to facilitate the use of a continuous quality improvement model.

Conclusion

The success of any regulatory regime is dependent upon the language used in the Act and regulations to the extent that it is understandable, can be readily applied and produces the desired outcomes (Diver 1998)

Informed consideration of the out-of-home care sector, prior to the Act being drafted, might have avoided the development of a regulatory model that the majority of agencies were unable to comply with. If there had not been a delay in the proclamation of the out-of-home care provisions in the Act, the commencement of the accreditation requirements could have had unfortunate consequences. In the longer term, the quality improvement program developed under the transitional regulation in response to the problems with the Act, because it provides for quality assurance and is more inclusive, has more to offer the sector than the accreditation program with its pass/fail outcome. In addition, its operation would be considerably enhanced if a quality improvement framework could be introduced.

The challenge for both the regulator and those regulated is to ensure that not only is quality is maintained between reviews, but that there is an ongoing improvement in the standard of care provided (Rooney and van Ostenberg 1999). One way of achieving this is to encourage the integration of the accreditation and quality improvement programs with each service providers strategic-planning and evaluation processes. Doing so will also reduce the staff time required to participate in both programs (Fairbrother and Gleeson 2000)

However, given the nature of politics and the process by which legislation is developed, made and reviewed, the success of any regulatory regime is very much dependent, not just upon how well it achieves its objectives, but how well it is perceived to do so and at what perceived cost. Participation in the accreditation and quality improvement programs represent a significant change for agencies and is demanding of staff time and resources. It remains to be seen if the benefits not only outweigh the cost, but also are perceived to do so.

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ⁱ Out-of-home care can be defined as the twenty four care of a child or young person at a place other than their home, by a person other than a parent or immediate relative of the child or young person, and not including the care provided by a children's service (such as a child care centre) or health related services. In Australia out-of-home care can also be referred to as substitute care, foster care and residential care.