



**AUSTRALIAN DENTAL
ASSOCIATION INC.**

**Submission in response to the ACSQH Consultation Paper:
NATIONAL SAFETY AND QUALITY ACCREDITATION
STANDARDS**

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**Authorised by
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ACSQH Consultation Paper
NATIONAL SAFETY AND QUALITY ACCREDITATION STANDARDS**

Introduction.

The Australian Dental Association (ADA) would like to thank you for the opportunity to meet with representatives of the Australian Commission on Safety and Quality in Health Care (ACSQH) at its recent consultation meeting where the Consultation Paper: An Alternative Model for Safety and Quality Accreditation of Health Care (The Paper) was discussed.

The ADA notes the request for a general call for written submissions on the alternative model and thanks you for the opportunity to present further to the Commission on the Paper.

General comments on the Paper.

The Commission has recognised the case put forward by a number of health sector groups, including dentistry, which questioned the need for accreditation. Despite the recognition of this issue, the Commission has still not put forward evidence in the Paper to substantiate the need for the creation of these standards.

As submitted previously and as mentioned in the Consultation meeting, the ADA recognises that the quest for safer delivery of health care is an admirable objective. Having said this, the ADA strongly questions if there is any actual necessity for the introduction of National Safety and Quality Accreditation Standards for dental practices in Australia. National Safety and Quality Accreditation Standards may well be needed in complex health care settings where patients are treated by multiple practitioners but the practice of dentistry is unique in the health setting environment. It involves practitioners who are running office based practices that are ultra small businesses, where the patients' critical and irreversible treatment almost always involves only a single practitioner.

Existing registration and other regulatory measures applicable to dentists and their surgeries adequately protect public health and safety in relation to the delivery of dental services. No evidence has been produced to demonstrate that there is any significant shortcoming or dangers associated with the delivery of dental care in Australia that require attention. The relative absence of adverse consequence reports suggest the existing measures are already comprehensive and adequately address issues of safety and quality. The addition of a further layer of regulation is not necessary.

In summary, there is no need to impose any further costly and time consuming 'red tape' administrative standards in what is essentially an

area of health delivery that is relatively safe and more than adequately addressed by existing standards and practices.

If the Commission maintains the need for the creation of accreditation then the ADA calls for the evidence to be presented to substantiate the need for the administrative burden that will be created. Without presentation of a justifiable case supporting this change, the ADA sees there will be reluctance on the part of practice operators to actively comply with the processes required. Provision of a case demonstrating the benefits to patients will assist in creating the motivation required to achieve the objectives sought.

The Paper refers to duplication in reporting on safety and quality compliance and specifically refers to requirements relating to separate state and territory licensing and safety and quality reporting mandated by health funds etc. It goes on to recognise that these separate requirements are likely to continue “unless relevant organisations agree that the national minimum safety standards (NMSS) and quality improvement framework meet their needs and that additional measures are unnecessary.”

The ADA identifies this as the crux of the problem in this area. There is just a plethora of standards etc to be complied with in the practice of dentistry. If the move for creation of NMSS exists, why is it that the Commission cannot itself create universal recognition now for the NMSS thus putting to an end the mandating of additional separate requirements? If this could be achieved then the ADA would support the process but as matters stand it sees no justification for the additional processes being created.

The ADA is the peak national professional body representing about 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. Practice owners are the group whose settings will be impacted upon by the commission’s task. As such they must be crucially involved in the process as it is these practitioners that will be able to provide the knowledge and experience to direct the process in the way required.

ADA Responses to the matters raised in the Consultation paper.

The Commission is seeking stakeholder input on the alternative model, its components and the associated reform proposals. The Commission has raised a number of questions/issues for comment which are set out below. The ADA has provided responses where the question was considered relevant to dental practice. Where questions were not considered relevant, the question has been included but no responses have been provided.

1. Separation of safety assurance and quality improvement assessment processes

The Commission is seeking stakeholder input on:

- i. The appropriateness and effectiveness of separating safety assurance and quality improvement;*

The ADA agrees that the separation of safety standards from quality standards is a good idea.

In practice though it is felt that both safety assurance testing and quality improvement ought to be conducted contemporaneously at the health care setting. This would enable greater efficiencies in time utilization for the processes.

The ADA sees both the standard setting and quality assurance roles as being continuous requiring ongoing development to ensure that both are abreast of developments in the practice of dentistry.

- ii. Timeframes for the implementation of a separation of safety assurance and quality improvement; and*

There are currently only a small number of isolated dental practices which have sought accreditation from ACHS or AGPAL (QIP) – estimated to be less than 20 throughout Australia out of a total of over 6000 private practices.

As such the practice of dentistry will not have been a health service subject to accreditation previously and therefore considerable time will be needed to develop the safety standards to be implemented. A rigorous education program will then need to be put in place to enable practitioners to familiarize themselves with the process and to then implement any changes that may be required to achieve compliance with the standards. The Commission must also consider the creation of incentives for compliance and settlement of suitable penalties for non compliance. (See additional comments in respect of this issue later in this submission.)

A two phase process is envisaged:

Phase 1: The first two years would be dedicated to the very substantial editorial and research activity required to modify existing policies and guidelines so that they are presented in an appropriate format to be described and accepted as NMSS. The key for Stage 1 is therefore the publication of the NMSS both online and in hard copy format.

Phase 2: The second stage is also expected to take around two years, and involves the promulgation of the new standards and delivery of State-by-State professional development and training activities to ensure that the widest possible cross section of dentists become fully conversant with the NMSS and are given assistance to implement them

in their practices. The key for Stage 2 is the provision of training and professional development activities in all jurisdictions, and in both metropolitan and regional settings. The timing of this program will require coordination with the ACSQH plans for practice accreditation, which are expected to become fully operational in 2011.

The ADA would plan to partner with a specialist accrediting / auditing agency in the roll out of this stage. Significant ADA Branch involvement would be used as the vehicle for delivery of information and hands on assistance to enable dentists to comply with the NMSS in process.

iii. The resource implications of this change and funding options that should be considered.

The dental profession has a commitment to safety and quality and the ADA has been instrumental in the development of a range of policy and good practice guidelines for its members. The ADA would be happy to embark on the preparation and development of these existing resources to create the required NMSS so that they are consolidated and made relevant to the Commission's objectives as outlined in the Paper. Development of the standards by dentists is essential as creation by peers is needed rather than by non-qualified personnel.

As outlined earlier, the dental health setting is one in which the dentist is the primary provider, the leader of the dental team and often the practice owner. As such it is appropriate that the dentist be the major contributor to the development of any standards that will impact on the practice setting in which they operate. It further follows that the dentist's professional association, the ADA (which has as members over 90% of Australia's practising dentists) be primarily involved in the creation of the NMSS. Professional ownership of the standards is a key factor in the acceptance, credibility and sustainability of these standards. Any improvement in the quality of dental care must embrace the relevant elements of established systems. The ADA through the expertise of its members is best suited for the task. It makes no sense for an external agency to create these NMSS as that would be counterproductive and based upon past experience the NMSS would be potentially impractical and not relevant to dental practice.

The project is of such complexity and scale that it would require both a Project Manager and a Project Officer full time for the first two years (Stage 1), followed by a further two years for the Project Manager only (Stage 2).

Normal office facilities will be required including workstations, phone, fax and other basic office facilities. Travel and accommodation expenses will need to be covered in Stage 2 to ensure uniform processes are delivered across Australia.

The ADA Inc. and ADA Branches would seek considerable funding assistance from governments to cover the project costs.

Senior management time and the contribution of steering committee members to oversee the project will be contributed at no charge.

The cost and impact on a small practice must also be considered. This applies particularly to solo practitioners in regional, rural and remote settings. Financial assistance will be needed here.

2. Separation between safety standards development and assessment of health services.

The Commission is seeking stakeholder input on:

iv. The mechanism for achieving this change

The ADA agrees also with these roles being separated as standards setting and assessments need to be created/ carried out independently of each other. If not, the whole process would be subject to criticism relating to good governance in that the creation of standards and then self assessment would lack creditability by the public.

If the proposals outlined for creation of the NMSS are accepted, the ADA would then partner with an appropriate accrediting agency to assist in the assessment of dental services.

What is envisaged is a process similar to that which has been adopted by the Australian Physiotherapy Association with regard to both standard setting and then assessment of practitioners against those standards. NMSS will be prepared by the ADA in consultation with appropriate expert input; education and training would then jointly be provided to practice settings seeking to be accredited and quality assessments would be undertaken by the accrediting agency.

As stated in the ADA Policy on Quality Assurance (Policy statement 5.2) (<http://www.ada.org.au/about/policies.aspx>):

"The exercise of measures to improve the quality of dental care must embrace the relevant elements of all established systems within the quality assurance/quality management spectrum."

v. Timeframe for the implementation

See comments above in response to question ii.

vi. The resource implication of these changes and funding options that should be considered

Reference is made to the responses in ii above. What has not been canvassed there is the cost to the practice setting of undergoing the training, education and accreditation process. Considerable resources will be expended by the practice to achieve accreditation. Both

professional time and administrative time will be spent in the endeavour. Bearing in mind the existing regulatory environment within which dentistry is being practiced, the ADA would seek funding from government to be provided to offset these costs. While it is appreciated that ACSQH will seek to have the level of regulation concentrated into a more uniform fashion, as distinct from the various levels that exist now, the fact remains that compliance with the ACQHS model will create an additional layer of regulation and the ADA considers the cost of this should rest with government.

While the ADA will seek to utilize economies of scale in delivery of the educative process for dental practices, which it would be prepared to supply on a cost shared basis with its members, compliance cost estimates for practice settings ought to be quantified as an average per practice and this cost be offset against registration costs for practitioners. Participation of non-members would attract a fee for service on a time expended basis.

3. Accreditation of all settings of care where services are provided by registered health professionals.

The Commission is seeking stakeholder input on:

vii. The appropriateness of including services provided by registered professionals, where they are registered in only one or two states and territories;

This question has no application to dentists, as all practicing dentists and relevant allied dental personnel are required to register.

viii. Transition arrangements required to implement the assessment of national minimum safety standards in all settings of care;

The staged introduction proposed is supported. The ADA would encourage the process creating simplification of regulatory compliance under the one set of Standards.

ix. A prioritisation process for the staged implementation of changes for services that are not currently accredited;

See responses above.

x. Timeframes for the implementation of safety assessment processes;

See responses above.

xi. The resource implication of these changes and funding options that should be considered; and

See responses above.

xii. Incentives that could be considered

See responses above.

4. National minimum safety standards that apply across all settings of care

As mentioned above, the ADA considers that the development of the NMSS should be left to the practitioners with the experience and knowledge to develop them, namely dentists. As indicated in the *General comments* above, the ADA believes it is well suited to create the NMSS. The ADA notes the suggestion that “responsibility for NMSS’ development would rest with a national body.”

The ADA believes the ‘national body’ should approve NMSS and that the State and Territory Dental Boards (in the interim period prior to the COAG initiatives coming into effect) or the national dental board that is currently envisaged by the COAG proposals would be a suitable “national body” to be charged with this function. The reasons for this are that these bodies already have the requisite skills and experience to carry out this task. Dental Boards develop codes of practice and would therefore be skilled in overseeing the development process of the NMSS by the ADA. Boards have over the years developed considerable skills and knowledge in this area and this resource should not be wasted. Creation of an additional entity to be tasked with this duty would be superfluous to need.

xiv. The areas to be addressed by the standards and the coverage of each standard;

The ADA agrees with the paper in relation to the areas of practice to be covered by the NMSS. Central to any NMSS in dentistry would be standards applicable to:

- Infection Control
- Medication safety
- Record keeping
- Consent to treatment.

The ADA would see these topics to be absolutely essential and the minimum coverage of standards to be created. These would address the major issues relating to patient care.

xv. The priority order for the development of standards, which may be risk-based;

As indicated in the preceding paragraph, the four topics for standards set out there represent the threshold level of standards that need to be created. Those identified closely address those areas of practice that relate to patient safety. Once those are established, the ADA

would suggest that the NMSS be supplemented by other titles which would then go on to assist with Quality Assurance/Improvement objectives. (See later for suggested areas to be covered.)

xvi. Whether the assessment outcome against minimum safety standards should be pass or fail.

The ADA does not consider that a sole pass/fail rating ought to apply to assessment outcomes. The objective of the ACSQH is to achieve a theoretical improvement in the delivery of health. The focus of assessment should be confined to this and not entail any significant disciplinary role. The assessment process should be directed to safety and quality improvement and therefore where NMSS are not met the process should adopt an educative role and provide guidance to the health care setting as to what action is required to address any deficiency.

It is envisaged that there will be levels of non-compliance with NMSS that may be more or less important than others. The promptness with which a setting must comply with NMSS should vary with the seriousness of the non-compliance. Education and improvement should remain the focus not discipline.

The ADA recognises that in some limited cases there may be such continuing departure from NMSS compliance that some disciplinary action should be taken. Such action should be taken in a format that will enable the health setting to comment on the assessments it has received and disciplinary action taken only after rules of natural justice have been complied with.

Existing disciplinary procedures exist now through the Boards and the ADA suggests that those processes be incorporated here.

Confidential quality assurance mechanisms exist within the various ADA Branches and these should be utilized. As stated elsewhere the ADA Branches will be able to provide hands on training and advice to dental practice settings to enable settings to adapt to the NMSS in a time efficient manner.

xvii. What a failure would mean for a health service;

See response to xvi above. Referral of a recalcitrant health setting to a State or Territory Dental Board or its equivalent under the proposed COAG changes would be appropriate.

xviii. Under what circumstances a 'fail' rating would be applied;

As stated, failure and later action based on that failure should only follow production of evidence showing an established ongoing inability of the health setting to satisfy NMSS.

xix. Sanctions or penalties that would result;

As the alternative model creates NMSS, compliance must be compulsory. The degree of sanctions and penalties ought to be determined by the disciplinary committees of the Dental Boards charged with this function. They have developed appropriate skills in this area. Penalties should reflect the severity of the non-compliance and the compliance history of the health setting.

xx. Mechanisms to ensure mandatory compliance against national minimum safety standards. Detailed consultation with jurisdictions on how to most effectively implement mandatory compliance will be undertaken by the Commission;

Initially, conformity of all practice settings will not be able to be provided. Complete assessment of all practice settings may take some years.

Because of this, in the initial years of the accreditation process, the ADA would envisage that upon registration of the dental provider with the appropriate registering authority, the dental care provider would be asked to identify the practice settings within which they operate and/or have operated in the preceding period since prior registration and to provide an assurance that those settings were compliant against NMSS. Such a process would at least quickly address compliance issues for all practice settings. Failure to provide such an assurance from a practitioner in respect of a practice setting would trigger the need for an immediate conformity assessment. This process would target questionable settings and enable a conformity assessment to be undertaken and then compliance processes to be undertaken if required. In the interim all practice settings identified in the registration of practitioners' procedure would be notionally compliant. Notional compliance would transfer to actual compliance once the actual conformity assessment was completed.

Such a process would result in little disruption to the practice of dentistry. At the same time it provides a process whereby accreditation is being gradually implemented.

Over time the assessment process carried out by the conformity assessors would then provide certification to all practice settings.

xxi. Options for assessing national minimum safety standards and mechanisms to reduce the subjectivity of the outcome and inter-assessor reliability. For example, they may be suited to assessment through desk top audit and complemented by unannounced surveys;

Development of the NMSS.

As indicated earlier the ADA feels it is the organisation best placed to create the NMSS due to the resources, knowledge and expertise it

already possesses from the functions it already provides to its members. The ADA Inc. and its Branches have a long history of publishing and distributing policies, guidelines, protocols and templates which are recommended to members as a means by which to ensure the safety and quality of dental service delivery. These reference materials are regularly reviewed by expert committees within the ADA to ensure they remain a contemporary guide to members on the issues they address. The ADA would use outside expert advisors to ensure the NMSS provides a level of consistency for such standards.

Review processes in place in the accreditation scheme would be able to respond to concerns that have been identified

Certification of NMSS.

Good governance and transparency would dictate an independent review of the NMSS created. As stated State and Territory Dental Boards (in the interim period prior to the COAG initiatives coming into effect) or the national dental board that is currently envisaged by the COAG proposals should independently assess the NMSS created and sign off on them as the "National Body". This organisation would be the certifying body.

As NMSS must include ongoing review of the NMSS to keep abreast of technological changes and other developments in dental health care delivery, ongoing annual review of the development and certification roles are required.

Referral of the NMSS would from the National Body to health ministers for approval.

Assessor certification and conformity

Assessors engaged to provide certification of practice settings should be skilled in this role. The ADA has in mind partnering with a recognised conformance / certifying group. Certification of the NMSS will entail training of this group to ensure consistent application of the standards by assessors. This educative function should be the joint responsibility of the ADA and/or its Branches (for local assistance) and the certifying body.

Practice support.

ADA Inc and its Branches will be well placed to educate practice owners of the requirements of the NMSS.

Generally the ADA is happy with the NMSS diagrammatic presentation presented at the Consultation meeting.

Survey/ Assessment reporting.

Reporting of the results of the Assessment processes should be provided to the certifying body, the ADA, and to the national body. The certifying body would then make recommendations to the ADA and national body on modifications to the NMSS or other processes to maintain focus on provision of compliant practice settings.

Through this process of review, quality assurance will then develop.

xxii. Mechanisms to recognise bodies to assess against national minimum safety standards. For example, the approval process could include agreement by the assessing body to provide assessment information to the national entity and for them to be externally accredited by independent bodies such as ISQUA and JASANZ. There may also be specific requirements about the training, competence assessment, performance management, experience and reliability of assessors;

Agreed. See preceding paragraphs.

xxiii. Information assessment bodies will be required to provide to the National Entity on assessment outcomes against the national minimum safety assurance standards;

Agreed. See preceding paragraphs

xxiv. Timeframes for the development and implementation of national minimum safety assurance standards; and

Previously addressed

xxv. Resource implication of these changes and funding options that should be considered.

Agreed. See preceding paragraphs.

5. Assessment of non-clinical and technical compliance

The alternative model recognises that health services will continue to be required to comply and be assessed against jurisdictional regulation. Non-clinical and technical compliance standards will need to be identified and mechanisms developed to ensure recognition of these processes as part of a broader mutual recognition of accreditation which reduces duplication.

The ADA agrees.

The Commission is seeking stakeholder input on:

xxvi. The appropriateness and effectiveness of assessing separately non-clinical and technical compliance of a health service;

In dental practice, non-clinical and technical compliance issues are heavily inter-related with clinical practice and should be assessed at the same time.

xxvii. Timeframe for the identification of non-clinical and technical compliance requirements; and

xxviii. The resource implication of these changes, if any and funding options that should be considered.

6. Development of a national framework for quality improvement

The alternative model proposes that a national quality improvement framework be developed for endorsement by Health Ministers and implementation by health services.

Generally the ADA is happy with the NMSS diagrammatic presentation presented at the Consultation meeting.

The Commission is seeking stakeholder input on:

xxix. The structure and content of a quality improvement framework;

Quality improvement is seen as an essential component of the process. It is suggested that built onto the NMSS should be the creation of additional areas where standards of practice be set. These standards would cover areas such as: Access to care; Information about the practice; Health promotion and prevention of disease; Diagnosis and management of specific health problems; Continuity of care; Coordination of care; Content of patient health records; Collaborating with patients; Education and training; Practice systems; Management of health information; Facilities and access; Equipment for comprehensive care and Clinical support processes.

Again as the body with the appropriate level of knowledge and hands on experience, the ADA sees itself as best equipped to provide these standards and to be able to conduct ongoing review of them in accord with results obtained from the auditing of practices' information that is forthcoming from that process.

In this way an initial level of quality assurance will be created which can then be reviewed to provide an ongoing process of improvement in response to data obtained. Initial quality assurance will be delivered and then refined in the ongoing processes to create validated standards.

The ADA would see itself as well equipped to conduct the refinement process and to report to the national body on developments. Through this process the creation and development of a comprehensive suite of standards would be created to provide a consistent, workable set of practical standards through which safer delivery of dental health care would be assured.

xxx. International or local examples of a quality framework that could be considered in the development of an Australian quality improvement framework;

xxxi. Timeframe for the development and implementation of a national framework for quality improvement;

ADA believes the National Entity would only be required to sign off on the design of the process and then once established it is disbanded. Therefore the ACSQH may need to have its term extended to enable this task to be completed.

xxxii. The impact of these reforms on the accreditation service industry and their capacity to make the proposed changes;

xxxiii. Implementation issues that may arise; and

xxxiv. The resource implications for development of, and compliance with, a national quality framework and funding options available.

7. Establishment of a National Entity to lead and coordinate changes

The alternative model proposes that a National Entity be established to provide coordination and leadership of accreditation nationally. The National Entity will report to

- 1. Health Ministers;*
- 2. industry;*
- 3. community; and*
- 4. the Australian Commission on Safety and Quality in Health Care in relation to safety and quality matters.*

It will manage the processes of standards development, assessment of safety assurance, monitoring and reporting.

The ADA sees the National Entity as being a management body only as distinct from a body charged with the development of the standards and their application into the dental practice environment. Such roles would be left to the organizations/structures identified earlier. The National Body would provide sign off to processes and be an overseeing body and in so doing provide a degree of independence to the processes and thus satisfy appropriate governance requirements.

The Commission is seeking stakeholder input on:

xxxv. Issues that may arise in the establishment of a National Entity;

xxxvi. Options for the establishment of a National Entity. For example, whether it should be establishment within an existing body, as a secretariat, or by the creation of a new body. The National Entity could operate as a statutory body, an incorporated body or as an advisory body in the way the Australian Commission on Safety and Quality in Health Care (the Commission) operates;

See responses above. Simplicity and clarity should be the focus. If a body exists to carry out the roles allocated then utilize that body in lieu of the creation of a new body. If practice accreditation and quality assurance roles can fit within the roles of State and Territory Dental Boards (in the interim period prior to the COAG initiatives coming into effect) or the national dental board that is currently envisaged by the COAG proposals then this ought to be utilized.

xxxvii. Mechanisms for ensuring stakeholder representation, particularly consumers;

The model proposed by the ADA provides suitable stakeholder representation. Consumers will have available to them access to Boards. The profession will have input through the ADA and the ADA will have input to the National Body which will in turn report to the Health Ministers. The reporting processes devised will enable proper communication between all sectors.

xxxviii. Timeframe for the establishment of a National Entity; and

Dealt with previously.

xxxix. The resource implication of establishing a National Entity and funding options that should be considered.

As no demonstrable case has been able to be provided to justify the actual need for this process to be developed and as it seems to have been created based on perceptions only of consumer dissatisfaction or on the perceived need for government to create yet another overseeing role for health settings, all costs should be borne by government.

8. Review of surveyor training

The alternative model proposes that there be a review of surveyor training and assessment across the range of accreditation programs.

The Commission is seeking stakeholder input on:

xl. The priority of carrying out such a review;

xli. The scope of the review of surveyor training and assessment;

xlii. The timeframe for the review; and

xliii. The resource implication of this review.

See previous comments and submissions of the ADA.

9. Associated Reforms

In addition to the changes in the alternative model there are a number of reforms that could be progressed as part of the implementation of broader reforms or as separate projects, as described above. These include:

- using unannounced surveys to assess the national minimum safety standards, (after appropriate piloting);*
- piloting tracer methodology (patient journey);*
- developing a best practice guide to standards development and review;*
- mapping of standards;*
- developing appropriate mechanisms, timing and format for public reporting; and*
- developing a process for mutual recognition of accreditation processes and outcomes.*

The ADA provided comment on modes of surveys in its original submission to the ACSQH. The major concerns the ADA has on the survey processes that need to be addressed are:

- Receipt of dental treatment is often a psychologically traumatic event for some patients. The arrival of unannounced assessors into a practice setting may only cause additional trauma to the patient and adverse consequences may follow.
- Unannounced surveys or tracer methodology may create in the minds of the patient some suspicion or uncertainty as to the calibre of the practice the patient is attending. Whilst recognizing that short notice of an assessment may eliminate the creation of a “constructed” compliance by a practice setting, the dangers of the creation of an adverse impression on patients must be avoided.
- Surveys will have a disruptive effect on the efficient running of the practice. In a climate where all dentists’ services are in high demand, the participation in a compliance assessment may create significant disruption to the practice. This would

cause inconvenience to patients and in some cases the need for cancellation of what may have been a long awaited dental appointment.

The Commission is seeking stakeholder input on:

- xliv. The priority of carrying out each of the proposals;*
- xlv. The scope of each of the proposals;*
- xlvi. The timeframe for the implementation of each of the proposals;
and*
- xlvii. The resource implication of the proposals.*

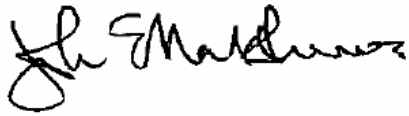
In respect of these questions see the comments made above.

CONCLUSION

The ADA maintains;

- There is no evidence produced that accreditation achieves improvements in public health and safety. Nor is there evidence that a health and safety problem exists in Australian dental practices.
- There is no evidence that the public is demanding further regulation of dental practices.
- If there is going to be an overarching review of the dimensions addressed in standards, then there should also be an economic impact analysis and assessment of the compliance burden on practices and the costs they are going to be obliged to pass on to their patients.
- Alternatively, while there may be a need for some reform in large and complex health settings, such reform is not required in all health settings and in particular the environment within which most dentistry is practised.
- As part of this ongoing role of standard creation and quality improvement focus be given to the creation of one comprehensive universally applicable set of regulations and standards in lieu of the myriad that exist now.
- It is necessary that dentists be the major contributor to the development of any standards that will impact on the practice setting in which they operate.

- The ADA believes that as it represents over 90% of all practising dentists and has built up an expertise in development of guidelines and recommendations as to dental practice; it is best suited to develop the NMSS.
- The ADA would then work with others within the frameworks as identified within the Paper to achieve the outcomes required.

A handwritten signature in black ink, appearing to read "John E. Matthews". The signature is written in a cursive style with a large initial "J" and "M".

Dr John E Matthews.
President
Australian Dental Association Inc.

5 October 2007.