COUNCIL OF
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MANUAL
OF DENTAL PRACTICE

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Preface

The revised Manual of Dental Practice in the EU was commissioned by the Council of European Dentists[1] in November 2007. The work has been undertaken by the Dental Public Health Unit in Cardiff University, Wales, United Kingdom. Although the unit had editorial control over the content, most of the changes were suggested and validated by the member associations of the Committee.

About the authors[2]

Anthony Kravitz graduated from the University of Manchester, England, in 1966. Following a short period working in a hospital he has worked in general dental practice ever since. From 1988 to 1994 he chaired the British Dental Association's *Dental Auxiliaries' Committee* and from 1997 until 2003, was the chief negotiator for the UK's NHS general practitioners, when head of the relevant BDA committee. From 1996 until 2003 he was chairman of the *Ethics and Quality Assurance Working Group* of the EU Dental Liaison Committee. He is an Honorary Research Fellow at the Dental School,Cardiff University, Wales and his research interests include healthcare systems and the use of dental auxiliaries.

President of the BDA from May 2004 until May 2005, he was awarded an honour (OBE) by the Queen at the end of 2002.

Elizabeth Treasure graduated from the University of Birmingham in 1979, following which she completed a PhD. She then worked in the community dental service before emigrating to New Zealand to become a full-time academic in 1990. She returned to Wales in 1995. She is Dean of the Dental School of Cardiff University and is Professor and Honorary Consultant in Dental Public Health. She has been a scientific advisor to the Department of Health in London.

Her research interests include clinical effectiveness, epidemiology and clinical trials. She has been a member of the UK Medical Research Council group on fluoridation and on a European Union Expert group reviewing the concentration of fluoride in paediatric toothpaste. She is one of the authors of the 1998 UK Adult Dental Health Survey and has chaired a review of dental workforce in Wales. She was the leader on the oral health specialist branch of the National Electronic Library for Health.

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The Chief Dental Officers of the EU (CECDO)
Conference of Orders and Assimilated Bodies of Dental Practitioners in Europe (CODE)
The World Health Organisation (WHO)
The Union Bank of Switzerland (UBS)
The Organisation for Economic Cooperation and Development (OECD)
The CIA Worldfactbook
The International Monetary Fund (IMF)

Disclaimer

The Manual was sent for publication in October 2008, when ratification of the Treaty of Lisbon (2007) had not been completed.

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Contents

Introduction

Background

In common with many other professionals, dentists are increasingly seeking opportunities to work and live in other countries. Within the EU, the ability for dentists to move and work in any country has never been greater and national dental associations have experienced a considerable increase in the number of enquiries from members about practising abroad. The problems and expense of answering these questions on an *ad hoc* basis, and the need for associations to conduct their national political negotiations in the context of international experience, resulted in the European Union Dental Liaison Committee (EUDLC) commissioning the Dental Public Health Unit of the University of Wales Dental School in Cardiff (UK), in 1993, to produce a comprehensive reference document describing the legal and ethical regulations, dental training requirements, oral health systems and the organisation of dental practice in 18 European (EU and EEA) countries.

Following publication of early drafts, the first full edition of this review was published as a Manual of Dental Practice in the EU in 1997, and this was updated in January 2000.

The EUDLC again commissioned the University of Wales, in November 2002, to further update the Manual and extend it to embrace the countries which were acceding to membership of the EU in May 2004 and January 2007.

The EUDLC became the Council of European Dentists (CED) in May 2006 and the University of Wales became Cardiff University in 2005. The CED commissioned Cardiff University in November 2007 to update the 2004 Manual and produce another version relevant to 2008 – to include Bulgaria (missing from the 2004 version) and Croatia which was expected to join the EU in January 2009.

The scope and presentation of the review

The Manual aims to provide comprehensive and detailed information for dentists who are considering working in another country. The authors have endeavoured to construct a basic, minimum framework as an introduction to the most relevant topics, and a well-informed starting point for further questions which individuals may raise.

It has been written as a practical "handbook" in which information is easy to find and to understand. The country chapters also aim to balance information about formal requirements including laws, codes of practice and other regulations with descriptions of how things work in reality.

An introduction to the EU and dental practitioners

The opening chapters outline the origins of the EU and its attitude to health; how the EU functions including descriptions of its formal institutions (for example, the Commission, the Council, the European Parliament, the Court of Justice) and the current membership of the EU. We have also described the EU Dental Directives which are directly relevant to dentists, and we have listed the titles and qualifications to which the Directives relate.

The comparative analysis

Further chapters provide a simple comparative analysis of the different systems for the delivery of oral healthcare service, the nature of education, training and the constitution of the dental workforce, different practising arrangements, and other regulatory frameworks and systems within which dentists work. We have briefly covered ethical codes, the monitoring of standards, specialist and auxiliary personnel, and the relative importance of oral health services provided outside general or private practice.

The country chapters

The bulk of the Manual contains the detailed descriptions of the oral health systems, and the ways in which dentists practise in each of 32 countries. In addition to the 27 countries of the EU, Iceland, Liechtenstein and Norway (the EEA), Switzerland and Croatia are included. Croatia is included as it is expected to join the EU in 2009. Greenland and the Faroe Islands are described in the chapter for Denmark. There are self-governing islands in the British Isles and these have been included in the UK section.

Each country chapter includes:

- A brief description of the historical background, political system and any features of the country's society, economy or geography that are significant for the organisation of health services.
- The main features of the health system, including: how it is funded, how health policy is decided, and how the provision of health services is organised.
- A section on oral healthcare which provides a general overview of the bodies responsible for its provision, the population groups who have access, and the services that are available to them.
- A description of entry to and content of dental school (undergraduate) education and training, and the requirements for registration - including the requirements for legal practice, the bodies which approve applications, the documents which need to be submitted, and any other conditions which need to be met. Additionally, any postgraduate education and training (including specialist training) is described. The paragraphs on *Specialists* list the dental specialties that are recognised, including the formal training required for each, and its location and duration.
- A section on what constitutes the dental workforce in each country, including numbers of dentists and specialists. There are several paragraphs on *Dental Auxiliaries*, which list the types of auxiliary that are recognised, what procedures they are allowed to carry out, where they work and the rules within which they may legally practise.
- Paragraphs on Working in General Practice, Working in the Public Dental Service (where appropriate), Working in Hospitals, and Working in Universities and Dental Faculties. For each of these, there is a brief

description of the staff titles and functions, the minimum formal qualifications required, and how dentists are paid. For general or private practice this usually involves details of the administration of any fee-scales, whether remuneration is part of a contract, rules for prior approval, and some practical details of how to join or establish a practice.

- A section on dentistry in each country which is described as "Professional Matters" and includes an explanation of the framework for dental practice in terms of professional organisations, ethical codes and any other systems for monitoring standards and handling complaints.

- A "Financial" section, which briefly introduces many financial considerations for practice.

- Finally there is an *Other useful information* section which provides the name, address, telephone and fax numbers of the main national dental associations, together with some other general data.

What's new in this edition?

- Health data: more information has been collected, including information about Caries levels (in children), edentulousness and fluoridation.
- More economic data and analysis relating to oral healthcare
- More information about dental schools and numbers of dental students
- More information about registration of dentists and dental auxiliaries
- Information about tooth whitening, ionising radiation rules and hazardous waste regulations
- Information about dental workers' incomes has been dropped as the data was inconsistent and out of date quickly

Information collection and validation

The original information was collected in early 1996, in three stages using a questionnaire to the main dental associations in each of the then 18 countries involved (the 15 EU countries, plus Norway, Switzerland and Iceland). For countries where there was no single main national association, more than one questionnaire was sent to obtain the most complete picture possible.

After the initial exercise, validation interviews were conducted to clarify and extend the information provided by the questionnaires.

The interview stage of the information collection process was essential for identifying important differences between countries, resolving potential ambiguities and exploring in detail those issues briefly covered by the questionnaire, which were more important for dental practice in a particular country.

The first draft of each country chapter was written using the interview notes, questionnaire answers and any other documents which the national dental associations were able to supply. The draft of each country chapter was then checked for clarity, completeness and accuracy, before publication.

This process was repeated for the second edition and the content was extended to include more information.

The third edition was revised and updated using two methodologies: for the "candidate" (new) countries of the EU new questionnaires were devised, based on an analysis of the information supplied by the existing countries in the first and second editions. Interviews were then conducted by the authors, with the representatives of the relevant countries, at various international meetings during 2003.

The data and information for the existing EU countries were analysed and cross-checked for common information and then the individual country sections were marked by the authors for clarification, modification, expansion and revision, before being sent to the dental associations in February 2003.

Following receipt by the authors of the corrected country sections, clarification of any ambiguous information was undertaken, again at international meetings and by Email. The data was then validated with dental associations of the countries, many chief dental officers, and some dental councils and registration bodies, before publication.

The same process – as in 2003 - was used for this (4th) edition. The two new countries – Bulgaria and Croatia – were approached with questionnaires in December 2007 and then the exisiting countries were approached for new data from March until September 2008. International meeting in Slovenia (May) and Sweden (September) were used for direct data validation.

Documentary sources of information used are listed in Annex 1.

Additional explanatory notes

It was not possible to obtain a single, valid reference date for all data, across all countries of Europe. The collection of data took place during 2008, and so this should be assumed to be the reference year for the data, except where another date is shown.

English language conventions have been used for expressing numbers and figures, so that:

- Decimals are expressed with a point, eg 5.3
- Millions are expressed with a comma, eg 1,000,000
- "Billion" refers to One Thousand Million
- The sign for a Euro is € and this is placed before the number, eg €100
- The term "Accession Countries" refers to the ten new EU countries at May 2004: Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia; and Bulgaria and Romania, whose membership of the EU was from 2007; and Croatia from January 2009.
- Data was inserted into the Manual to October 1st 2008 and the severe financial and currency problems which arose after this date are not reflected here.

Definitions

Percentage of Gross Domestic (or National) Product (GDP/GNP) spent on oral health

This refers the proportion of a country's overall wealth which is spent on dentistry – through national health/social insurance AND private care, if known.

Private care

This refers to dental care that is paid for entirely by patients either directly to the dentist or through private dental insurance, without any government or social insurance subsidy or reimbursement. It does NOT refer to co-payments made through a national health or social insurance scheme.

Private insurance for dental care

This refers to insurance for dental treatment which patients buy from independent insurance companies not directly controlled by either the government or any social insurance scheme.

Percentage of Oral Health (OH) expenditure private

This refers to the total expenditure (in money terms) by patients on dentistry, using private care (as defined above) only. Expenditure by patients on co-payments in any state scheme or through any social insurance is NOT included in this figure.

Co-payments

These are payments made by patients towards the cost of their dental treatment in a state or social insurance scheme. Also, where the scheme involves reimbursement, the amount not reimbursed is a co-payment.

Vocational training

This refers to a period AFTER graduation, following registration with the competent authority, when the new dentist practises in a mandatory supervised environment (such as a training practice or public clinic or hospital department). The training period may - but not necessarily - include mandatory further education and a further examination before the dentist can practice in a non-supervised environment and own his or her own dental practice.

Cost of registration

This refers to the annual cost of registration with the competent body which registers dentists in a country

Specialists

These are dentists who have completed a further period of special training following their basic qualification as a dentist and then been registered with some national authority as a "specialist". The only EU-wide acknowledged specialists are orthodontists, oral surgeons and oral maxillo-facial surgeons – but many countries have additional classes of specialists.

Overseas dentists

This refers to dentists who have received their primary dental qualification in any country other than the listed (host) country, even if they are nationals of that country.

A dentist who is not a national of the country, but has qualified in that country is an "overseas dentist" for the purpose of this Manual.

Active dentists

This refers to dentists who remain on their country's register or other such list of dentists who practise in a clinic, general practice, hospital department, administrative office or university. The difference between the number of dentists in a country and the "active dentists" should represent those dentists who are retired or no longer undertake any form of dentistry including administrative dentistry.

General Practice (in some countries referred to as "Liberal" Practice)

This refers to practice in premises in which the practice is wholly owned by a dentist ("general dental practitioner") or company (corporate); alternatively, the premises may be rented from the government or some other (private) person or company.

The owner dentist or company is responsible for the running costs of the practice, including the employment and labour costs of those employed there, such as other dentists and dental auxiliaries.

Salaried dentists who work in dentist-owned practices are also described as general dental practitioners.

The income for the general practice may be derived from a number of sources:

- direct payments by patients, such as "co-payments" for state or social insurance schemes, or fully private dental care
- payments from state or social insurance schemes
- payments by private insurance companies

The ownership of the practice, rather than the method of income, defines a general practice.

Public dental services

"Public dental services" refer to dental care which is provided in government health centres or publicly owned clinics, organised by municipalities or some other local or national organisation, singly or collectively. Dental services are often part of other local health services. The dentists working in these clinics are paid by salary. Often they work part-time in the clinics and may fill the remainder of their working time in general practice or some other category of dentistry.

"Public dental services" does NOT refer to dental care given in a general practice through a state funded or social insurance supported scheme.

Corporate Dentistry

This refers to limited companies which own and manage dental practices. The Board of the company may comprise non-dentists although usually at least one (if not all) of the members must be a dentist or dental auxiliary. The company will employ the dentists (and dental auxiliaries) who provide the dental care.

Part 1: The European Union

The origins of the EU

The European Union (EU) was set up after the 2nd World War. The process of European integration was launched on 9 May 1950 when France officially proposed to create "the first concrete foundation of a European federation". The Treaty of Paris which was signed on 18th April, 1951, created the European Coal and Steel Community (ECSC) in 1952. Six countries (Belgium, the Federal Republic of Germany, France, Italy, Luxembourg and the Netherlands) joined from the very beginning. The success of this limited agreement persuaded the six signatories to extend their commitment.

To achieve this, on 25th March, 1957, they negotiated and agreed the two Treaties of Rome which created the European Economic Community (EEC) and the European Atomic Energy Community (Euratom). These three collectively became known first as the EEC, then as the European Community (EC) and finally the European Union (EU).

Subsequently, there have been several waves of accessions, so that by January 1st 2007 the EU comprised 27 member states.

Membership of the EU

- Belgium, France, Germany, Italy, Luxembourg and the Netherlands (March 1957) – were the founding countries
- Denmark, Ireland and the United Kingdom (January 1973)
- Greece (1981)
- Spain and Portugal (January 1986)
- Austria, Finland and Sweden (January 1995)
- Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia (May 2004)
- Bulgaria and Romania (January 2007)

At the time of writing Croatia was expected to join the EU in January 2009.

On 1st January 1994, some of the privileges of the Community, for example "freedom of movement" were extended through the Treaty on the European Economic Area (EEA) to the countries of the European Free Trade Area (EFTA). These remaining non-EU EFTA countries are Iceland, Liechtenstein and Norway. One other EFTA country, Switzerland, was included in the initial agreement, but withdrew after a referendum in which its population rejected the concept. This decision has also delayed the involvement of Liechtenstein because of its "customs union" with Switzerland.

Objectives of the EU

The European Union is said to be based on the rule of law and democracy. It is neither a new State replacing existing ones nor is it comparable to other international organisations. Its Member States delegate sovereignty to common institutions representing the interests of the Union as a whole on questions of joint interest. All decisions and procedures are derived from the basic treaties ratified by the Member States.
It has been suggested that European integration has delivered half a century of stability, peace and economic prosperity. It has helped to raise standards of living, built an internal market, launched the euro and strengthened the Union's voice in the world.

Principal objectives of the Union are:

- *Establish European citizenship*
- *Ensure freedom, security and justice*
- *Promote economic and social progress*
- *Assert Europe's role in the world*

The EC treaty was amended on 1st July, 1987, by the Single European Act (SEA). This restated the objectives of the EC by formalising the commitment to the completion of the "Internal Market" by 1992. The Act also extended the competence of the Community to new areas such as environmental improvement and the strengthening of social cohesion and modified the decision making process by extending the use of majority voting in the Council of Ministers.

The 1993 Maastricht Treaty, which led to the creation of the European Union further developed these concepts and a "Green Paper" on European Social Policy was introduced in December of that year. Issues addressed included unemployment, social protection and social standards, the Single Market and effective freedom of movement, equal opportunities for men and women and the transition to economic and monetary union.

Between March 1996 and June 1997 an Intergovernmental Conference (IGC) developed the consolidated Treaty of Amsterdam – which came into force on May 1st 1999 - revising the original Treaties on which the European Union was founded. The IGC is the formal mechanism for revising the Treaties, which are the constitutional texts of the European Union. Any changes are agreed following negotiations between governments of the Member States which belong to the Union.

The extension of the EU to embrace the new countries of Eastern Europe was agreed at the IGC held in Nice in 1999.

On December 13th 2007 EU leaders officially signed a new Treaty at a Special Summit in Lisbon. Ratification by all member countries of the EU has to take place before this treaty is implemented, but at the time of the publication of this Manual the position was unclear as a result of the rejection of the Treaty in a referendum in Ireland. In all events, it is unlikely that this treaty could come into force before 2010 at the earliest.

Health

In the context of the EU's objectives, an Article requires the Community to "complement national policies" and to direct

Community action "towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action will cover the fight against the major health risks by promoting research into their causes, their transmission and their prevention, as well as health information and education". The Article also states that the Commission may develop guidelines/standards in the health area.

Also in 2007, the European Commisssion published a White Paper for another EU Health Strategy, following a wide-ranging public consultation. This *"aims to provide, for the first time, an overarching strategic framework spanning core issues in health as well as health in all policies and global health issues. The Strategy aims to set clear objectives to guide future work on health at the European level, and to put in place an implementation mechanism to achieve those objectives, working in partnership with Member States"*.

For further information about the strategy see Annex 3

As this Manual was completed (in October 2008), it was expected that that the Commission would publish a Green Paper on Health Professionals in December 2008. There will be a public consultation process to obtain stakeholders' views on a wide range of issues.

The issues to be addressed include workforce supply issues facing health systems against a backdrop of an ageing population, an ageing workforce, feminisation of the workplace, increased mobility and targeted recruitment drives from outside the EU, the extent of available data and evidence about the health workforce and how trends are monitored, human resources strategies for recruitment, retention and training capacity, Public Health capacity, the ethical dimension of recruitment from outside EU, the role of new technologies and telemedicine in supporting the workforce and its training implications and the role of clinical entrepreneurs.

At the end of 2008 or in early 2009, Commission initiatives dealing with patient safety, including a Council recommendation on patient safety which will in particular address the issue of Health Care Associated Infections were expected. There was a Commission consultation published earlier in 2008, to which the CED responded. The response and a CED resolution on Patient Safety can be found at Annex 14.

The Institutions

The EU is run by five institutions, each playing a specific role:

- *European Parliament* (elected by the peoples of the Member States);
- *Council of the Union* (composed of the governments of the Member States);
- *European Commission* (driving force and executive body);
- *Court of Justice* (compliance with EU law);
- *Court of Auditors* (sound and lawful management of the EU budget).

Five further bodies are part of the institutional system:

- *European Economic and Social Committee* (expresses the opinions of organised civil society on economic and social issues);
- *Committee of the Regions* (expresses the opinions of regional and local authorities on regional policy, environment, and education);
- *European Ombudsman* (deals with complaints from citizens concerning maladministration by an EU institution or body);
- *European Investment Bank* (contributes to EU objectives by financing public and private long-term investments);
- *European Central Bank* (responsible for monetary policy and foreign exchange operations).

A number of agencies and bodies complete the system. For further information about each institution, go to Annex 2.

The Economy of the EU

The traditional way of measuring the "wealth" of a nation is through its Gross Domestic Product (GDP). The GDP measures output generated through production by labour and property which is physically located within the confines of a country. It excludes such factors as income earned by its citizens working overseas, but does include factors such as the rental value of owner-occupied housing.

The measure of a country's output of goods and services is calculated using personal consumption, government expenditures, private investment, inventory growth and trade balance. GDP is the broadest measure of the health of an economy but is often expressed now in Purchasing Power Parity (PPP) see below.

The Gross National Product (GNP) is the total value of all final goods and services produced for consumption in society during a particular time period. Its rise or fall measures economic activity based on the labour and production output *within* a country. The figures used to assemble data include the manufacture of tangible goods such as cars, furniture, and bread, and the provision of services used in daily living such as education, health care, and auto repair. Intermediate services used in the production of the final product are not separated since they are reflected in the final price of the goods or service. The GNP does include allowances for depreciation and indirect business taxes such as those on sales and property. The GNP is not usually used nowadays as it does not facilitate international comparisons in an accurate manner.

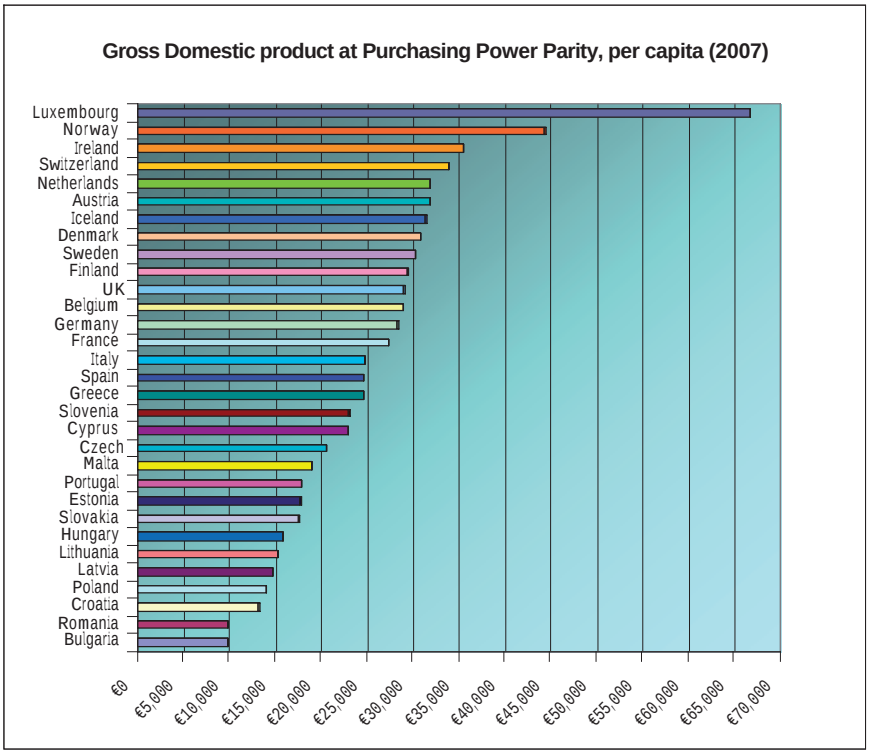
PPP is a theory which states that exchange rates between currencies are in equilibrium when their purchasing power is the same in each of the two countries. This means that the exchange rate between two countries should equal the ratio of the two countries' price level of a fixed basket of goods and services. When a country's domestic price level is increasing (ie. the country experiences inflation), that country's exchange rate must be depreciated in order to return to PPP.

The basis for PPP is the "law of one price". In the absence of transportation and other transaction costs, competitive markets will equalize the price of an identical good in two countries when the prices are expressed in the same currency.

For example, a particular TV set that sells for €750 in Calais should cost £500 in Dover, when the exchange rate between the UK and France is €1.50 = £1. Clearly, PPP between different countries within the Eurozone is easier to measure. So, looking at relative wealth for 28 EU/EEA countries using PPP has slightly changed the order of countries within the chart, but still shows the apparent disparity between the richer and poorer countries of Europe.

These figures must be taken into account when comparing incomes and fees between individual countries. So, GDP is a crude measure for oral healthcare comparisons, and a better measure is GDP per capita, based on current purchasing power parities:

Chart 1 – GDP per capita at PPP in 2007 (some countries 2006):
source IMF (http://www.imf.org/external/pubs/ft/weo/2008/01/weodata/weoselgr.aspx)



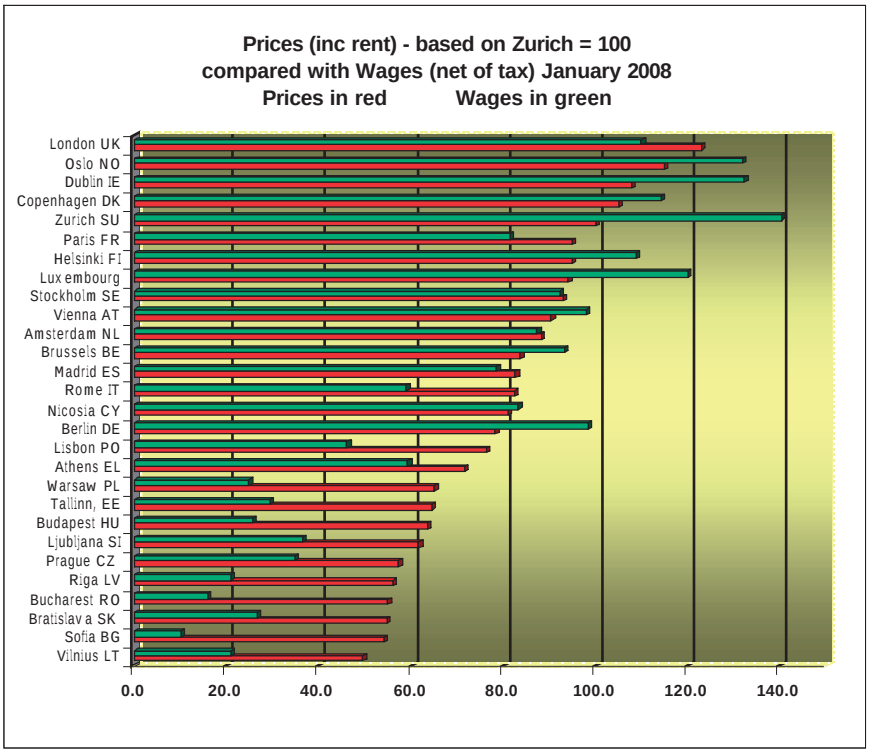


Chart 2 – Comparitive prices, including rent, in 2008 – based on Zurich = 100 – also compared with wages net of tax
source UBS

However, for individuals, their own income and what this will buy may have more relevance. UBS bank produces data which compares prices and earnings in the largest city in each EU/EEA country. The earnings data uses a basket of earnings from various trades and professions:

Chart 2 shows that in January 2008 London was the most expensive city in which to live (red row) with Oslo the next most expensive. Vilnius was the least expensive. However, wages net of tax are the highest in Zurich, followed by Dublin and Oslo. The lowest were in Sofia.

However, these comparisons do not take into account currency and so UBS do produce a third index – that of Domestic Purchasing Power:

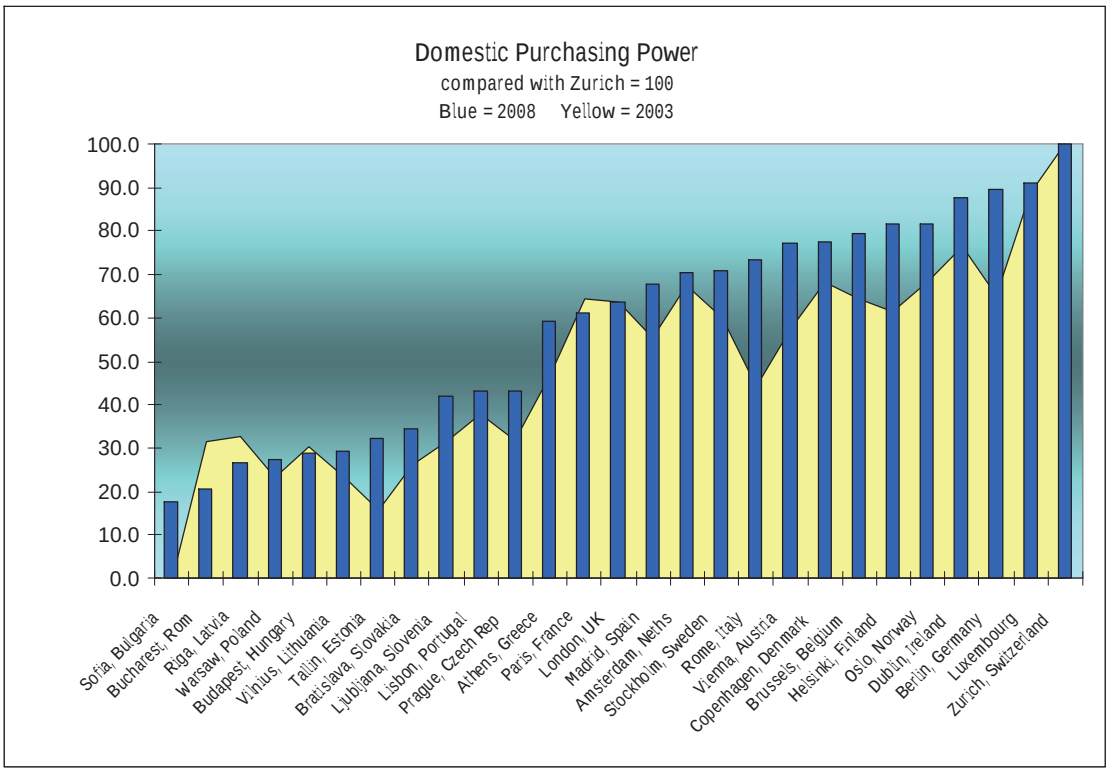


Chart 3 – Comparison of Domestic Purchasing Power, in 2008 – based on Zurich = 100 (also compared with 2003 data)

source UBS ((figures for Sofia were not available earlier).

Chart 3 shows that Zurich has the best balance of income, prices and currency, with Luxembourg as the next best. Sofia and Bucharest are the least favourable – and Bucharest has fallen back since last measured in 2003. Conversely, the DDP in Rome has improved considerably since 2003.

Part 2: The Dental Directives, Acquired Rights & the Freedom of Movement

A Directive is a piece of European legislation which is addressed to Member States. Once such legislation is passed at the European level, each Member States must ensure that it is effectively applied in their legal system. The Directive prescribes an end result. The form and methods of the application is a matter for each Member State to decide for itself. In principle, a Directive takes effect through national implementing measures (national legislation). However, it is possible that even where a Member State has not yet implemented a Directive some of its provisions could have direct effect. This means that if a Directive confers direct rights to individuals, then individuals could rely on the Directive before a judge without having to wait for national legislation to implement it. Furthermore, if the individuals feel that losses have been incurred because national authorities failed to implement Directive correctly, then they may be able to sue for damages. Such damages can only be obtained in national courts.

The Dental Directives

Until 2007 dentistry and the provision of healthcare was governed by the EC Dental Directives (78/686 and 78/687 EEC) and the General Directives on the mutual recognition of Higher Education Diplomas (1975 to 1994).

Since October 2007 these have been superseded by the Directive on the recognition of professional qualifications 2005/36 EC.

The EC Dental Directives (78/686 and 78/687 EEC)

These provided that nationals of an EU member state possessing an EU dental qualification could practise in any other EU member state. In addition, under the European Economic Area agreement, freedom of movement also applies to Norway, Iceland and Liechtenstein. The mutual recognition of diplomas, certificates and any other evidence of the formal qualifications of dental practitioners were governed by the Directives which set out:

- *The titles to which the Directives apply;*
- *the diplomas, certificates and other evidence of formal qualifications that are mutually recognised);*
- *the diplomas, certificates and other evidence of formal qualifications that are mutually recognised for specialist practice. (To be recognised as a speciality, a discipline had to be recognised in two or more member states and accepted by the Commission. In 2004, only two specialities met these criteria - Orthodontics and Oral Surgery) - see Annex 5 for a list of specialties;*
- *undergraduate training requirements;*
- *the duration and content of training;*
- *Acquired rights - Diplomas, and certificates which did not meet the criteria for free movement, as defined, but which were completed before the implementation of the Directives, could also be recognised, under an Acquired Rights provision. They had to be accompanied by a certificate stating that the holders have effectively and lawfully been engaged in the dental practice for at least three consecutive years during the five years prior to the date of issue of the certificate;*
- *the use of academic titles;*
- *specific conditions relating to the right to practise;*
- *freedom of movement of dentists;*

The principle of freedom of movement of personnel, which was established in 1969, was intended to "abolish any discrimination based on nationality between workers of the Member States in employment, remuneration and other conditions of work and employment".

In essence, this means that every worker who is a citizen of a member state has the right to:

- accept offers of employment in any EU country
- move freely within the Community for the purposes of employment
- be employed in a country in accordance with the provisions governing the employment of nationals of that country.
- remain in the country after the employment ceases

Limitations to this fundamental principle will only be allowed if they can be justified on grounds of public policy, public security or public health.

Since 1980, freedom of movement has applied to dentists from those member states whose dental education and training met the requirements of the Dental Directives. Any dentist who is an EU national and has a primary dental degree or diploma obtained in a member state is able to practise in any country in the Community.

Dentists wishing to practise in the EU must register with the competent authority in the country in which they wish to work. A list of the competent authorities who are responsible for certifying that diplomas, certificates and other qualifications held by a dental practitioner meet the requirements are set out at the end of every country section.

Each country also has an information centre which may be the registration body or national dental association which will provide details of the registration procedure and any special requirements that there may be. The names and addresses of these centres are at the end of every country section.

In theory member states cannot put any additional obstacles, particularly language requirements to prevent an EU national with an EU qualification from practising. However, although the Directives facilitate free movement, they do not override all internal requirements and a host country may place the same restrictions on an immigrant dentist as it does on its own nationals.

Some dentists who wish to emigrate, make use of the services offered by agents in a country to help them with the registration procedures. Such services can be very expensive and are not normally necessary. Their use is not recommended.

From the beginning of 1994, freedom of movement has also applied to those EFTA countries who are members of the EEA.

Freedom of movement and the Accession countries

The Accession countries had to ensure that, concerning the free movement of workers, there were no provisions in their legislation which are contrary to Community rules and that all provisions, in particular those relating to criteria on citizenship, residence or linguistic ability, are in full conformity with the *acquis* (of accession).

The key issue is that of *free movement of workers* and it has been treated in a broadly similar way for all countries. The political and practical importance of this area of the *acquis* and the sensitivities and uncertainties surrounding mobility of workers led to transitional measures. It was expected that the predicted labour migration from the Accession countries would be concentrated in certain member states, resulting in disturbances of the labour markets there. Concerns about the impact of the free movement of workers are based on considerations such as geographical proximity, income differentials, unemployment and propensity to migrate. The EU was also worried that this issue threatened to alienate public opinion and to affect overall public support for enlargement.

The EU did not request a transition period in relation to Malta and Cyprus. However for all the other countries a common approach was put forward. The essential components of the transition arrangement were as follows:

- A two year period during which national measures would be applied by current Member States to new Member States. Depending on how liberal these national measures were, they could result in full labour market access.
- Following this period, reviews were held, one automatic review before the end of the second year and a further review at the request of the new Member State. The procedure included a report by the Commission, but essentially left the decision on whether to apply the acquis up to the Member States.
- The transition period should come to an end after five years (2011), but it may be prolonged for a further two years in those Member States where there are serious disturbances of the labour market or a threat of such disruption.
- Safeguards may be applied by Member States up to the end of the seventh year.

The transitional arrangement also includes a number of other important aspects, such as a standstill clause, whereby current Member State labour markets cannot be more restricted than that prevailing at the time of the signature of the Accession Treaty. Also current Member States must give preference to acceding country nationals over non-EU labour.

Austria and Germany have the right to apply flanking national measures to address serious disturbances or the threat thereof, in specific sensitive service sectors on their labour markets, which could arise in certain regions from cross-border provision of services.

Under the transitional arrangement the rights of nationals from new Member States who were already legally resident and employed in a Member State were protected. The rights of family members were also taken into account consistent with the practice in the case of previous accessions.

This arrangement was accepted by the accession countries subject to some minor adaptations. The solution reached was identical - reciprocity vis-à-vis current Member States and the possibility to apply safeguards against new Member States once at least one new Member State is subject to national measures. Malta was concerned that its labour market could come under pressure following accession and so a safeguard clause was agreed, which will run until 2011. A joint declaration was also attached to the Act of Accession allowing for recourse by Malta to Community institutions, should Malta's accession have given rise to difficulties in relation to free movement of workers. With respect to Cyprus, no transitional arrangements were requested by either Cyprus or the EU.

Freedom of movement and Family Members

European Parliament Directive 2004/38/EC legislates on the right of citizens of the European Union and their family members to move and reside freely within the territory of the Member States. The Directive was implemented on 30 April 2006 and is effective from that date.

For further information, please see Annex 9 of this Manual.

The Mutual Recognition of third country diplomas and professional qualifications

Member States may recognise dental qualifications from non-EU/EEA countries and allow the dentists who hold them to practise, provided they are satisfied that the training received conforms to the EU Dental Directives. This does not confer the right of freedom of movement. However, see *Acquired Rights* (Annex 9).

In Spain and Portugal, there is a tradition of reciprocal recognition of diplomas from other countries, notably in Latin America, but the legality of this has been challenged by the Commission from time to time. However, practical comparison of the training received by the immigrant dentists is difficult.

The issue of how to treat qualifications obtained in third countries arose again for some Accession countries. For example, how should the EU treat qualifications obtained in respect of citizens from the Accession countries who completed their education when individual candidate countries were part of the Soviet Union (in the case of the Baltics) or Yugoslavia in the case of Slovenia?

The solution devised by the EU aimed on the one hand to guarantee the integrity of professions in the EU and protects citizens of the EU and also to give effect to these rights in a way that is simple and clear to all citizens of an enlarged Union, and which does not result in an unnecessary administrative burden for individuals or administrations. The EU has retained the notion of a *declaration* by the relevant country bodies of the equivalence of the qualifications in question to their diplomas (which, upon accession, was automatically recognised in the EU), accompanied by an

attestation that the holders of the qualification have been recently engaged in the activities in question. This double approach (declaration and attestation) is said by the Commission to offer all reasonable guarantees to EU citizens.

However it was difficult to ascertain with certainty the standard of qualifications dispensed in the Accession countries and as a result extremely tough monitoring provisions, in particular for the sectoral Directives, took place initially.

All the Accession countries were encouraged to step up their efforts to introduce the necessary administrative structures as well as education and training programmes to guarantee the level of competence of the qualified professionals required by the EU Directives.

For professional qualifications obtained before harmonisation, these countries had to take measures to ensure that all their professionals can meet the requirements laid down by the Directives and can therefore benefit from professional recognition throughout the EU from accession, in line with the procedures applied in past accessions. At the time of accession, dental training in Estonia, Hungary, Latvia, Lithuania and Malta complied with the requirements of the Dental Directives. This training complied at a later date in the Czech Republic, Poland, Romania, Slovakia and Slovenia (see the individual country sections). There is no dental training in Cyprus.

The General Directives on the mutual recognition of Higher Education Diplomas 1975 to 1994

The first "Sectoral Directive" which covered medical practitioners came into force in 1975, three years before its dental equivalent. At that time, it was intended that each profession should have its own Directive in due course. This approach was ultimately abandoned by the Commission as impractical because of the time taken to negotiate with some of the more complex professions. As an alternative, "General Directives" were introduced which applied to hundreds of professions providing they had received equivalent levels of education and training and were satisfactorily regulated.

The first "General Directive" dealt with those professions whose entry is regulated by a qualification based on a minimum of three years full time (or equivalent) higher education or training leading to the award of a diploma. It became law on 1st January, 1991, and allowed freedom of movement of the individual in the professions concerned.

The second "General Directive" included professional qualifications which did not conform to the definition of a "three year higher education diploma". It was implemented in June, 1994, and extended the general system to include qualifications obtained after post secondary courses of 1-3 years, taken after qualifications, which are necessary to enter University. Vocational qualifications were included in this definition. Where a migrant's training and education varied substantially from that required by the regulatory body in the country where they wished to work, they were required to undertake an "aptitude test" on areas of the discipline which they had not covered or an "adaptation period" of assessed supervised training.

Neither of the General System Directives applied to professions that were subject to Sectoral Directives.

Directive on the recognition of professional qualifications (PQD) 2005/36 EC

On 20 October 2007 a new Directive came into force and replaced the earlier Directives and 13 others. The system of automatic recognition of dental qualifications will continue, however, under the new Directive.

A number of changes have been introduced compared with the previous rules, including greater liberalisation of the provision of services, more automatic recognition of qualifications and increased flexibility in the procedures for updating the Directive. The Directive also aims to make it easier for regulated professionals to provide services on a "temporary and occasional" basis in Member States (MS) other than the MS of establishment with a minimum of bureaucratic impediment.

The Commission also proposes to develop its cooperation with the Member States, in order to keep citizens better informed about their rights and give them more help in getting their qualifications recognised.

- *General system for the recognition of professional qualifications (Chapter I of the Directive).*

This system applies as a fallback to all the professions (such as dental auxiliaries) not covered by specific rules of recognition (such as dentists) and to certain situations where the migrant professional does not meet the conditions set out in other recognition schemes. This general system is based on the principle of mutual recognition, without prejudice to the application of compensatory measures if there are substantial differences between the training acquired by the migrant and the training required in the host Member State. The compensatory measure may take the form of an adaptation period or an "aptitude" test. The choice between one or other of these tests is up to the migrant unless specific derogations exist.

- *System of automatic recognition of qualifications for specific professions* (Chapter III of the Directive).*

The automatic recognition of training qualifications on the basis of coordination of the minimum training conditions covers dental practitioners and specialised dental practitioners (see Annexes 6 and 7 of this Manual).

- *Minimum training requirements*

The system of automatic mutual recognition works on the basis of coordinated minimum training requirements. Dental training has to entail the completion of a minimum five-year full-time theoretical and practical course which includes at least certain commonly agreed subjects and which guarantees that the person concerned has acquired commonly agreed knowledge and skills (see Annex 5).

- *Diplomas guaranteeing compliance*

The Directives lists the diplomas from each Member State which serve as evidence of having completed dental training which complies with the minimum training requirements. Each Member State must automatically recognise these diplomas and allow the holder to practise in that Member State (see Annexes 6 and 7).

- *Principle of the free provision of services*

The "temporary and occasional nature" of the services provided should be assessed on a case by case basis, in relation to their "duration, frequency, regularity and continuity". This term is not further defined in the Directive. The assessment will therefore be a matter for the judgement of the competent authorities (regulatory bodies) in each case.

- *Exemptions*

One of the key aspects of the services regime in the Directive is the exemption in principle from the requirement for migrants to be registered in a professional register (see Article 6(a)).

However, it is stated that Member States may provide for automatic temporary registration, or pro forma Membership in order, particularly, that disciplinary provisions may be applied to temporary service providers. Competent authorities may not however charge for this.

- *Declaration to be made in advance*

Article 7.1 of the Directive allows Member States to require service providers to inform competent authorities of their intention to provide services of a "temporary and occasional" nature, by providing a written declaration in advance. This declaration must be renewed once a year if the service provider intends to provide temporary or occasional services during the following year. There is therefore no provision in the implementing legislation for regulators to impose time limits of less than 52 weeks on service providers: this is not an option according to the Directive. It is of course open to regulators to review cases periodically once the migrant is registered in the MS, to assess whether or not the service provision is genuinely temporary and occasional.

The service provider may provide this written declaration by any means, but for administrative convenience the European Commission's implementation committee was (in 2008) discussing a prototype declaration form that prospective service providers could use to inform competent authorities.

There are provisions which set out the documents etc. which member States may require under Article 7.2 of the Directive. So, the MS can decide it will require documentation accompanying the declaration and proof of the service provider's nationality, legal establishment and professional qualifications. The MS cannot require providers to supply further details as a pre-condition for registration.

Under the Directive, the service provider is entitled to practise once they have provided the required declaration and documents.

- *Continuing professional development in cases of "temporary and occasional" provision of services*

Access to pursuit of their profession in another Member State is (Recital 3) "without prejudice to compliance by the migrant professional with any non-discriminatory conditions of pursuit which might be laid down by the latter MS, provided that these are objectively justified and proportionate". Recital 39 specifically refers to the importance of *lifelong learning* but states that it is for MS to "adopt the detailed arrangements under which, through suitable ongoing training, professionals will keep abreast of technical and scientific process".

It would not be reasonable and proportionate to expect a temporary service provider who has to fulfil CPD requirements as a condition of legal establishment in their home Member State to have to meet the host MS's requirements too.

- *Qualifications, and timescales*

Member States are given the option, under Article 7(4) of the Directive, of requiring competent authorities to check the professional qualifications of certain service providers. This applies to (a) general systems professions with public health or safety implications (ie all the general systems health and social care professions), and (b) sectoral professions, in cases which fall within Article 10 of the Directive.

The Directive does not afford any flexibility in stipulating the timescales within which competent authorities have to give the service provider a decision. There is one month to acknowledge receipt of an application and to draw attention to any missing documents. A decision has to be taken within three months of the date on which the application was received in full. Reasons have to be given for any rejection and it is possible for a rejection, or a failure to take a decision by the deadline, to be contested in the national courts.

Member State nationals are able to use the title conferred on them (or possibly an abbreviated form), as well as the professional title of the corresponding host Member State. If a profession is regulated in the host Member State by an association or organisation, MS nationals must be able to become members of that organisation or association, in order to be able to use the title.

- *Sectoral professions subject to the general systems regime*

There are some sectoral professionals (eg dentists) who for one reason or another may not qualify for automatic recognition under the sectoral regime. For example, they may wish to practise as specialists in another Member State where their specialist training is not mutually recognised, or they may hold a qualification from a country outside Europe and have less than three years' professional experience in a European Member State. These specific cases are listed in Article 10 of the Directive. Such cases now fall within the general systems regime.

- *Derogation on compensation measures*

Where compensation measures are needed to make up for a shortfall in the applicant's training or experience, the

applicant will be able to choose whether to sit an aptitude test or undergo an adaptation period before admission to the register unless the Member State (MS) stipulates otherwise by "derogating" from this principle. Article 14 allows MS to stipulate either a test or an adaptation period in respect of the five sectoral health professions – including dentistry - (in certain cases).

However, in relation to the general system professions, derogation under Article 14(2) requires a business case to be agreed by the Commission. The Commission has indicated that very few, if indeed any business cases would receive approval.

- *Common platforms*

The Directive introduces "common platforms", relating to the general systems professions, which are agreements between professional bodies in Member States describing differences between professional qualifications. This has the potential to increase transparency for a given profession and promote labour mobility and flexibility. It is possible that some of the nonsectoral professions may wish to avail themselves of these provisions some time in the future.

- *Documentation and formalities in establishment cases*

Competent authorities may demand various documents and certificates listed in Annex VII of the Directive. In a case where competent authorities have justified doubts, they may also require confirmation of the authenticity of the migrant's evidence, and (for the sectoral professions) confirmation that the migrant's qualification meets the minimum training conditions for their profession set out in the Directive.

- *Language competence*

Directive 2005/36 does not alter the existing law, whereby individuals moving under either the sectoral or general systems Directives cannot be required to take a language test as a condition of registration in the host member state. However, Member States may require migrants to have the knowledge of languages necessary for practising the profession. This provision must be applied proportionately, which rules out the systematic imposition of language tests before a professional activity can be practised.

It should be noted that any evaluation of language skills is separate from the recognition of professional qualifications. It must take place after recognition, when actual access to the profession in question is sought. Therefore, it is up to individual employers to check they have the communication skills necessary to do the job in question.

Exchange of information between competent bodies

Article 56(2) of the Directive places a duty on the competent authorities of the host and Member States to exchange information about registrants (or potential registrants) regarding disciplinary action or criminal sanctions taken or any other serious, specific circumstances likely to affect patient safety.

Article 8 places a similar duty on competent authorities in respect of "temporary and occasional" service providers.

- *Reports*

All Member States are required to report to the European Commission every two years about how well the mutual recognition system is working, and in particular if there are any problems that need sorting out.

For a further detailed description of the Directive relating to the sectoral professions see Annexes 4 to 9 of this Manual.

Part 3: Other Directives directly relevant to dentists

Medicinal Products and Medical Devices

Medicinal products

Medicinal products are only available for dental treatment if they are licensed by the member state where they are used in accordance with Directive 65/65 (and amending Directives). Further harmonisation of the regulations governing free movement of pharmaceuticals is established with the establishment of the European Agency for the Evaluation of Medicinal Products, in London (http://www.emea.europa.eu/). The Agency is responsible for co-ordinating the evaluation and supervision of medicinal products for human and veterinary use in the Community, in order to remove remaining barriers to trade. EudraVigilance is the European data-processing network and database management system for the exchange, processing and evaluation of Individual Case Safety Reports (ICSRs) related to medicinal products authorised in the European Economic Area (EEA).

Medical devices

The Medical Devices Directive (93/42/EEC), which applies to all medical and dental products which are non-pharmaceutical and inactive, also has as its major purpose the removal of the final barriers to trade and sets requirements governing safety and efficacy.

The Directive requires all manufacturers to register with the national competent authority and to observe certain design and manufacture requirements, clinical evaluation and conformity assessment procedures and provide for verification. The precise procedures and requirements vary according to the classification of the product: as custom-made, class I, Ia, IIb or III, depending upon the nature of the device.

The EU Member States have to apply a new Directive 2007/47/EC amending Directive 93/42/EEC on Medical Devices and Directive 90/385/EEC on Active Implantable Medical Devices, as national law by March 21st 2010. The implementation of the new Directive will change, or may affect, some of the existing provisions under the current regime of the Directive 93/42/EEC on Medical Devices.

This section provides an overview of the major issues relevant for the dental profession.

- Normally it is the dental technician who is the manufacturer of a dental prosthesis. To be a manufacturer, a dentist would have to be registered as such, meaning far-reaching obligations, such as registering all raw materials for prostheses etc. The new Directive does not change the provisions of the "old" Directive and the situation remains the same.
- The new Directive makes it clear that custom-made devices are excluded from the obligation to carry CE marking.
- According to the new Directive the patient is to be identified by name, acronym or a numerical code. Under the old Directive, only patient identification by name was provided for, and yet in some countries, acronyms and numerical codes were and are used.
- The new Directive introduces the requirement of validating software which are used in medical devices or are medical devices themselves (eg electronics in the unit, UV lamps, x-ray machine). Software has to be validated by the manufacturer, and the burden on the dentist will depend on the instructions of the manufacturer – eg if the manufacturer insists on revalidation every three years, then the dentist will have to comply.
- The new Directive adds a new section according to which, for custom-made devices, the manufacturer "must undertake to review and document experience gained in the post-production phase´". This could be interpreted as meaning that if no experience was gained – i.e. if no negative incidents relating to the medical device were notified – then there would be nothing to review.

Data Protection

Although national laws on data protection aimed to guarantee the same rights, some differences existed. The EC decided these differences could create potential obstacles to the free flow of information and additional burdens for economic operators and citizens. Additionally, some Member States did not have laws on data protection.

To remove the obstacles to the free movement of data, without diminishing the protection of personal data, Directive 95/46/EC (the Data Protection Directive) was enacted to harmonise national provisions in this field.

For further information, especially how this relates to dentistry, see Annex 10.

Consumer Liability

The main features of the Directive on Liability for Defective Products (85/374/EEC) include the principle of "liability without fault" - the Directive establishes the principle of objective liability or liability without fault of the producer in cases of damage caused by a defective product. If more than one person is liable for the same damage, it is joint liability. The word "*Producer*" has a wide meaning including: any participant in the production process, the importer of the defective product, any person putting their name, trade mark or other distinguishing feature on the product, or any person supplying a product whose producer cannot be identified.

The injured person must prove: the actual damage, the defect in the product and the causal relationship between damage and defect. As the Directive provides for liability without fault, it is not necessary to prove the negligence or fault of the producer or importer.

The general public is entitled to expect safety and determines the defectiveness of a product. Factors to be taken into account include: presentation of the product, use to which it could reasonably be put and the time when the product was put into circulation.

The producer is freed from all liability if he proves (in particular relation to dentistry) that the state of scientific and technical knowledge at the time when the product was put

into circulation was not such as to enable the defect to be discovered. The producer's liability is not altered when the damage is caused both by a defect in the product and by the act or omission of a third party. However, when the injured person is at fault, the producer's liability may be reduced.

For the purposes of the Directive, "damage" means damage caused by death or by personal injuries.

The Directive does not in any way restrict compensation for non-material damage under national legislation. The injured person has three years within which to seek compensation. This period runs from the date on which the plaintiff became aware of the damage, the defect and the identity of the producer. The producer's liability expires at the end of a period of ten years from the date on which the producer put the product into circulation. No contractual clause may allow the producer to limit his liability in relation to the injured person.

National provisions governing contractual or non-contractual liability are not affected by the Directive. Injured persons may therefore assert their rights accordingly.

The Directive allows each Member State to set a limit for a producer's total liability for damage resulting from death or personal injury caused by identical items with the same defect.

Misleading and Comparative Advertising

The Directives on Misleading and Comparative Advertising were introduced to protect consumers, competitors and the interest of the public in general, against misleading advertising and its unfair consequences.

Misleading advertising is defined as any advertising which, in any way, either in its wording or presentation deceives or is likely to deceive the persons to whom it is addressed or whom it reaches; by reason of its deceptive nature, is likely to affect their economic behaviour; or for those reasons, injures or is likely to injure a competitor.

Comparative advertising is defined as any advertising, that explicitly or by implication, identifies a competitor or goods or services offered by a competitor.

National rules may allow persons or organisations with a legitimate interest in prohibiting misleading advertising, or controlling comparative advertising, to take legal action and/or go before an administrative authority. Consumers have to check which system (judicial or administrative) their national authorities have chosen.

The national courts or administrative authorities have enough power to order advertising to cease, either for a certain period or definitively. They can also order its prohibition if the advertising has not yet been published, but publication is imminent. A voluntary control by the national self-regulatory bodies can also be carried out.

Advertisers should always be able to justify the validity of any claims they make. Therefore advertisers (not consumers) have to provide evidence of the accuracy of their claims.

Electronic Commerce

The E-Commerce Directive was adopted on 8 June 2000 and published in the Official Journal of the European Communities on 17 July 2000. The objective was to ensure that information society services benefit from the internal-market principles of free movement of services and freedom of establishment, in particular through the principle that their provision cross-border throughout the European Community cannot be restricted.

The Directive covers information society services and services allowing for online electronic transactions, such as interactive online shopping. Examples of sectors and activities covered include online newspapers, online databases, online financial services, online professional services (such as lawyers, doctors, accountants and estate agents), online entertainment services (such as video on demand), online direct marketing and advertising and services providing access to the Internet.

The chief aim of the Directive is to ensure that the Community reaps the full benefits of e-commerce by boosting consumer confidence and giving providers of information society services legal certainty, without excessive red tape.

For further information, especially how this relates to dentistry, including ethical guidance for the use of the internet, see Annex 11

Unfair Commercial Practices Directive

The Directive 2005/29/EC on Unfair Commercial Practices (UCPD) was adopted on 11 May 2005. The deadline for transposition into national laws was 12 June 2007 but in the Summer of 2008 the Commission reported that several Member States were late in transposing the Directive into their national laws.

There are 4 key elements in the new Directive, which are:

- A General Clause: A far reaching general clause defining practices which are unfair and therefore prohibited;
- Misleading Practices (Actions and Omissions) and Aggressive Practices - the two main categories of unfair commercial practices - are defined in detail;
- Safeguards for vulnerable consumers: The Directive contains provisions that aim at preventing exploitation of vulnerable consumers;
- Black List: An extensive black list of practices which are banned in all circumstances.

In particular, the Directive obliges businesses not to mislead consumers through acts or omissions; or subject them to aggressive commercial practices such as high pressure selling techniques. The Directive also provides additional protections for vulnerable consumers who are often the target of unscrupulous traders.

The Directive's wide scope – it applies to all business sectors – and flexible provisions means that it will plug gaps in existing EU consumer protection legislation; and set

standards against which new practices will automatically be judged.

Implementation of this Directive is said to help EU countries to ensure their consumer regimes are amongst the level of the best in the world.

The Directive's broad scope means that it overlaps with many existing laws. In addition, because the UCPD is a maximum harmonisation Directive (ie setting out the maximum level of restriction permissible in respect of unfair commercial practices which harm consumers' economic interests) a supplementary objective in transposing the Directive was to achieve, where possible, some regulatory simplification.

Cosmetics Directive

In the early 1970's, the Member States of the EU decided to harmonise their national cosmetic regulations in order to enable the free circulation of cosmetic products within the Community. As a result of numerous discussions between experts from all Member States, Council Directive 76/768/EEC was adopted on 27 July 1976. The principles laid down in the Cosmetics Directive were to take into account the needs of the consumer, while encouraging commercial exchange and eliminating barriers to trade. For example, if a product is to move freely within the EU, the same labelling, packaging and safety regulations must apply. This was one of the main objectives of the Cosmetics Directive: to give clear guidance on what requirements a safe cosmetic product should fulfil in order to freely circulate within the EU, without pre-market authorisation.

The 1976 Directive initiated the regulation of cosmetic products, and within its definition of *"cosmetic product"* included "any substance or preparation *intended to be placed* in contact with the various external parts of the human body…or with the teeth and the mucous membranes of the oral cavity with a view exclusively or mainly to cleaning them, perfuming them, changing their appearance and/or correcting body odours and/or protecting them or keeping them in good condition."

Article 4 of the Directive required Member States to prohibit the marketing of certain cosmetic products (mainly hair-care) containing hydrogen peroxide – no control of products for the teeth was made at this stage. However, developments were made during the 1980s and in 1992: "oral hygiene products" were included within the range of products for which a maximum concentration of hydrogen peroxide was directed. The substance hydrogen peroxide (H_2O_2) was widened to include compounds that release it, such as carbamide peroxide and zinc peroxide. Directive 92/86/EEC, of October 21st 1992 thereby prescribed that "oral hygiene products" should include a maximum concentration of 0.1% of H_2O_2 present or released. There is no definition of "oral hygiene products".

For the implications for dentistry please see the relevant paragraphs in each country's section (later), as each country has their own interpretation of this Directive.

(Proposed) Directive on patients' rights in cross-border healthcare

On 2nd July 2008 the European Commission published a proposal for a Directive on the application of patients' rights in cross-border healthcare. The objective of the text is to clarify patients' existing rights of access to healthcare services in EU member states.

For further information see Annex 13.

Part 4: Healthcare and Oral Healthcare Across the EU/EEA

Expenditure on healthcare

The overall expenditure by countries on all forms of general healthcare (including dentistry) in the EU/EEA varies by a large amount, generally but not wholly according to a country's wealth as measured by GNP/GDP or PPP. However, there are major exceptions to this rule – so whereas Luxembourg and Denmark have a high GNP/GDP/PPP, their spending on health is about the average of 6.1%. Conversely, healthcare spending in Slovenia was high, in comparison with their GNP/GDP/PPP.

An attempt was made to compare expenditure on overall healthcare in countries, with reported spending on dentistry, but this was not possible as the interpretation of what constituted spending on dentistry varied significantly. Some countries provided data for state spending only (as there was no data for spending by private patients) and some were unable to supply overall spending data.

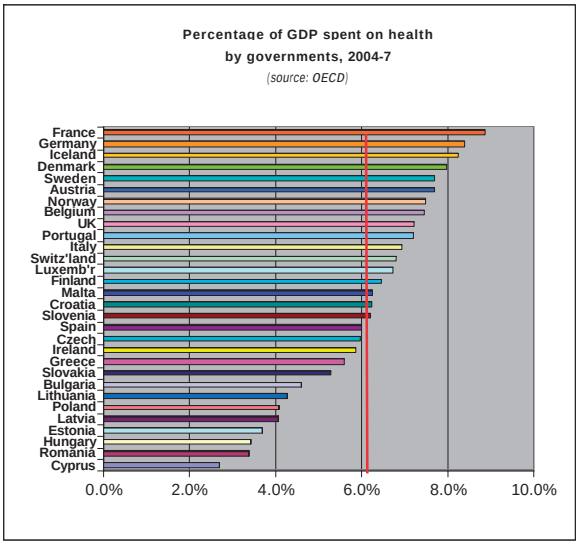


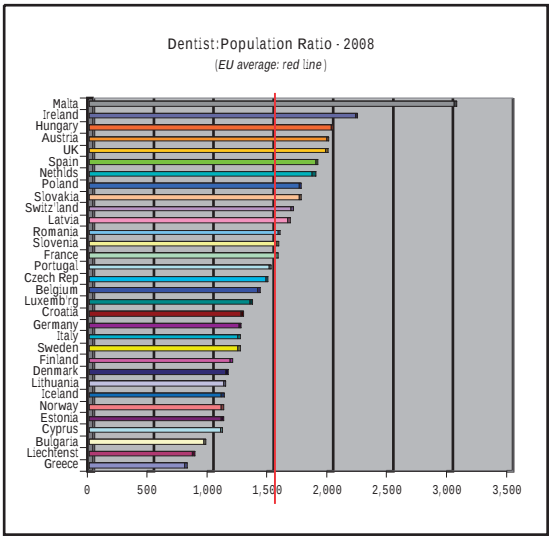
Chart 4 - percentage of GDP spent on health by governments in 2004-05 as reported by the OECD in 2008[3]

Population Ratios

One measure of the provision of dentistry/oral healthcare in countries is the *dentist to population ratio*. However, some caution should be employed when using these figures, as there are a number of factors which might skew the conclusions.[4]

The population of the areas covered by this Manual (the EEU/EEA and Croatia) was about 515 million in 2008[5]. The dental associations reported that there were about 345,000 *active* dentists – which excludes, for example, dentists totally retired or on maternity leave (but still registered) - see Part 7, Workforce. This leads to an (average) dentist to population ratio of 1:1,501. However, there were wide variations from this figure:

Chart 5- (Active) Dentist to Population ratio



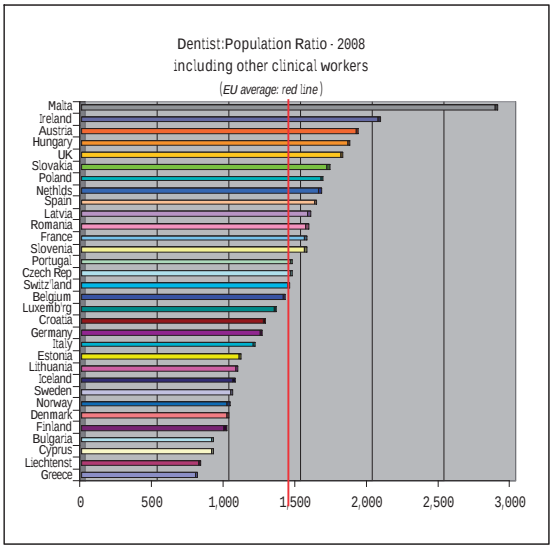


Chart 6 – (Active) Dental Clinical Worker to Population ratio

[3] nb: the percentages refer to different years recorded for each country, with the oldest at 2004 and the newest at 2007; no data for Liechtenstein was supplied

[4] A number of factors may make the interpretation of population ratios hazardous – eg what proportion of dentists are female (female dentists are described by many commentators as having a smaller working life "output"), the level of support given by clinical auxiliaries, whether dentists have chairside support from dental assistants and other factors.

[5] Population figures derived from Eurostat July 2008

The use of clinical auxiliaries should improve the provision of clinical care.

Chart 6 was devised using the formula that one clinical dental auxiliary delivered 0.43 of the whole-time equivalent care of a whole-time dentist[6]. However, caution should be used as this figure may not be accurate. See Part 7 (The Dental Workforce for numbers).

Entitlement and access to care

In all countries of the EU/EEA oral healthcare is available through private practice, using "liberal" or "general" practitioners. Although entitlement for all to receive state or insurance funded health care is a constitutional right in some countries and a stated principle in others, it is rarely guaranteed.

For the majority of the population in Europe access to oral health care is determined by:

- the geographical proximity of 'private' dental practitioners;
- the level of fees charged to patients for different treatments; and
- access by particular population groups (for example children) to special services.

Where governments or other agencies offer financial assistance, or directly provide services, for particular population groups who would otherwise not receive care, this is always a restricted "standard package" of care. The standard package often only consists of basic conservative treatments (examination, fillings), exodontia and some preventive care, but usually excludes all complex treatments (including, in many countries, emergency care following an accident). There is some evidence from individual countries that the content of the standard package has been reduced since 2000, with a consequent increase in co-payments.

Financing of oral health care

In every country examined, dental care is typically funded by direct patient payments to a greater extent than other areas of general health care. In most countries the reliance on, and acceptance of, direct patient payments, especially for adults or those with an income is exceeded only by that of the cost of drugs or payments for optometrists' services.

While patient payments (or co-payments) for state or insurance funded dental care are widely accepted across Europe, every country also has a system (or systems) where individuals pay prospectively for their dental care, through insurance or taxation (or both). This system is usually a part of, or closely reflects the system of funding for general health care. There is no identified "model" system, except perhaps for general oral health care for the adult population, where some form of "social insurance" system is the most widely used.

Almost all countries have a specific alternative system which enables individuals to collectively pay for some of the costs of oral health care. These systems range from national social security systems or health services, state recognised or compulsory health insurance (from "sick funds"), to voluntary insurance from private companies. Additionally, in every country there is some form of financial assistance, subsidy or special services for population groups who cannot afford to pay directly or collectively for dental care, or have special oral health needs (such as children, the unemployed, handicapped people, hospital inpatients or war veterans). As children are not in a position to earn an income and pay for their own dental care, they most commonly have the best access to free or subsidised care. Indeed, in countries with a national health service or a state-organised social security system, the publicly funded dental service is primarily for schoolchildren. In the other countries children generally only receive subsidised dental treatment if they are covered by a parent's sick fund or private insurance.

It is important to note that whatever the actual route by which individuals indirectly pay for their dental care, the administrative mechanisms employed to keep dental care affordable (for instance, fixed fees), appropriate (for example, prior approval) and profitable to the private dentist flexible, periodically negotiated fee-scales are common to many systems. In the countries where direct patient payments are the dominant form of finance, there is typically a limited social security system.

For the patient, the cost of care is further complicated by the varying size of subsidy offered for different treatments. At one extreme individual dentists may contract with individual insurance schemes to provide certain care at certain prices. However, in other countries there is a nationally negotiated agreement between representatives of the dental profession - the providers of care - and the purchasers of care, whether they are a union of sick funds, or the government.

There appear to be four models of provision of healthcare into which the 31 countries examined fit:

National Health Service type healthcare

Categorical

In this group, the bulk of funding is from national or local taxation, but the scheme may be limited to certain people, for example, children, the unemployed, handicapped people, hospital inpatients or war veterans. Generally, treatment for the under 18s will be free (except for some orthodontic care in some countries), but there may be some co-payment necessary by adult patients, especially for prosthodontic appliances.

For patients outside the defined group other arrangements will apply.

Universal

In this group, funding is again from national or local taxation, and in theory NHS treatment is available to all citizens. Where NHS treatment is available, this is free to the under 18s and (often) to other groups of adults - related to age, welfare status or medical conditions. However, in practice availability is limited – through a shortage of dentists who will provide the service in rural and socially deprived areas, or from low fees offered.

In the countries where adult oral health care is subsidised as part of the national social security system (or health

[6] this figure was used by the UK when a Dental Workforce Survey was published in 2004

service), for example in Denmark, Finland, Iceland, Sweden and the UK these subsidies are from a government body. However, often local government or local social insurance offices administer the subsidy system. In Iceland, although the subsidies are from the government, they are limited to a few eligible patient groups.

Table 1 - Healthcare systems in EU/EEA countries

The Four Models of Healthcare Provision	
National Health Service type Public in nature Financed by taxes and patient co-payments Fully private (liberal) provision for remaining care	
Categorical the scheme may be limited to certain people, for example, children, the elderly, low-income families	Cyprus*, Iceland, Ireland, Malta and Spain
Universal Available to all citizens, but the treatment choices may be limited and/or access, in some geographical areas, restricted due to low fees	Denmark, Finland, Greece, Italy Norway and the UK
Social Insurance type ("Sick Funds") Compulsory public health insurance, maybe supplemented with voluntary supplementary insurance Contributions to the insurance usually related to income Patients make co-payments for claim reimbursements from the sick funds Fully private (liberal) provision for remaining care (prices may be regulated)	
Income ceiling There are income criteria for excluding some adults from access to all or most of care within the schemes. So, there is mainly private provision and finance, with a government organised residual health service for specific "priority" groups.	Germany
No Income ceiling There may be other criteria for access – but usually full access for the elderly and children, other medically compromised and low income adult groups. Part access (ie limited care) for adults above a low level of earnings * Cyprus will have a new system in 2009	Austria, Belgium, Bulgaria, Croatia The Czech Republic, Estonia, France, Hungary, Latvia, Liechtenstein, Lithuania, Luxembourg, The Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Sweden and Switzerland

Oral health care through social insurance

The essential features of a social insurance-based oral health care system are:

- individuals have membership of an appropriate institution which is usually funded by contributions deducted from their income;
- membership of an insurance institution may be compulsory for some sectors of the population;
- employers also usually have to contribute;
- insured members, and usually also their dependants, can then access a defined range of dental services;
- the cost of these services is usually partially controlled by the insurance organisations;
- for a specified range of dental services the insured individual receives a partial or full subsidy, either by claiming from the insurance institution or only part-paying the dentist (who then in turn claims the remainder from the insurance organisation).

Twenty-one countries have health care organised through sick funds, but their exact constitution, membership and funding rules vary considerably. Government involvement typically extends only to the rules on compulsory membership. As a result, membership of compulsory sick funds generally covers over 80% of these 21 countries' populations.

Sick funds are typically locally based or centred on an employee's occupation-type. They are independent, democratic and self-organised to a large extent, but also cooperate nationally in negotiations with the dental and medical professions. For example, in France, Belgium and Luxembourg the separate 'caisses' are organised as a single scheme for the purposes of deciding some of the dentists' fees (in the 'convention'), and setting a national budget. The split between employees' and employers' average contributions also varies considerably, but is always calculated as a proportion of salary. In some countries this percentage is fixed and does not vary between sick funds while in others there is variation in the contribution level between funds.

Income Ceiling

Germany and The Netherlands allow access to the social insurance system for those whose incomes are inside various norms, and more or less exclude adults whose incomes are above certain thresholds. Adult patients excluded from the state system may arrange private insurance care.

No Income Ceiling

Over half of the countries examined, who provide care through sick funds, have other criteria for access to subsidised care. Usually there is a categorical access (as above, in NHS schemes) for groups such as children, the elderly, the unemployed, handicapped people, medically compromised, hospital inpatients or war veterans. Limited care may be offered for adults above a low level of earnings.

Frequency of attendance

The decision about the frequency of attendance of patients to receive oral health re-examinations is largely a decision between dentists and their individual patients. However, there are a number of influences on these decisions, which may include individual and population disease levels, preventive strategies (including water fluoridation), socio-economic and cultural attitudes and external funding arrangements.

We received estimates of patient normal re-attendance from most countries (many others reported that there was no measurable average attendance any more).

All countries made the point that patients with active disease may be seen more frequently than the normal time period reported. In almost every European country, the overall levels of expenditure and the amount of care provided is directly influenced by the regulations which govern patients' fees and private dentists' remuneration. Because of the dominance of "private practitioners" in oral health care provision, regulations about patient payments, fixed remuneration fees, and subsidy systems all affect the dentist's incentive to treat and the patient's incentive to seek treatment.

Approximately 6 monthly	The Czech Republic, Malta and Poland
9 to 12 monthly	Denmark, Estonia, the Netherlands, Slovenia and Switzerland
Annual	Austria, Belgium, Cyprus, France, Germany, Hungary, Iceland, Ireland, Italy, Latvia and Romania
18 months or more	Finland, Slovakia and Sweden

Table 2 - Patient re-examination periods

Health data

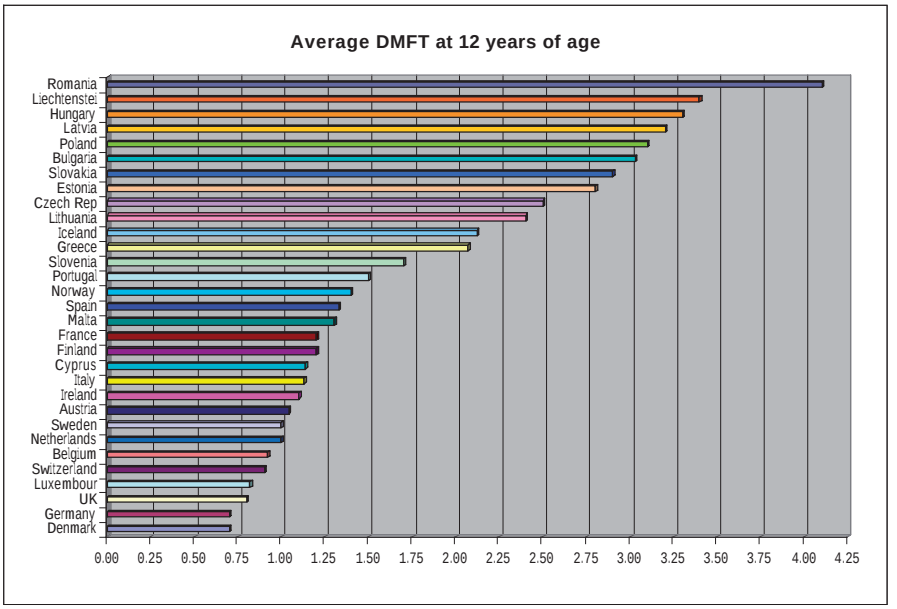


Chart 7 – the average Decayed, Missing, Filled Teeth at the age of 12 years (DMFT)

Unfortunately, health data is not collected by countries in a uniform manner on fixed dates, so comparison between the data published by individual countries is difficult and should be viewed with circum-spection.

However, many countries do collect data on 3 fixed items and publish these through various sources (see the individual country sections for sources and dates of collection).

Chart 8 – the proportion of children of 12 years of age with no Decayed, Missing, Filled Teeth (DMFT)

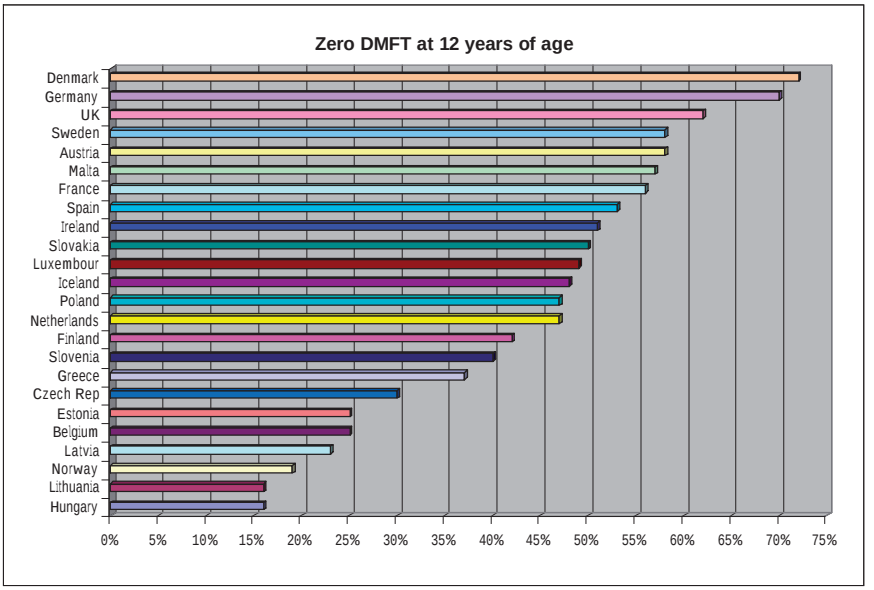
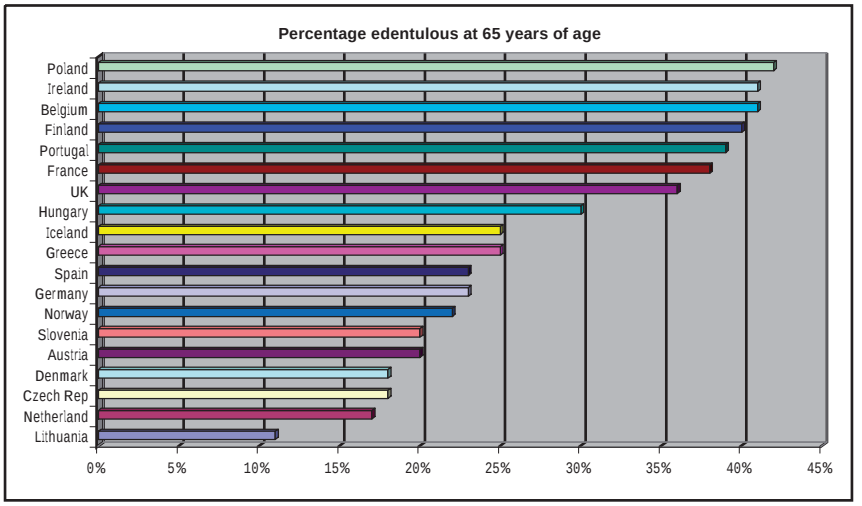


Chart 9 – the proportion of adults 65 years (or older) with no teeth (edentulous)



Fluoridation

Table 3 · Community fluoridation

Austria	None
Belgium	Some natural
Bulgaria	Milk fluoridation schemes
Croatia	None
Cyprus	Some natural
Czech Rep	Salt fluoridation
Denmark	Some natural
Estonia	None
Finland	None
France	Salt and free toothpaste
Germany	Salt fluoridation
Greece	None
Hungary	Artificial public water fluoridation
Iceland	None
Ireland	Artificial public water fluoridation
Italy	Natural fluoridation and free toothpaste
Latvia	Free tablets and toothpaste for children at risk
Liechtenstein	None
Lithuania	None
Luxembourg	None
Malta	Some natural, plus free toothpaste scheme
Netherlands	None
Norway	None
Poland	Some natural
Portugal	Some free toothpaste schemes
Romania	None
Slovakia	Salt fluoridation
Slovenia	Some natural
Spain	Artificial public water fluoridation + natural in Canary Islands
Sweden	Some free toothpaste schemes
Switzerland	Salt fluoridation
UK	Natural and public fluoridation and free toothpaste

Fluoride is a substance which gives protection to tteeth against tooth decay, if ingested in optimal quantities, or applied to the surface of the teeth by means of toothpaste or other methods.

Fluoride may be found naturally at optimal or suboptimal levels in water supplies or in some countries (Hungary, Ireland, Spain and the UK by the addition of fluoride to the water supplies).

Other methods for providing fluoride for systemic ingestion are milk (Bulgaria), tablets (Latvia) and salt (the Czech Republic, France, Germany, Slovakia and Switzerland). Many countries provide free fluoride toothpaste for those at risk of decay, especially children.

Part 5: The Education and Training of Dentists

The content of the education and training necessary, and the titles of qualified dentists, as described in the Dental Directives are in Annexes 5 and 6 of this Manual.

The separate recognition and training of dentists is now a reality in all countries of the EU/EEA. The existence of a class of dentists (often known as stomatologists), who were originally trained as medical doctors is also a historical legacy in Austria, Italy, Spain and Portugal, and most of the Accession countries - but for all of these countries membership of the EU has brought substantial changes in dental education.

Table 4 – Dental schools, numbers of students and gender

Dental schools across the EU/EEA and their students								
	Year	No of schools	Public	Private	Annual intake	Annual graduates	Percentage female	Course duration
Austria	2008	3	3	0	120	119	65%	6 years
Belgium	2007	5	4	1	230	175	80%	5 years
Bulgaria	2008	3	2	1	170	126	50%	5.5 years
Croatia	2008	3	2	1	160	80	67%	5 or 6 yrs
Czech Rep	2007	5	5	0	260	250	38%	5 years
Denmark	2008	2	2	0	160	135	71%	5 years
Estonia	2008	1	1	0	30	30	87%	5 years
Finland	2008	3	3	0	145	81	74%	5 years
France	2008	16	16	0	1,047	900	55%	6 years
Germany	2006	31	30	1	2,547	1,539	60%	5 years
Greece	2008	2	2	0	280	270	62%	5 years
Hungary	2007	4	4	0	255	210	53%	5 years
Iceland	2008	1	1	0	7	6	67%	5 years
Ireland	2008	2	2	0	84	64	60%	5 years
Italy	2008	34	30	4	850	800	30%	5 years
Latvia	2008	1	1	0	35	30	87%	5 years
Lithuania	2006	2	2	0	118	117	74%	5 years
Malta	2007	1	1	0	8	8	50%	5 years
Netherlands	2007	3	3	0	300	226	55%	6 years
Norway	2007	3	2	1	153	110	50%	5 years
Poland	2008	10	10	0	855	809	80%	5 years
Portugal	2007	7	3	4	591	425	59%	5 years
Romania	2008	11	8	3	1,500	1,000	60%	5 years
Slovakia	2008	2	2	0	101	45	60%	6 years
Slovenia	2008	1	1	0	70	49	70%	6 years
Spain	2007	17	12	5	2,842	2,842	70%	5 years
Sweden	2008	4	4	0	247	166	67%	5 years
Switzerland	2007	4	4	0	173	126	45%	5 years
UK	2008	15	15	0	1,063	844	52%	5 years
		196	175	21	14,401	11,582	61%	
			89%	11%				

Dental Schools

Cyprus, Liechtenstein and Luxembourg do not have dental schools and rely on other EU/EEA trained dentists for their workforce.

Across the EU/EEA (including Croatia), all dental undergraduate education and training takes place in universities – usually in Colleges or Faculties of Medicine or Dentistry.

In 2008, there were nearly 200 dental schools in the EU/EEA – from one each in Estonia, Iceland, Latvia, Malta and Slovenia, to 31 or more in Germany and Italy. However, although most were publicly funded, many of these dental schools charged course fees to their students.

Additionally, 11% of schools were privately funded – these were in Belgium, Bulgaria, Croatia, Germany, Italy, Norway, Portugal, Spain and Romania. No public funding supported these institutions.

In 2008, in the dental schools of the EU/EEA, plus Croatia, there were over 70,000 dental students in training. Approximately 12,000 graduate each year (60% female).

In half of EU/EEA countries entrance into dental school is by means of a competitive examination – with a strict *numerus clausus* (restriction) on the numbers. In some countries this examination is at the end of the first year of training. In the remaining countries the results of the secondary school leaving examination or matriculation determine the entry into dental school.

In France, there is (joint) first year training with medicine, and the entrance into the subsequent 5-year dental course follows an end of year competitive examination.

The UK has two "graduate-entry" dental schools with a further one planned for the North of Scotland. Entrants must have a primary degree in biological sciences.

Annually, over 14,000 enter

into dental schools as undergraduates and across the EU/EEA on average about 80% of that number eventually graduate as dentists.

Undergraduate education and training

Mutually recognised diplomas guarantee that, during the complete training programme, the student has acquired:

- adequate knowledge of the sciences on which dentistry is based and a good understanding of scientific methods, including the principles of measuring biological functions, the evaluation of scientifically established facts and the analysis of data;
- adequate knowledge of the constitution, physiology and behaviour of healthy and sick persons as well as the influence of the natural and social environment on the state of health of the human being, insofar as these factors affect dentistry;
- adequate knowledge of the structure and function of the teeth, mouth, jaws and associated tissues, both healthy and diseased, and their relationship to the general state of health, and to the physical and social well-being of the patient;
- adequate knowledge of clinical disciplines and methods, providing the dentist with a coherent picture of anomalies, lesions and diseases of the teeth, mouth, jaws and associated tissues and preventive, diagnostic and therapeutic dentistry;
- Suitable clinical experience under appropriate supervision.

Whilst most teaching takes place in the language of the relevant country, about one third of all EU/EEA countries teach their undergraduates in English for all or part of the curiculuum.

Across the EU/EEA at any one moment there are about 72,000 dental students undergoing basic dental training to become dentists. By 2008 about 60% were female (compared with 52% in 2003).

The duration and content of training

The criteria described below are the minimum training requirements. A Member State may impose additional criteria for qualifications acquired within its territory. It may not, however, impose them on practitioners who have obtained recognised qualifications in another Member State.

Austria	Iceland
Bulgaria*	Netherlands
Croatia**	Slovakia
France	Slovenia

* 5.5 years
** 5 or 6 years, depending upon university

Table 5 – Undergraduate Training greater than 5 years

Duration

A complete period of undergraduate dental training consists of a minimum 5 year full-time course of theoretical and practical instruction given in a university, in a higher-education institution recognised as having equivalent status or under the supervision of a university. However, in the United Kingdom, with graduate entry into dental school dental training is (a minimum of) 4 years in these schools. In 8 countries basic dental training is for more than 5 years.

o be accepted for such training, the candidate must have a diploma or a certificate which entitles him/her to be admitted to the course of study concerned.

Training in specialised dentistry involves a full-time course of a minimum of three years' duration supervised by the competent authorities or bodies.

Such training may be undertaken in a university centre, in a treatment, teaching and research centre or, where appropriate, in a health establishment approved for this purpose by the competent authorities or bodies. The trainee must be individually supervised. Responsibility for this supervision is placed upon the establishments concerned.

Content

The programme of undergraduate studies must include the subjects listed in Annex 5.

Post-qualification education and training

Vocational Training

About half of all EU/EEA countries insist on further post-qualification vocational training (VT) for their new graduates, before they are given full registration, or entitlement to independent practice, or entitlement to participation in the state oral healthcare system as independent clinicians. In some countries this vocational training may be voluntary.

The nature of this VT, where it takes place may vary considerably – it is best to refer to the individual country sections to examine what takes place. However, usually the training of the new graduate takes place in a "sheltered" environment, under the direction or supervision of an experienced dentist. There may, or may not be parallel formal learning, in an educational establishment such as a dental school and there may be a final "completion" examination.

Mandatory vocational training was reported in 2008 in:

	No of mnths		No of mnths
Belgium	12	Lithuania	12
Czech Republic*	36	Poland	12
Denmark	12	Slovakia*	36
Finland	12	Slovenia	12
Germany	24	United Kingdom	12
Latvia	24		

Table 6 – Mandatory Vocational Training

*Mandatory 36 months VT ends in the Czech Republic and Slovakia in 2009

Mandatory CPE	Amount
Austria	Not mandatory
Belgium	Mandatory, 60 hours over 6 years, a minimum of 6 hours in any year
Bulgaria***	Mandatory, 30 hours in 3 years
Croatia***	Mandatory, 7 hours per year
Cyprus	Not mandatory
Czech Republic**	Mandatory, with Certificates of Proficiency (leads to higher payments from health system)
Denmark**	Mandatory from January 2009 – 25 hours annually
Estonia	Not mandatory
France***	Mandatory, at least 800 units (hours) in 5 years, with a minimum of 150 per year
Finland	Not mandatory
Germany**	Mandatory with recertification every 5 years
Greece**	Proposals for mandatory being discussed in 2008
Hungary	Mandatory, 250 hours over 5 years
Iceland	Voluntary scheme only (20 hours a year)
Ireland**	Mandatory from January 2010
Italy***	Mandatory with at least 150 units (hours) within a 3-year period (2008-10), including a minimum of 30 & a maximum of 70 each year.
Latvia	Mandatory, 250 hours over 5 years
Lithuania	Mandatory, 120 hours over 5 years
Luxembourg**	Mandatory – but dentist decides what he needs
Malta	Not mandatory (under discussion)
Netherlands	Not mandatory
Norway	Ethical obligation only
Poland***	Mandatory, 200 points (hours) needed in 4-years
Portugal***	Expected to be mandatory by January 2009 – requirements not yet determined
Romania	Mandatory, 200 hours over 5 years
Slovakia	Mandatory, 250 credits (hours) over 5 years
Slovenia	Mandatory, 75 points/hours (about 10 courses) per 7 years
Spain	Not mandatory
Sweden	Not mandatory
Switzerland	Mandatory, 10 days per year
United Kingdom	Mandatory, 75 hours of formal courses + 175 hours informal, over 5 years – and slightly more for specialists.

*** changed entry since 2004 Manual*
**** new entry since 2004 Manual*

Table 7 – Mandatory Continuing Education

VT is only mandatory for those graduating from their own universities. However, by 2008 the situation in Belgium relating to the need for VT by overseas graduates was confused and awaiting a verdict of the Supreme Court. There were differences depending upon the country of graduation and the nature of the proposed work (whether within or outside the social security reimbursement scheme).

Continuing Education and Training

Every EU and EEA country has at least an ethical obligation for dentists to undertake continuing professional education of some kind – and some arrangements to deliver this.

In 2004 only 10 countries had a mandatory requirement to undertake a minimum amount of such training.

By 2008, this had increased to 17 countries with 3 more introducing the requirement by 2010 and 2 others actively discussing it. So, by the end of the decade it is expected that the majority of countries will have a mandatory continuing education requirement for their dentists.

Specialist Training

Specialists, as defined in the EU Directives, are recognised in most countries of the EU/EEA. Orthodontics and Oral Surgery (or Oral Maxillo-facial Surgery), are the two specialties which are usually recognised, but not in Austria, Luxembourg and Spain, where there is no recognition of specialists. However, in Austria, Belgium, France and Spain, Oral Maxillo-facial Surgery is recognised as a medical specialty (only), under the EU Medical Directives.

Many other specialties have *de facto* recognition in various ways in different countries (for example by formal training programmes), but these may not be formally recognised under the Dental Directives.

Specialist Diplomas and certificates that are mutually recognised are listed in Annexes 7 and 8.

There is no specialist training in Austria, Cyprus, Iceland, Luxembourg, Malta and Spain. See the individual country sections to note the arrangements for training in Cyprus, Iceland and Malta, where specialists are recognised.

European Dental Education

The EU Directorate on Education and Culture funded an innovative pan-European project DentEd, www.dented.org to promote a common approach to dental education across Europe.

Over six years many dental schools in the EU and Accession countries received advice and peer support from visiting teams of dental academics, supported by several international conferences on trends and strands in dental curricula. Work is continuing through the Association for Dental Education in Europe (ADEE) to develop a profile for a graduating dentist from a European dental school. Much of the work undertaken by DentEd and ADEE will link to the need for dental education in Europe to meet the requirements of the Bologna Declaration.

The Bologna Process

The Bologna Process was launched by the Bologna declaration in 1999, where the Education Ministers of some 40 countries (including all EU/EEA countries except Cyprus) expressed the desire to create a European Higher Education Area by 2010. The goal is that it should be easy to move from one country to another within the Area; that European higher education should be made more attractive to non-European prospective students; and that the Area should provide Europe with a broad, high quality and advanced knowledge base.

Amongst the proposals is the adoption of a system essentially based on the splitting of the curriculum into two main cycles – undergraduate (Bachelor) and graduate (Master). Access to the second cycle is intended to require successful completion of first cycle studies, lasting a minimum of three years. The degree awarded after the first cycle would need to be relevant to the European labour market as an appropriate level of qualification. The second cycle should lead to the master and/or doctorate degree as in many European countries. For more information please log on to:
http://ec.europa.eu/education/policies/educ/bologna/bologna.pdf

Part 6: Qualification and Registration

All countries of the EU/EEA require registration with a competent authority – more frequently this authority is separate from the dental association, and may be government appointed.

To legally practise in each country a basic qualification is always required (degree certificates), but a certain amount of vocational experience, evidence of EU citizenship, a letter of recommendation from a dentist's current registering body and sometimes evidence of insurance coverage may be necessary. When examining the situation in a particular country it is important to distinguish legal registration to practise in any capacity (usually with government department or agency, sometimes as a 'licence') from registration with a social security or social insurance scheme. Where registration is with the national dental association or another non-governmental body a private practitioner may also require a 'licence to practice' from a government ministry. Registration with social security or insurance schemes will often depend on different criteria, and may also entail linguistic, contractual as well as ethical obligations.

For details in each country please see the relevant country section of the Manual.

The use of academic titles

Provided that all the conditions relating to training have been fulfilled, holders have the right to use their lawful academic title or, where appropriate, its abbreviation, in the language of the Member State of origin or the State from which they come. Some Member States may require this title to be followed by the name and location of the establishment or examining board which awarded it.

In some cases, the academic title can be confused in the host State with a title for which additional training is necessary. In that event, the host State may require that different, suitable wording be used for the title.

A complete list of titles is in Annex 5.

Specific conditions relating to the right to practise

Good character and good repute

A host Member State which requires from its nationals proof of good character or good repute when they register as a dental practitioner for the first time, must accept as sufficient evidence a certificate issued by a competent authority in the Member State of origin or the State from which the person comes.

Where the Member State of origin or the Member State from which the person comes does not require proof of good character or good repute, the host Member State may ask for an extract from the "judicial record" or, failing this, an equivalent document issued by the appropriate competent authority.

If a host Member State has detailed knowledge of a serious problem which has occurred outside its territory before the person concerned took up residence in that State, it may inform the Member State of origin or the Member State from which the person comes. The aim is to verify whether the problem is likely to affect practice in the host country.

The Member State of origin or the Member State from which the person comes must verify the accuracy of the facts. The authorities in that State decide on the nature and extent of the investigation to be made. They then inform the host Member State of any consequential action which they take about the certificates or documents they have issued. Obviously, the Member States ensure the confidentiality of any information which is forwarded.

Language

Directive 2005/36 does not alter the existing law, whereby individuals moving under either the sectoral or general systems Directives cannot be required to take a language test as a condition of registration in the host member state.

The survey carried out for this manual seems to indicate that some countries are not following the Directive and are continuing with language testing prior to registration.

Member States may require migrants to have the knowledge of languages necessary for practising the profession. So, for example an employer (such as an NHS system) can insist on the necessary language skills prior to registration with the employing authority. But, this provision must be applied proportionately, which rules out the systematic imposition of language tests before a professional activity can be practised.

Some countries have acknowledged the discrepancy between their own laws and the Directive by pointing out that their law is being amended or tested in their courts.

Serious professional misconduct and criminal penalties

The same procedure is followed in the case of serious professional misconduct and conviction for criminal offences. In that event, the Member State of origin or from which the person comes must forward to the host Member State all the necessary information about any disciplinary action which has been taken against the practitioner concerned, or criminal penalties imposed on him/her.

If, for its part, the host Member State has detailed knowledge of a serious problem before registration, it may inform the Member State of origin or the Member State from which the person came. The procedure, which then follows, is the same as that which governs good character and good repute.

Physical or mental health

Some Member States require dentists wishing to practise to present a certificate of physical or mental health. Where a host Member State requires such a document from its own nationals, it must accept as sufficient evidence the

document required in the Member State of origin or the Member State from which the person comes.

Where the Member State of origin or from which the person comes does not require a document of this nature, the host Member State must accept a certificate issued by a competent authority in that State, provided that it corresponds to the certificates issued by the host Member State.

Duration of the authorising procedure

The procedure for authorising the person concerned to work as a dental practitioner must be completed as soon as possible and not later than three months after presentation of all the documents, unless there is an appeal against any unsuccessful application.

Alternative to taking an oath

If there are any doubts about the good character, good repute, disciplinary action, criminal penalties, or physical or mental health of the applicant, a request for re-examination may be made which suspends the period laid down for the authorisation procedure. The Member State consulted must give its reply within three months. On receipt of the reply or at the end of the period, the authorisation procedure is resumed.

Some Member States require their nationals to take an oath or make a solemn declaration in order to practice. Where such oaths or declarations are inappropriate for the individual, the host Member States must ensure that an appropriate and equivalent form of oath or declaration is offered to the person concerned.

		REGULATION OF THE DENTAL WORKFORCE 2008		
		Dentists		
		Name of regulator	Cost (2008)	
Austria		Austrian Dental Chamber via their regional organisations	% of income	
Belgium		Federal Ministry of Health	€550 pa	
Bulgaria		Bulgarian Dental Association by means of its Regional Colleges.	€51 pa	
Croatia		Croatian Dental Chamber	Data not given	
Cyprus		Cyprus Dental Council & Cyprus Dental Association	€34.17 + €120 pa	
Czech Rep		Czech Dental Chamber and the Regional Authority*	Included in annual sub	
Denmark		National Board of Health (and the DDA)*	Data not given	
Estonia		Healthcare Board/General Dental Council, within the Commission for Licence	€65 pa	
Finland		National Authority for Medicolegal Affairs	€300 pa	
France		Ordre National	€354 pa	
Germany		Kassenzahnärztliche Vereinigungen (KZV)	Included in annual sub	
Greece		Ministry of Health and Social Solidarity and Regional Dental Society	Variable according to region	
Hungary		Ministry of Health	No fee	
Iceland		The Ministry of Health and Social Security	Data not given	
Ireland		Irish Dental Council	€150 pa	
Italy		Federazione Ordini dei Medici Chirurghi e degli Odontoiatri	Variable according to region	
Latvia		Pauls Stradins' Clinical University Hospital	None	
Liechtenstein		Amt für Gesundheitsdienste, a public authority	€620 pa	
Lithuania		The Licensing Committee at the Lithuanian Dental Chamber	€17 and then €43.50 pa	
Luxembourg		Ministry of Health	€200 pa	
Malta		Medical Council. Until 2011 overseas dentists need a work permit.	€35 pa	
Netherlands		Ministry of Public Health Welfare & Sport - also, the BIG register	€80 pa	
Norway		Norwegian Registration Authority for Health Personnel	€116 pa	
Poland		The Regional Chamber of Physicians and Dentists (Okregowa Izba Lekarska).	None	
Portugal		The Ordem dos Médicos Dentistas (OMD)	Variable, €250 to €1,000	
Romania		Romanian Collegiums of Dental Physicians	Only initially	
Slovakia		The Slovak Chamber of Dentists	€ 15	
Slovenia		The Medical Chamber of Slovenia	€ 70	
Spain		Regional colegios (central list held at Consejo General in Madrid)	Variable (€216 - €600 pa)	
Sweden		National Board of Health and Welfare unit for Qualification and Education	€ 64	
Switzerland		Federal Board but registers kept by each of the 26 Cantonal authorities	No fee	
UK		General Dental Council	€550 pa	
		* Dentists qualified outside the CR must register (free) with the Ministry of Health		
		* Registration with the DDA is not necessary to work as a salaried assistant		

Table 8 - Regulation of dentists (2008)

Part 7: Dental Workforce

The dental workforce provides oral healthcare and includes dentists, clinical dental auxiliaries and other dental auxiliaries. In some countries stomatologists or odontologists still exist (for a description of these two classes(see below).

In all countries, whatever classes of dental auxiliaries exist, most oral healthcare is provided by dentists. As described in Part 2, the description of what a dentist may provide is regulated by the Dental Directives and EU countries do not have the ability to enact laws which amend this. However, the regulations relating to dental auxiliaries are less circumscribed. So, the permitted duties of such as dental chairside assistants (nurses), hygienists, therapists and clinical dental technicians may vary from country to country. However, in all countries, dental technicians do not provide services directly to patients, except for the provision of repairs to prosthodontic appliances which do not need intervention orally (see dental auxiliaries).

Dentists

The numbers of dentists in each country is known as in every one there is a legal requirement to register with a competent authority.

Table 9 - Numbers of dentists

	Year of data	Population	Number Registered	Female	Number Active	Female
Austria	2008	8,331,930	4,501	39%	4,206	39%
Belgium	2007	10,666,866	8,423	48%	7,576	48%
Bulgaria	2005	7,640,238	7,987	66%	7,987	66%
Croatia	2007	4,435,383	4,137	65%	3,500	65%
Cyprus	2008	794,580	1,018	47%	728	65%
Czech Rep	2007	10,381,130	8,146	65%	7,048	65%
Denmark	2008	5,475,791	7,298	50%	4,800	83%
Estonia	2008	1,340,935	1,358	87%	1,220	87%
Finland	2007	5,300,484	5,866	69%	4,500	69%
France	2008	63,753,140	40,968	37%	40,968	37%
Germany	2008	82,221,808	83,339	39%	65,929	39%
Greece	2008	11,214,992	14,126	46%	14,126	46%
Hungary	2008	10,045,000	5,500	57%	4,973	57%
Iceland	2008	314,321	360	35%	284	35%
Ireland	2008	4,419,859	2,578	33%	1,990	33%
Italy	2007	59,618,114	54,190	34%	48,000	34%
Latvia	2008	2,270,894	1,457	88%	1,372	88%
Liecht'stein	2008	35,365	41		41	
Lithuania	2008	3,366,357	3,010	83%	3,010	83%
Luxemb'rg	2008	483,799	363	30%	360	30%
Malta	2008	410,584	176	25%	135	25%
Nethlds	2008	16,404,282	10,901	28%	8,791	28%
Norway	2006	4,737,171	5,735	45%	4,300	45%
Poland	2008	38,115,641	29,947	78%	21,750	78%
Portugal	2008	10,617,575	7,514	53%	7,064	53%
Romania	2008	21,528,627	14,000	68%	13,687	68%
Slovakia	2007	5,400,998	3,185	61%	3,085	61%
Slovenia	2008	2,025,866	1,637	63%	1,296	63%
Spain	2008	45,283,259	24,515	53%	24,000	53%
Sweden	2005	9,182,927	14,355	49%	7,414	49%
Switz'land	2008	7,591,414	4,500	22%	4,500	22%
UK	2008	61,185,981	35,873	40%	31,000	40%
EU/EEA Totals		**514,595,311**	**407,004**		**349,640**	46%

In France, Liechtenstein, Luxembourg & Switzerland the numbers of registered and "active" dentists are deemed the same

Despite the continued increase in the numbers, across the EU, many dental associations report that the geographical distribution remains uneven, with people in rural areas often having large distances to travel to the nearest service. Formal incentive schemes are rare, and more commonly a rural community will create an opportunity itself to attract a dentist.

Also, in some countries, for example Germany, there are geographical manpower controls, using incentives for setting up new practices.

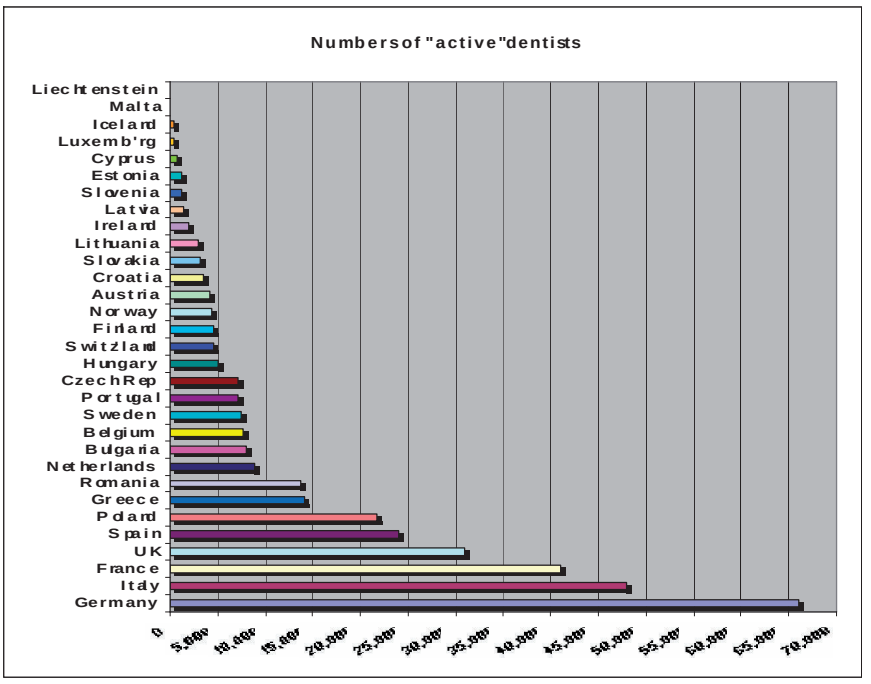
The total number of registered dentists in the EU/EEA including Croatia in 2008 was about 400,000.

The number of "active dentists"

"Active dentists" refers to dentists who remain on their country's register or other such list of dentists who practise in a clinic, general practice, hospital department, administrative office or university. The difference between the number of dentists in a country and the "active dentists" should represent those dentists who are retired or no longer undertake any form of dentistry including administrative dentistry.

Some countries are unable to assess how many of these dentists are "active", so accurate figures for the number of such dentists are difficult to assess. But, from the information provided we estimate that about 345,000 dentists were "active" in 2008.

Chart 10 – the number of "active dentists" in each country



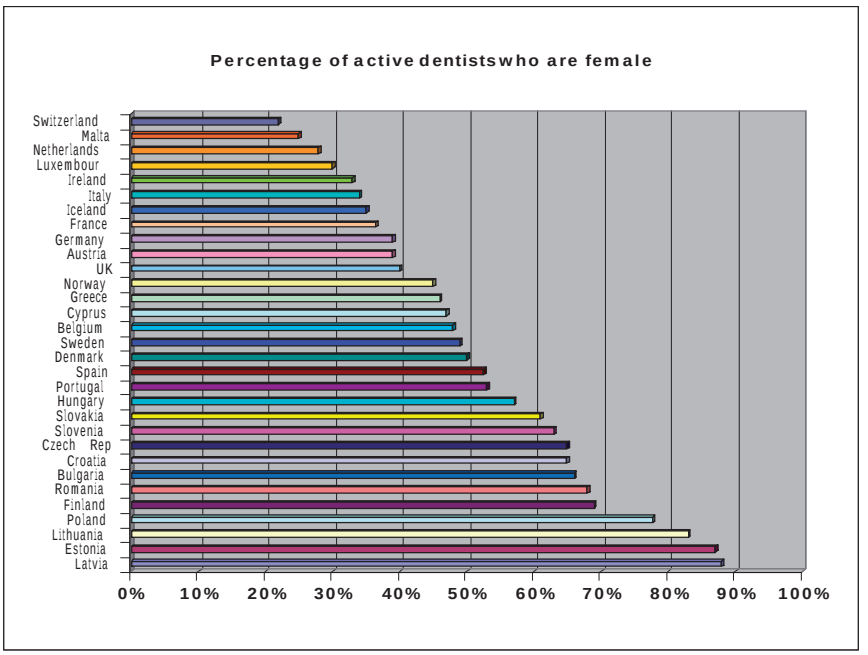
The Gender Mix of Practising Dentists

Table 10 - Gender of dentists

	Proportion of female dentists (active)					
Latvia	88%		Hungary	57%	Germany	39%
Estonia	87%		Portugal	53%	France	37%
Lithuania	83%		Spain	53%	Iceland	35%
Poland	78%		Denmark	50%	Italy	34%
Finland	69%		Sweden	49%	Ireland	33%
Romania	68%		Belgium	48%	Luxemb'rg	30%
Bulgaria	66%		Cyprus	47%	Nethlds	28%
Czech Rep	65%		Greece	46%	Malta	25%
Croatia	65%		Norway	45%	Switz'land	22%
Slovenia	63%		UK	40%		
Slovakia	61%		Austria	39%		

The change of gender balance in some countries, with the increase in proportion of female dentists who historically are said to be unable to work for as many hours as males, also alters the measure of whole-time working equivalence of the total number of dentists, even with the increased total numbers.

Across the EU/EEA just under half of active dentists are female, but with wide variations. Generally, but not exceptionally, countries with strong public dental services (the Eastern European and Nordic countries) had higher numbers of female dentists – nearly 90% in Latvia – down to 22% in Switzerland.



However, the trend is very much to an increase of females as a proportion of the dentist population. In the five years since the figures were last measured there have been marked increases in several countries. For example, the proportion of females is up by one third in the UK and by a quarter in Denmark, Norway and Spain.

Chart 11 – the gender of "active dentists" in each country

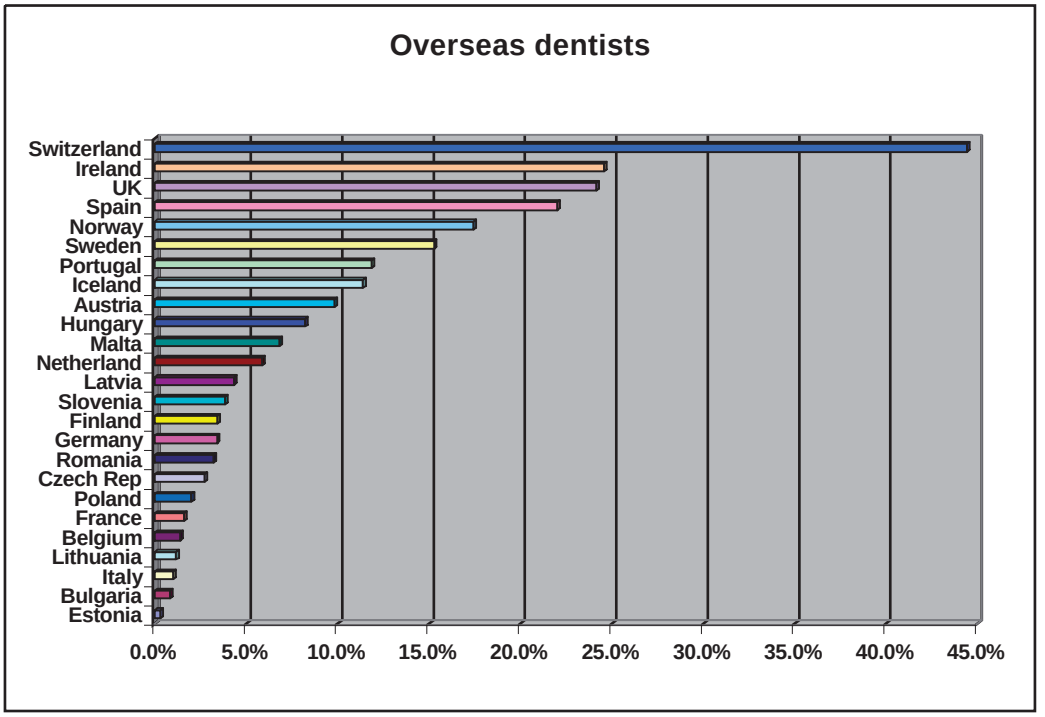
Overseas dentists

This expression refers to dentists who have received their primary dental qualification in any country other than the listed (host) country, even if they are nationals of that country. A dentist who is not a national of the country, but has qualified in that country is an "overseas dentist" for the purpose of this Manual.

The harmonisation of qualifications and the introduction of "Acquired Rights" has made travel between EU/EEA countries for the purposes of working as a dentists much easier.

We have examined countries' reports of the numbers of overseas dentists working within their borders:

Chart 12 – the proportion of "overseas dentists" in each country



No figures were submitted for Croatia, Denmark, Greece and Slovakia. Three countries – Cyprus, Liechtenstein and Luxembourg do not have their own dental schools, so by definition all dentists practising there qualified abroad and are not shown.

Unemployment

Dentists are more likely to move to other countries than the one they graduated in, if they are unable to find work as a dentist. It is likely that in every country some short-term unemployment is possible, perhaps for days or weeks, immediately upon qualification or completion of vocational training, unless the new dentist is prepared to move away from the area of the dental school.

In 2003 ten countries reported longer-term unemployment for dentists, but this had fallen to only four by 2008 (Finland, Germany, Greece and Italy), and also Croatia.

Specialists

Table 11 - Types of specialties, and numbers in each

(nb: endodontics and periodontics are often combined as one specialty, so the numbers shown for some countries may actually be combined)

	Year	Orthodontists	OS	OMFS	Endo	Paedo	Perio	Prostho	DPH	Others
Austria	2004	0		120						
Belgium	2007	380		290			95			
Bulgaria	2005	35	226	45	417	577	31	115	17	Yes
Croatia	2008	160	98		93	145	94	145		Yes
Cyprus	2008	40	13							
Czech Rep	2007	299		70						
Denmark	2008	258		91						
Estonia	2008	52		22						Yes
Finland	2007	149	85		3	86	2	144	105	Yes
France	2008	1,937								
Germany	2007	3,309	2,048				40		480	
Greece	2007	396		174						
Hungary	2008	268	43	208		285	40	NK		
Iceland	2008	10	3		2	4	10	4	4	Yes
Ireland	2008	110	35	5						
Italy	2007	1,900		640						
Latvia	2008	17	0	34	5	21	6	16		
Liechtenstein	2008	2	2				1			
Lithuania	2008	73	75	23	31	56	35	285		
Luxembourg	2007									
Malta	2008	7		1	1	2	2	1	2	Yes
Netherlands	2008	261		214	60	40	80			
Norway	2008	192	59	0	40	18	74	46		Yes
Poland	2008	1,078	713	260	1,622	478	369	1,441	71	
Portugal	2007	38	4	90						
Romania	2008	412	157	234						
Slovakia	2007	198	89	26		74	95	64		
Slovenia	2008	106	28	28	20	50	33	47		
Spain	2004									
Sweden	2005	255	0	143	42	85	105	117		Yes
Switzerland	2007	260	154				102	61		
UK	2008	1,158	768	220	187	224	280	377	116	Yes
		13,360	4,600	2,938						

- Orthodontics and Oral Surgery/Oral Maxillo-facial (OS and OMFS) are the two specialties which are recognised formally in some way by almost all of the EU/EEA countries described (the names, diplomas or other specialist qualifications recognised in each country are listed above and more fully in Annex 5).
- Many other specialties have national recognition in various ways (for example formal training, dental school departments) in different countries, but may not be formally recognised under the EU Dental Directive.
- In many countries Maxillo-facial Surgery is treated as a medical rather than a dental specialty (see above).

Austria, Spain and Luxembourg do not recognise the concept of specialisms. In Austria, it is possible to train in any of the 3 universities in the "subspecialty" of oral surgery through a further 3 years education (officially, oral surgery still is a sub-speciality of medicine).

In most countries patients may access specialists directly, without the need to go via a primary care dentist. However, in Estonia, Ireland, Italy, Latvia, Portugal, Slovenia, Sweden and the UK a referral from a primary care dentist is necessary first.

Dental Auxiliaries

There is a wide variation across Europe in the regulations concerning an auxiliary's ability to work in the patient's mouth, and their level of independence from the instructions and supervision of a dentist. Considerable international variation exists in the level of training required, and the obligation to register with an association or other body. Additionally, in the Netherlands, Dental Hygienists are not legally dental auxiliaries, as they form an independent profession.

Table 12 illustrates the considerable variation in the level of recognition of dental auxiliaries. Generally, in those countries where the dominant form of practice is dentists working alone in independent or liberal practice there is less reliance on other dental professionals.

Dental Hygienists

There are Dental Hygienists in most countries (23), although they do not need to register in 6 countries (Cyprus, the Czech Republic, Italy, Lithuania, the Netherlands and Poland). Slovenia has had hygienists since 2005, although there are no plans for registration of them.

Qualification nearly always leads to a diploma or degree, with which the hygienist has to register with a competent authority in most countries. Hygienist training in most countries with such training is for 2 or 3 years, but in Hungary one year only is necessary. Conversely, in the Netherlands, Lithuania and the UK training may be for up to 4 years.

There are varying rules within the different countries relating to the degree of supervision of hygienists, and the duties they may perform. Many countries allow their hygienists to diagnose and treatment plan. Please refer to the individual country sections to check the varying rules.

Dental Technicians

Dental Technicians, who provide laboratory technical services, are recognised in all countries. Formal training is offered in all but two countries (Luxembourg and Cyprus) and takes place in special schools. The training is for a variable number years (2 to 5). In 22 countries they must be registered to provide services.

Dental technicians normally provide services to dentists, only, although in most countries they are permitted to repair dental appliances directly for patients, provided they do not need to take impressions or otherwise work in the mouth

Clinical Dental Technicians

Only 5 countries (Denmark, Finland, the Netherlands, the UK and Switzerland in some cantons)[7] allow Clinical Dental Technicians or Denturists who may provide oral health services – specifically full (complete) or partial dentures - directly to the public. This means that they are trained to work inside the mouths of patients. The United Kingdom introduced this class of auxiliary only in 2007.

Training generally takes place in special schools, sometimes – but not always - associated with the dental schools. The training is for one or two years, often following prior training as a dental chairside assistant or dental technician.

Dental Assistants

In all countries, dentists have staff variously called *dental surgery assistants*, *dental nurses*, or *dental chairside assistants*, or *dental receptionists* who may assist with chairside duties. However, the development is not as great in some countries (Belgium, Greece and Portugal) where most dentists work without the help of another person at the chairside, and Cyprus, France, Lithuania and Poland less than half of dentists work with such help.

In about half of the countries there is a dental assistant or nursing qualification available, and in half of these there is a registerable qualification, which the assistant may have to have to work with the dentist.

Dental Therapists

In a few European countries there is formal recognition of another type of clinically operating auxiliary – Dental Therapists, who provide limited clinical conservation and exodontia services (Sweden, Switzerland and the United Kingdom) and Orthodontic Auxiliaries (Sweden and the UK). Again, like hygienists, there are different rules about the duties they may perform and the degree of supervision they may need.

In Latvia, therapists were trained in the 1960s, but few remain in practice and further training has not taken place for many years.

Other Auxiliaries

Many countries permit dental nurses to provide oral health education to patients, or have a formal class of auxiliary (without registration) to provide this service.

[7] *Romania report having hygienists and denturists but have not provided any further information*

Table 12 - Types of auxiliary recognised in each country

Country	Dental Hygienist (formal training is always necessary)	Dental technician (formal training is always available)	Denturist/ Clinical Dental Technician (formal training is always necessary)	Dental chairside assistant (DCA) or nurse	Other
Austria		R		F	Some DCAs specialise in oral health prevention
Belgium		R		NFT	
Bulgaria		R		NFT	
Croatia		N		NFT	
Cyprus	N	R**		NFT	
Czech Republic	N	N		F	
Denmark	R	N	R	F	Hygienists may work without supervision
Estonia		R		F/R	There are some registered Dental Therapists, trained in the 1950s (26 in 2008).
Finland	R	R	R	F/R	
France		N		F	
Germany	R	R		F/R	Also have specialised dental nurses (ZMF/ZMP/ZMV)
Greece		R		F/R	
Hungary	N	R		F/R	
Iceland	R**	R		F/R	
Ireland	R	N		F	There are also Oral Health Educators (who do not need to be registered).
Italy	N	R		F	
Latvia	R	R		F/R	There are some registered Dental Therapists, trained in the 1960s, who work with children, only
Liechtenstein	R**	R**		NFT	
Lithuania	R	R		F/R	
Luxembourg		N		NFT	
Malta	R	R		NFT	
Netherlands	N	N	R	F	Hygienists and CDTs are independent professions (and are not auxiliaries)
Norway	R	R		F/R	
Poland	N	N		NFT	
Portugal	R	R		NFT	
Romania***		R		F/R	
Slovakia	R	R		F/R	
Slovenia	N	R		NFT	
Spain	R	N		NFT	Technician registration is mandatory in some regions
Sweden	R	R		F/N	There are registered orthodontic operating auxiliaries
Switzerland	R	R	R	F/N	There are Registered Dental Therapists and Denturists in some cantons
United Kingdom	R	R	R	F/R	There are Registered Dental and Orthodontic Therapists, Expanded Duties Dental Nurses There are also Oral Health Educators (who do not need to be registered).

*** formal training must take place outside the country*

R = Registration with a competent authority necessary (always following formal training and qualification)
N = No registration necessary to work
NFT = No formal training necessary
F = Formal training available
Blank cell indicates that this class of dental auxiliary is not recognised

Table 13 - Regulators of dental auxiliaries

	Name of regulator
Austria	Local trade federations
Belgium	No auxiliaries
Bulgaria	Technicians: Ministry of Health
Croatia	No registration
Cyprus	Technicians must register with the Dental Technicians' Council
Czech Rep	No registration
Denmark	Hygienists and denturists only: National Board of Health
Estonia	Healthcare Board/General Dental Council (technicians and nurses)
Finland	All auxiliaries (including Assistants) - the National Authority for Medicolegal Affairs
France	No registration
Germany	Kassenzahnärztliche Vereinigungen (KZV) - dental hygienists and assistants
Greece	Technicians must register with the Ministry of Health and Welfare
Hungary	Master technicians by the regional Chambers of Industry**
Iceland	Hygienists: Ministry of Health, Technicans: Ministry of Industry, Assistants: Chief Medical Officer
Ireland	Hygienists: Irish Dental Council
Italy	Technicians have to be registered with the *Camera di Commercio* of each Province
Latvia	Pauls Stradins' Clinical University Hospital Centre of Dentistry
Liechtenstein	Hygienists and technicians register with the public *Berufsbildungsamt* (no fee).
Lithuania	The Licensing Committee at the Lithuanian Dental Chamber
Luxembourg	Only a diploma allows a qualified technician to own a dental laboratory.
Malta	Hygienists and technicians: Board for Professions Supplementary to Medicine
Netherlands	No registration necessary.
Norway	All auxiliaries (including Assistants) - the Registration Authority for Health Personnel
Poland	Register planned - but none in 2008
Portugal	Hygienists and technicians must register with the Ministry of Health
Romania	Dental Technicians must register with the Romanian Order of Dental Technicians
Slovakia	The Association of Dental Hygienists and the Slovak Chamber of Dental Technicians
Slovenia	Only technicians must register (with the Economy Chamber)
Spain	Voluntary registration at regional colegios (some becoming mandatory)
Sweden	National Board of Health and Welfare (hygienists and technicians)
Switzerland	Hygienists: professional education department of the Swiss Red Cross***
UK	General Dental Council
* only those technicians who run a laboratory register (with the dental technicians' guild)	
** Entrepreneurial technicians running a private firm - by the Court of Registration	
*** registration of technicians (and CDTs) varies across cantons.	
*** Therapists are SSO-trained and are also registered with the Association	

Continuing education for dental auxiliaries

Dental auxiliaries are required to undertake continuing education in Latvia, Lithuania, Slovakia and the United Kingdom.

Numbers of dental auxiliaries

In Part 4 (Healthcare and Oral Healthcare) we discussed the use of dental auxiliaries and the (perceived) effect of clinical auxiliaries on the Population per Dentist ratio. This effect is very subjective as even the use of non-clinical auxiliaries such as dental chairside assistants (dental nurses), dental technicians and oral health educators may improve the provision of healthcare whre they are employed – as this will release time for clinical workers to provide intra-oral care.

Table 14 – The numbers of dental auxiliaries

	DENTISTS			DENTAL AUXILIARIES										
	Year of data	Dent:Pop Ratio (active)	Any un-emplyd	Hygien-ists	Techs	CDTs	Assist-ants	Thera-pists	Others	F/T equiv at 0.43	Equivalent Workforce	Equivalent Pop Ratio	Active Dents per technician
Austria	2008	1,981	No	350	550	0	7,100	0	0	151	4,357	1,913	8
Belgium	2007	1,408	No	0	2,250	0	1,500	0	0	0	7,576	1,408	3
Bulgaria	2005	957	No	1,000	1,200	0	No data	0	0	430	8,417	908	7
Croatia	2007	1,267	Yes	0	1,200	0	No data	0	0	0	3,500	1,267	3
Cyprus	2008	1,091	No	338	200	0	340	0	0	145	873	910	4
Czech Rep	2007	1,473	No	200	4,500	0	7,000	0	0	86	7,134	1,455	2
Denmark	2008	1,141	No	800	1,100	565	4,400	0		587	5,387	1,016	4
Estonia	2008	1,099	No	2	137	0	1,644	0	26	1	1,221	1,098	9
Finland	2007	1,178	Yes	1,575	567	331	6,168	0	0	820	5,320	996	9
France	2008	1,556	No	0	19,500	0	15,000	0	0	0	40,968	1,556	2
Germany	2008	1,247	Yes	350	58,000	0	170,000	0	0	151	66,080	1,244	1
Greece	2008	794	Yes	0	5,000	0	0	0	0	0	14,126	794	3
Hungary	2008	2,020	No	1,000	3,000	0	4,668	0	0	430	5,403	1,859	2
Iceland	2008	1,107	No	30	125	0	304	0	0	13	297	1,059	2
Ireland	2008	2,221	No	338	350	0	1,800	0	0	145	2,135	2,070	6
Italy	2007	1,242	Yes	4,000	11,520	0	52,000	0		1,720	49,720	1,199	4
Latvia	2008	1,655	No	150	536	0	1,267	0	0	65	1,437	1,581	3
Liecht'stein	2008	863	0	5	14	0	80	0		2	43	820	3
Lithuania	2008	1,118	No	261	923	0	1,722	0	0	112	3,122	1,078	3
Luxemb'rg	2008	1,344	No	0	75	0	330	0	0	0	360	1,344	5
Malta	2008	3,041	No	17	34	0	75	0	0	7	142	2,885	4
Nethlds	2008	1,866	No	2,260	5,000	290	16,400	0	0	1,097	9,888	1,659	2
Norway	2006	1,102	No	812	708	0	3,112	0	0	349	4,649	1,019	6
Poland	2008	1,752	No	2,500	7,000	0	9,725	0	0	1,075	22,825	1,670	3
Portugal	2008	1,503	No	500	546	0	3,400	0	0	215	7,279	1,459	13
Romania	2008	1,573	No	100	6,000	8	6,000	0	0	46	13,733	1,568	2
Slovakia	2007	1,751	No	148	1,461	0	4,000	0	0	64	3,149	1,715	2
Slovenia	2008	1,563	No	15	759	0	1,275	0	0	6	1,382	1,555	2
Spain	2008	1,887	No	9,000	7,500	0	25,000	0	0	3,870	27,870	1,625	3
Sweden	2005	1,239	No	3,194	1,200	0	11,274	0	360	1,373	8,787	1,045	6
Switz'land	2008	1,687	No	1,500	2,200	60	5,500	250	0	778	5,278	1,438	2
UK	2008	1,974	Yes	5,340	7,094	93	40,665	1,154	10	2,832	33,832	1,809	4
EU/EEA Totals		1,472		35,785	150,189	1,347	401,749	1,404	396		366,210	1,485	
Total number of dentists			**407,004**										
Total number of auxiliaries			**590,870**										
Total number of dental workers			**997,874**										

From the figures in Table 14, in can be seen that the recorded dental workforce is just under one million workers. Adding in the workers not recorded here, such as cleaners, managers and those work in the dental trade, it is more than likely that over a million people directly derive their employment from dentistry in the EU/EEA.

Part 8: Dental Practice in the EU

Although countries in Europe exhibit many wide variations in how general health care is provided (for example, in terms hospital ownership, manpower structure, and the balance between primary and secondary care), the provision of dental care, in most countries, is dominated by non-salaried practitioners, working from privately owned premises ("private" or "liberal" or "general" practitioners). Over most of the EU/EEA these represent nearly 90% of practising dentists, with several countries (Belgium, Iceland, Luxembourg, Malta and Portugal) reporting virtually 100% of clinical dentistry being provided this way.

Proportion of active dentists who are in General Practice			
Sweden	44%	Belgium	90%
Finland	51%	Switzerland	90%
Slovenia	60%	Latvia	90%
Norway	68%	Hungary	81%
Denmark	70%	Spain	92%
Ireland	70%	Italy	93%
Lithuania	74%	Poland	93%
Greece	77%	Cyprus	94%
UK	77%	Estonia	94%
Malta	80%	Portugal	95%
Slovakia	83%	Germany	96%
Croatia	85%	Bulgaria	96%
Netherlands	85%	Romania	97%
Czech Rep	87%	Iceland	100%
France	87%	Luxembourg	100%
Austria	88%	Liechtenstein	100%
Total for the EU/EEA			89%

Table 15 - Percentage of dentists who are practising in general practice (source: the dental associations)

Only in countries where there is a large, publicly-funded dental service is the numerical dominance of the general practitioner less pronounced. Even so, since the public dental services are usually dedicated to providing care to special groups such as children, private practitioners are without a doubt the main, and often the only, provider of care to the adult population.

Liberal (General) Practice

The methods of establishing a liberal or general practice are similar across Europe, with most younger dentists employed as associates or assistants before they can afford to buy their own practice. However, in countries where solo private practice dominates (for example, France, Belgium and Norway) starting positions as associates or junior partners are very difficult to obtain. Government incentive schemes, usually to persuade dentists to set up in sparsely populated areas are also very rare.

Most dentists, as with any other business, have to take out commercial loans in order to purchase a practice. By buying an existing practice they usually buy a list of patients as well.

Many countries have some regulations which govern the location of premises where dentists may practise but usually there are only general planning requirements.

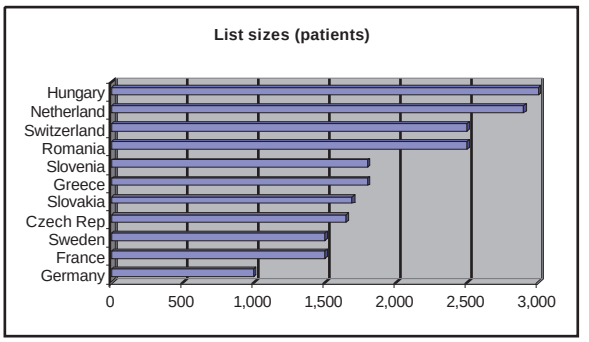
Generally, across Europe dentistry in general practice is carried out as small businesses, with only one, two or a few dentists practising together (in Greece, it is only since 2001 that dentists can share a clinic or dental chair). However, in most countries corporate practice is permitted (see Chapter 9 – Professional Matters) and so there are large, multi-dentist group practices – for example in the United Kingdom one company owns over 250 practices, employing several hundred dentists.

Dental associations report that premises for practices tend to be in converted houses or apartments, or converted public clinics (several of the new members of the EU report this). Shopping malls do not seem to be popular in Europe, for dental practices.

List Sizes

In many countries dental practices maintain a "list" of regularly attending patients. Sometimes this list is recorded by the National Health Service or social insurance scheme. However, only a few dental associations are able to estimate the average size of their dentists' lists as there are too many variables to affect the average:

Chart 13 – Dental practices "list" sizes



Public Dental Services

For the purposes of the description of the delivery of healthcare outside liberal (general) or private practice, we describe this as Public Dental Services. However, this is not strictly accurate as the boundaries between self-employed/salaried dentists, and privately owned/publicly owned facilities have become blurred in recent years.

So, there are salaried dentists in private practice - usually as assistants or associates to the practice owner, although

these may be paid by the state, by way of such as vocational training. In the same way, whilst most liberal dentists own or rent their premises from the private sector, in some countries (for example, Estonia) they may be renting the facility from the local health authority or municipality – which may even be supplying the auxiliary staff, equipment and materials.

Table 16 –Dentists working in public dental services

		PUBLIC CLINIC DENTISTS						
	Year of data	Population	No of Active Dentists	Public clinic dentists	Univer-sity* dentists	Hospital dentists	Armed Forces dentists	Other dentists
Austria	2008	8,331,930	4,206	396	106	120	0	
Belgium	2007	10,666,866	7,576	0	200	0	10	
Bulgaria	2005	7,640,238	7,987	0	258	35	48	70
Croatia	2007	4,435,383	3,500	446	137	No data	No data	33
Cyprus	2008	794,580	728	40		0	7	0
Czech Rep	2007	10,381,130	7,048	0	309	30	35	
Denmark	2008	5,475,791	4,800	1,200	142	63	55	
Estonia	2008	1,340,935	1,220		35	35	0	0
Finland	2007	5,300,484	4,500	2,135	136	72	10	
France	2008	63,753,140	40,968	2,389	276	250	42	
Germany	2008	82,221,808	65,929	450	2,000	200	450	
Greece	2008	11,214,992	14,126	934	226	578	73	
Hungary	2008	10,045,000	4,973	40	200	40	80	
Iceland	2008	314,321	284					
Ireland	2008	4,419,859	1,990	360	34	36	8	
Italy	2007	59,618,114	48,000	2,200	400	300	100	
Latvia	2008	2,270,894	1,372	65	33	31	6	
Liechtenstein	2008	35,365	41	0	0	0	0	
Lithuania	2008	3,366,357	3,010	538	80	0	16	
Luxembourg	2008	483,799	360					
Malta	2008	410,584	135	23	20	17	0	
Netherlands	2008	16,404,282	8,791	250	180	214	50	
Norway	2006	4,737,171	4,300	1,090	234	35	23	
Poland	2008	38,115,641	21,750	500	400	150	400	
Portugal	2008	10,617,575	7,064	43	200	90	31	
Romania	2008	21,528,627	13,687	1,200	950	234	80	
Slovakia	2007	5,400,998	3,085	622	93	29	24	
Slovenia	2008	2,025,866	1,296	514	21	21	0	
Spain	2008	45,283,259	24,000	1,251	800	340	340	
Sweden	2005	9,182,927	7,414	4,124	263	150	2	
Switzerland	2008	7,591,414	4,500	180	240	30	0	
UK	2008	61,185,981	31,000	1,800	400	2,000	210	250
			349,640	22,790	8,373	5,100	2,100	353
				6.5%	2.4%	1.5%	0.6%	0.1%
Proportion of total workforce:			11.1%					
* For the purpose of this table, this includes private universities								
Bulgaria, Lithuania, Romania and Swizerland: "active" means registered dentists								

Overall, about 11% of dentists in the EU/EEA work in public dental service clinics.

In some countries, the term "Public Dental Services" also applied to liberal practitioners working within the NHS system of that country. For the purposes of the description in this section of the Manual, this term is being applied to those who work in (usually) salaried practice, in state or social insurance funded facilities (clinics and non-private hospitals), within any state system or social insurance fund.

Public Clinics

Most countries have some form of state service operating from publicly funded clinics. The "culture" of dentistry provided from publicly funded clinics is especially strong in the Nordic and Baltic countries, where, with the exception of Estonia a large proportion of active dentists work in them.

There are no public clinics in 8 countries; and, in many countries dentists only work part-time in such clinics – either because they are females who stay home to look after their young families, or because low salaries mean that they also work part-time in private practice.

Table 17 - Countries without public clinics

Belgium	Estonia
Bulgaria	Iceland
Croatia	Liechtenstein
Czech Republic	Luxembourg

The common services provided by most of the countries with these clinics will include emergency care, domiciliary care, dental public health support, preventive services and postgraduate training. These services are available to all citizens and often without charges. However, in just over half the countries, general dental care may also be available to certain classes of patients – such as the under-18s, the elderly, medically compromised patients and low income adults. These services also are often provided without charges.

Hospital Dental Services

As said above, the strict definition of what is a hospital is not uniform across Europe. But, for the purposes of this section we are looking at premises which have facilities for patients undertaking general medical care to receive services for acute or chronic care, either as in-patients for one or more nights, and as out-patients. Dental schools without these facilities are not part of this review.

All countries have hospitals which provide services for trauma, oral maxillo-facial surgery and pathological services. Most also undertake postgraduate training for potential surgeons. There are state-funded facilities in every country, and some also have private hospitals which provide some care. The practitioners involved in providing the care are usually salaried in public hospitals – but in most countries they are also able to work additional hours in private practice.

Whether these services are provided as part of oral healthcare or medical healthcare depends upon individual countries. Apart from Iceland and Luxembourg salaried personnel are available for this provision, and there is often no charge for it.

In most countries there is provision for emergency dental treatment for in-patients, but this is often provided by local general practitioners. However, in six countries general dental care is provided for patients who are not in hospital – often as part of specialist services. These countries are Cyprus, Ireland and Malta (with historical links with the UK), Spain, Sweden and the UK. Indeed, in the UK this service is very developed, with nearly 10% of practising dentists involved in providing this care, or in postgraduate training.

Dentistry in the Universities

Some dental care is provided in dental schools, by academic dentists and (in most countries) by dental students. However, it is thought that the amount of oral healthcare delivered this way is very limited.

Dentistry in the Armed Forces

Many countries of the EU/EEA, especially the newly acceded countries, have national service in the armed forces. These countries and many of those with volunteer armed forces have formal arrangements to provide oral healthcare for their personnel, either from Armed Forces Dental Units, or from local arrangements with public clinics.

However, in Germany, Poland and the UK the Armed Forces Units are well developed and large numbers of dentists serve this way.

Illegal Practise of Dentistry

There were no reports of the illegal practise of general dentistry across the EU/EEA. However, there are reports of the provision of dentures and tooth whitening procedures by persons not legally able to provide these.

Several countries - Belgium, France, Greece, Hungary, Ireland, Italy and the UK - report illegal denturism, although with the introduction of (legal) clinical dental technicians in the UK in 2008 this illegal practise is expected to reduce. ANDI (Italy) report a considerable amount of illegal practise in Italy by dental technicians, some of which is thought (by ANDI) to be condoned by medical practitioners, who cover for the technicians concerned. And VVT (Belgium) report that there is a move to introduce legal denturism into Belgium.

Denturism is legal in Denmark, Finland, the Netherlands, parts of Switzerland and now in the UK – so the potential for illegal practise is reduced.

However, an increasing problem in most EU/EEA countries is the illegal provision of tooth whitening products in the mouth by unqualified persons (see page 51). Although deemed "Cosmetic Products" in the UK, the General Dental Council has ruled that their application must be limited to registered dental professionals and had prosecuted several non-qualified persons by 2008.

Part 9: Professional Matters

Professional representation

Although all countries have a main national dental association, some have two or more (for example, Belgium) and many are primarily *federations* of the regional associations (for example Denmark, Germany, Sweden and Spain).

The primary role of all national dental associations is to defend the interests of individual members and the dental profession as a whole. However, although the national dental association usually plays an important role in determining the level of "standard fees", in several countries the association is also the official trade union for dentists.

Membership of dental associations and chambers				
Mandatory membership in red				
		Numbers	**Year**	**Source**
Austria	Österreichische Zahnärztekammer	4,501	2008	Chamber
Belgium	Chambres Syndicales Dentaires	1,260	2008	FDI
Belgium	Société de Médecine Dentaire	1,057	2008	FDI
Belgium	Verbond der Vlaamse Tandartsen	3,400	2008	VVT
Bulgaria	Bulgarian Dental Association	7,987	2008	FDI
Bulgaria	Association Médicale	150	2007	FDI
Croatia	Dental Chamber	4,137	2008	Chamber
Croatia	Dental Society	1,748	2008	FDI
Cyprus	Cyprus Dental Association	728	2007	CDA
Czech Rep	Czech Dental Chamber	8,146	2007	Chamber
Denmark	Association of PH Dentists	1,263	2008	FDI
Denmark	Danish Dental Association	6,115	2008	DDA
Estonia	Estonian Dental Association	666	2008	Association
Finland	Finnish Dental Association	4,218	2008	FDI
France	ADF	20,800	2008	ADF
Germany	Bundeszahnärztekammer	65,929	2008	BZÄK
Greece	Hellenic Dental Association	9,100	2008	FDI
Hungary	Hungarian Dental Association	1,600	2008	FDI
Iceland	Icelandic Dental Association	303	2008	FDI
Ireland	Irish Dental Association	1,350	2008	FDI
Italy	ANDI	21,824	2008	ANDI
Italy	AIO	7,033	2008	FDI
Latvia	Latvian Dental Association	1,860	2008	FDI
Liechtenstein	Liechtenstein Dental Association	26	2008	LDA
Lithuania	Lithuanian Dental Chamber	3,010	2008	Chamber
Luxembourg	Association des Médecins	290	2008	AMMD
Malta	Dental Association of Malta	102	2007	FDI
Netherlands	Nederlandsche Maatschappij	6,650	2008	NMT
Norway	Norw egian Dental Association	5,599	2008	NDA
Poland	Polish Dental Association	5,217	2008	Chamber
Poland	Chamber of Physicians and	21,800	2008	Chamber
Portugal	Ordem dos Médicos Dentistas	5,700	2008	OMD
Romania	Romanian Dental Association	2,000	2007	FDI
Romania	Romanian Soc of Stomatology	200	2007	FDI
Slovakia	Slovak Chamber of Dentists	3,200	2008	FDI
Slovenia	Slovenian Dental Association	1,637	2007	SDA
Spain	Consejo General de Colegios	24,515	2008	FDI
Sweden	Sw edish Dental Association	7,005	2008	FDI
Switzerland	Société Suisse d'Odonto-	4,350	2008	FDI
UK	British Dental Association	20,680	2008	BDA
UK	Dental Practitioners Association	2,500	2008	DPA
	Total	**144,458**		

Table 18 - Membership of the dental associations

In about one third of the countries membership of the dental association, or as more frequently known, the Chamber is mandatory – often because the association or chamber acts as the registration authority as well. In some countries, as well as providing continuing education for dentists (and dental auxiliaries) the association or chamber is responsible for ensuring the participation in it.

In those countries where membership is voluntary uptake is very mixed. So, whereas in Finland 98% of dentists are members of the association, in Italy less than half of dentists (44%) are members of either ANDI or AIO, the two main associations there.

European Dental Associations and Committees

There are very many associations, specialist societies and committees representing dentists across the EU/EEA.

The *Council of European Dentists (CED)*, which commissioned this Manual, was established in the early 1960s at the request of the Department of Social Affairs of the European Commission. It is a committee representing dental associations, who appoint two members each to its plenary meetings – which are twice a year, once in a host EU country, and once in Brussels. Between plenary meetings an elected board and working groups attend to matters, and the CED has a permanent office and secretariat in Brussels.

The CED's primary task was to co-operate with the European Commission in developing the dental Directives published in 1978. Since then, the committee and member associations have worked closely with the European Institutions in a number of matters and is officially consulted by the European Commission on health matters.
http://www.eudental.eu/

The *European Union of Dentists* (*EUD*) was founded in 1974 to put dentists in touch within the Common Market. It is a trans-national organisation which offers individual membership to registered dentists from any country (not just Europe). To join you must be a registered dentist.

The EUD is organised into a network of Special Interest Groups (SIGs).
http://www.europeandentists.org/index.htm

The EUD is a non governmental organisation [NGO] which enjoys consultative status and is listed on the central database of the *Council of Europe*, Strasbourg. The EUD is permanently represented among the NGOs which have consultative status within the Council of Europe and contributes to several working groups. The EUD is represented by its Vice-President, who sits on the Group Santé (Health) of NGOs.

The *Council of European Chief Dental Officers* (CECDO) was inaugurated in July 1992 and was registered as an association under Dutch law with the Kamer van Koophandel (Chamber of Commerce) Den Haag in 1995.

The Council aims to provide a forum for the exchange of views on dental matters which affect EU/EEA member countries. It exists to offer advice to National Governments, to the Commission and others on matters affecting European dentistry through the creation and maintenance of a contact organisation for European Chief Dental Officers (CECDO).

There is exchange of knowledge and data between CDOs, which can influence the current and future policy of national governments with respect of dental care. This is achieved by organising two meetings each year, preferably in the country which holds the presidency of the European Union, to provide a confidential forum for this exchange of views.

The CECDO also co-ordinates pan-European activities related to improvements in technology, dental care and dental education. The Council also takes a proactive role in the development of programmes designed to improve the quality of dental public health, publishes articles and reports.
http://www.cecdo.org/

The *Conference of Orders and Assimilated Bodies of Dental Practitioners in Europe* (*CODE*) brings together European orders and bodies responsible for the regulation, registration and supervision of dental practitioners. CODE shares information and good practice on the regulation of dentists and aims to develop shared opinions on and approaches to new initiatives and legislation at European level, which affect the regulation of dental professionals.
http://www.code-europe.eu/spip.php?rubrique1

Professional Ethics

Dental practitioners in every European country have to respect ethical principles. Whether formally expressed as laws, oaths or as written guidelines these principles relate to their relationship with patients, other dentists and the wider public.

The commonest method of providing dentists with ethical guidance is through a simple written code. This is usually administered by the national dental association or in some countries by the separate regulating body (for example, as in France, Ireland and the UK). The application of these codes is usually by committees at a local level. Dentists' professional and other behaviour is usually also governed by specific laws (such as the Dental Acts in Norway and Iceland), more general medical laws (for example, in many of the new member countries of the EU, and in Austria, where dentists must also take the 'Hippocratic Oath') as well as laws on professional and business conduct.

Standards and Monitoring

Although the threat of patient complaints is probably still the strongest 'control' on the standard of care, increasingly oral health systems have other mechanisms for monitoring dental practice. These include external 'prior approval' of expensive or complex treatments, incentives or rules for participation in continuing education, as well as more basic controls on the level of billing and patterns of treatment of individual practitioners.

Some of the widest variations in dental practice across Europe relate to the monitoring of standards. In most countries monitoring is not of the quality of care, but is simply an administrative control, to ensure that the patient has been charged the correct amount for the type and amount of treatment received. Only in a few countries are there "examining dentists", who re-examine the patients of selected dentists, to see that the dentist has fairly claimed payment for work done. However, in these countries it is not usual for examining dentists to visit at random, and most re-examinations are the result of patient complaints. In some countries the threat of patient complaints offers the only real form of pressure on dentists maintaining the standard of care.

Advertising

There is tremendous variation across the EU/EEA as to what constitutes "advertising", in its truest sense, when applied to publication of information about dentists and their dental practices. So, in many countries even an entry in the "Yellow Pages" classified telephone directories could be counted as advertising. In the following countries the rules are very tight and practitioners are barred from any form of public announcements:

Table 19– Advertising not permitted

Belgium	Iceland	Portugal
France	Luxembourg	Romania
Greece	Malta	Slovakia

Advertising on the first opening of a dental practice only is permitted in Croatia, Cyprus and Slovenia. Only limited advertising is permitted in Hungary and Ireland was first allowing advertising later in 2008.

Websites

In contrast to the rules relating to advertising virtually all countries permit the use of dental practice websites – with only Luxembourg and Malta dissenting from this.

Data Protection

By 2008 all the countries of the EU, Norway and Switzerland had adopted the 1995 EU Data Protection Directive into their national legislation. National law in Iceland covered this area of dental practice.

Indemnity Insurance

In all EU/EEA countries, professional Indemnity Insurance, to protect dentists against having to pay damages and legal costs should a claim arise against them is available and recommended. However, in 21 countries indemnity insurance is mandatory:

Table 20– Indemnity Insurance mandatory

Austria	Germany	Norway
Belgium	Hungary	Poland
Bulgaria	Iceland	Romania
Czech Republic	Ireland	Slovakia
Denmark	Latvia	Spain
Finland	Lithuania	Sweden
France	Luxembourg	United Kingdom

This insurance is included in membership fees of the Danish Dental Association.

Ten countries reported that the mandatory or non-mandatory indemnity insurance may extend to the dentist working in another country – although this would usually be an adjacent country for working near the border or to any country but for a limited period (usually measured in months).

Table 21 – Indemnity Insurance may extend for work in another country

Croatia	Ireland	Slovenia
France	Luxembourg	Spain
Germany	Netherlands	United Kingdom
Greece		

Corporate Practice

Most countries permit dentists to set up their practices as limited liability companies (corporate bodies). Only in Croatia, Germany, Ireland, Luxembourg and Malta is this barred completely.

In the countries in the following table non-dentists may wholly or partly own the company, but in all cases only dentists can be responsible for clinical matters and usually one or more dentist must be on the board of the company and at least one dentist must be employed:

Table 22 – Corporate practice permitted

Austria**	Greece	Portugal
Belgium	Hungary	Romania
Bulgaria**	Iceland**	Slovakia
Cyprus	Italy	Slovenia
Czech Republic	Latvia	Spain
Denmark	Lithuania	Sweden
Estonia	Netherlands	Switzerland**
Finland	Norway	United Kingdom
France**	Poland	

** in these countries membership of the board of the company is limited to dentists only.

Tooth whitening

In the early 1970's, the EU decided to harmonise their national cosmetic regulations in order to enable the free circulation of cosmetic products within the Community. Directive 76/768/EEC was adopted on 27 July 1976. The principles laid down in the Directive were to take into account the needs of the consumer, while encouraging commercial exchange and eliminating barriers to trade. It introduced the regulation of cosmetic products, and within its definition of *"cosmetic product"* included "any substance or preparation *intended to be placed* in contact with the various external parts of the human body…or with the teeth and the mucous membranes of the oral cavity with a view exclusively or mainly to cleaning them, perfuming them, changing their appearance and/or correcting body odours and/or protecting them or keeping them in good condition."

The Directive required Member States to prohibit the marketing of certain cosmetic products containing hydrogen peroxide – no control of products for the teeth was made at this stage. However, in 1992 "oral hygiene products" were included within the range of products for which a maximum concentration of hydrogen peroxide was directed. The substance hydrogen peroxide (H_2O_2) was widened to include compounds that release it, such as carbamide peroxide and zinc peroxide. Directive 92/86/EEC, prescribed that "oral hygiene products" should include a maximum concentration of 0.1% of H_2O_2 present or released. There is no definition of "oral hygiene products".

About 40% of EU/EEA countries define the latest tooth whitening products as "cosmetic" and an equal number define them as "medicinal" (and so not subject to the above limitations). Most of the rest define them as "cosmetic" up to a defined percentage (not necessarily 0.1%) and then medicinal at higher percentages. A few countries have no legislation or were reviewing this in 2008. Generally, but not uniformly, countries insisted that these products were provided to patients in clinical situations only by dentists (or dental auxiliaries under prescription) but even then some countries allow any supplier or provider if concentrations are less than 0.1%.

So, in relation to tooth whitening and the supply of products or the undertaking of procedures, the situation in 2008 was very confused – see individual countries for the local position. In the Summer of 2008 the European Commission brought together all the interested parties in the matter (the

dental profession and the industry) and following this it was hoped that new regulations would be enacted in 2009.

Health and Safety at Work

All EU/EEA countries have rules about protection of dental workers and patients, including items such as the prevention of cross infection. So, the use of one-use only disposables - such as (for example) needles and gloves is widespread, with increasing numbers of items joining the list of "one-use only".

Inoculations against diseases, especially Hepatitis B for dental workers, are universal and recommended. However, in many countries inoculation against Hepatitis B is mandatory:

Table 23 – Inoculation against Hepatitis B mandatory

Belgium	Latvia	Romania
Czech Republic	Malta	Slovenia
France	Netherlands	United Kingdom
Hungary		

Ionising Radiation

All countries have regulations relating to use of radiographic equipment, which usually include mandatory regular inspection of machinery and often recording of this in a central database.

All dentists learn about ionising radiation as part of their undergraduate studies. However, in most countries the taking of radiographs is not necessarily limited to dentists in dental practices – other dental workers may undertake these if they have had the necessary education and training.

In half the countries the regulations relating to ionising radiation make continuing education about this subject mandatory on a regular basis – usually a specified number of hours in every 5 (or so) years:

Table 24 – Mandatory continuing education relating to ionising radiation

Belgium	France	Lithuania
Bulgaria	Germany	Luxembourg
Czech Republic	Hungary	Poland
Estonia	Italy	Slovakia
Finland	Latvia	United Kingdom

Hazardous Waste

Again, all countries have regulations relating to the storage, collection and disposal of waste, including clinical waste. Of particular relevance to dental practices is the collection of waste amalgam. Every country now recommends the fitting of "amalgam separators" – which collect waste amalgam before this reaches the main drainage system.

However, most countries insist upon these being fitted as a mandatory requirement. Sometimes this is necessary just in newly installed units, but often it is a mandatory requirement in every surgery, whether new or not.

Table 25 – Amalgam separators mandatory

Austria	Greece	Norway
Belgium	Hungary**	Slovakia
Croatia	Iceland	Slovenia
Cyprus	Latvia	Spain**
Czech Republic	Luxembourg	Sweden
Finland	Malta	Switzerland
France	Netherlands	United Kingdom
Germany		

** *for new units only*

Part 10: Financial Matters

Retirement

All countries of the EU/EEA have a state retirement age, which is the age at which dentists working in the public dental services, or liberal (general) dentists with contracts with a state system/sick fund have to retire. However, there is no universal rule about this, and it will vary from country to country. All countries permit continued private practice beyond the normal retirement age – with a further upper age limit in a few countries.

The following chart shows the normal retirement ages for males/females in each country:

Retirement ages						
Austria		65/60		Latvia		62
Belgium		65		Lithuania		62/60
Bulgaria		63/60		Luxembourg		65
Croatia		65/60		Malta		60
Cyprus		60		Netherlands		65
Czech Rep		62		Norway		67
Denmark		65		Poland		65/60
Estonia		65		Portugal		65
Finland		65		Romania		65/60
France		65		Slovakia		60/57
Germany		62-68		Slovenia		58
Greece		65		Spain		70
Hungary		62		Sweden		66
Iceland		67		Switzerland		65
Ireland		65		UK		65/60
Italy		65/63				
Romaniahas a variableretirementage						

Table 26 - normal (state) retirement ages – the first figure is for males, the second for females, where there is a variable age between genders. NB: Slovakia has a variable retirement age for females with children

Dentists' Incomes

Dentists who work within hospitals or for the public dental service tend to be salaried employees, and considerable numbers in general practice may work that way – either as assistants to practice owners in fee-based systems, or salaried within the state system (the UK).

Liberal/General private practitioners often contract to work part-time for the public dental service on a *fee-for-service* basis.

Given that a *fee for service* (or *fee-per-item*) system dominates for all private practitioners across Europe, and for some dentists working from hospitals or government health centres, the process of establishing standard or maximum fees is an important part of any oral health system.

A common model for deciding standard fees is to have a points system attaching relative values to each type of treatment, to reflect relative cost. A separate process then attaches a monetary value to each point. Sometimes the monetary values attached to different treatments, is derived from an overall 'target income' figure for the average dentist. In this way it is possible for governments to exercise partial control on overall expenditure. However, although in some countries the scale is one of maximum fees, more often there are flexible rules governing when a dentist can charge above the standard fee.

Tax rates

Trying to produce relevant information about tax rates across the EU/EEA would have been a complex and confusing task. However, we did ask about the top tax rate in each country – and the income levels above which it would be levied. Most countries supplied this information.

The highest rates reported were in Finland, with a top rate of 60% levied on earnings above €100,000 and Sweden (58%). The top rate in most countries was between 45 to 55%, with the lowest rates being in Bulgaria (10% flat rate on all earnings) and Slovakia (19%).

VAT

The cost of oral healthcare is specifically exempted from VAT charges in all countries, so dentists do not add VAT to the bills that patients pay.

However, within their costs dentists have to pay VAT on a number of services and consumables that they purchase (but not dental technicians' labour costs) – and these costs are included within the prices that governments, insurance companies and patients pay for dental care.

Again, the levels of VAT levied across the different countries, is very complex. The highest rate charged is 25% (Norway and Sweden – and Hungary for dental equipment), but the average is about 20 to 22%. The lowest general rate is in Latvia at 5%. However, often where there are two levels of VAT a lower level may be charged on medicinal products or equipment. In Malta, approximately 70% of dental materials and equipment needed are VAT free (medicinals, certain dental equipment and filling materials are exempt from VAT) and in several countries some dental consumables are rated at a lower rate of around 5 to 7%.

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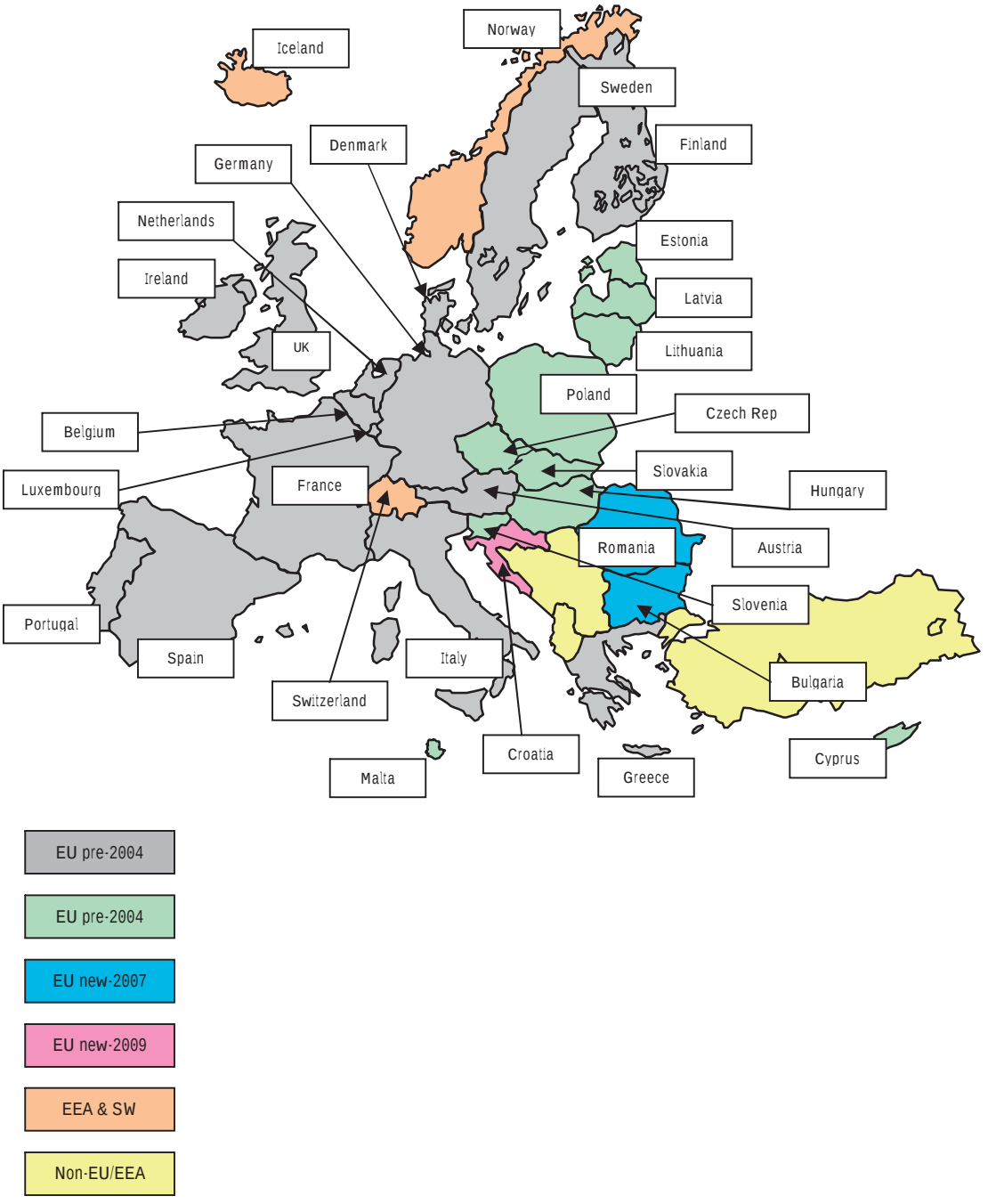
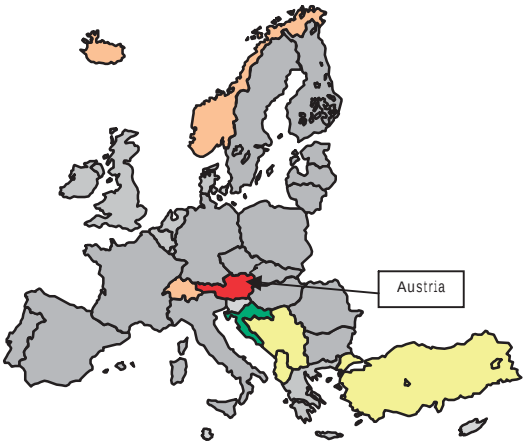
Part 11: Individual Country Sections



Austria



Date of last revision: 1st October 2008

In the EU/EEA since	1995
Population (2008)	8,331,930
GDP PPP per capita (2007)	€31,877
Currency	Euro
Main language	German

Entitlement to receive funded healthcare is through membership of health insurance organisations (or sick funds). These are provided by public compulsory and private supplementary insurance.

Number of dentists:	4,501
Population to (active) dentist ratio:	1,981
Members of Dental Association:	100%

Specialists do not exist in Austria and the use of dental auxiliaries is very limited. Continuing education for dentists is not mandatory.

Government and healthcare in Austria

Austria is a landlocked, federal republic in the geographical centre of Europe, surrounded by 8 adjacent EU states.

There is a bicameral Federal Assembly or *Bundes-versammlung* consisting of a Federal Council or *Bundesrat* (64 members; members represent each of the states on the basis of population, but with each state having at least three representatives; members serve a four- or six-year term) and the National Council or *Nationalrat* (183 seats; members elected by direct popular vote to serve four-year terms) consisting of 9 federal states. The capital is Vienna.

The federal government looks after all the competences for healthcare, including dentistry. There is a department for healthcare in the federal ministry for health, family and youth.

In Austria entitlement to receive healthcare is through membership of health insurance organisations (or *sick funds*). These are provided by public compulsory and private supplementary insurance. Approximately 99% of the population are covered by the compulsory schemes which are often called *paragraph 2* insurance, if they are with one of the large public regional institutions. Employees, their dependants and retired people are either members of one of the 9 regional "public health insurance institutions" (one in each *Bundesland*), 4 occupational insurance organisations (civil servants, railway workers, farmers and craftsmen), or the 9 health insurance institutions of large companies. The public compulsory insurance schemes are funded mostly by members (89% of their revenue), with employers paying half of each member's contribution. The public sick funds also earn some revenue through patients' co-payments for treatment and retention fees (6% of revenue), and government subsidies (5%).

Supplementary private health insurance mainly covers hospital care. The benefits generally include a more comfortable room and greater choice of doctor for inpatient care. There are about 1 million private health insurance contracts offering these extra benefits and their total expenditure is about one third of that of compulsory health insurance schemes.

Anyone who is covered by a public insurance scheme is supplied with a so called "e-card" by their sick fund. They have to pay €10.00 per year for this, and it entitles them to free care for most of their treatment needs.

		Year	Source
% GDP spent on all health	10.1%	2006	OECD
% of this spent by governm't	76.2%	2006	OECD

Oral healthcare

		Year	Source
% GDP spent on oral health	0.93%	2006	Chamber
% of OH expenditure private	46%	2006	Chamber

Public compulsory health insurance

Public compulsory health insurance provides cover for 41 conservative and surgical items, and 11 removable orthodontic and prosthodontic treatments. Crowns and bridges, implants, fixed orthodontic appliances and other complex or cosmetic treatments have to be paid for by the patients. There is a prescribed fee scale for all dentists who are contracted to the major public insurance organisations. Free or subsidised treatment is provided by any dentist in exchange for the e-card issued by the sick funds. If the e-card is valid, the dentist can claim fees from the insurance scheme quarterly.

The small sick funds, largely those for particular occupational groups, use the same list of items as a basis for dentists' remuneration but have different levels of fees. Generally, standard items attract an insurance subsidy of 100%, or 80% with small funds, which is claimed by the dentist and the patient pays the remainder where appropriate. For more complex types of treatment, for example removable prosthodontic appliances the insurance schemes provide subsidies of up to 50% of the cost. In such cases, where the overall value of the care is high, the treatment plan may have to be agreed with the insurance organisation.

Approximately 65% of dentists in general practice treat patients within this system through the contracts with the public insurance institutions. The fees claimed by dentists contracted with the major, public sick funds are set by the Association of Austrian Health Insurances (*Hauptverband der österreichischen Sozialversicherungsträger*) in annual negotiations with the Austrian Dental Chamber. Dentists' earnings are influenced by the level of pay negotiated for other doctors. Every regional *Ärztekammer* proposes and negotiates its own level of fees. The average increase of the 9 regions then determines the increase of the national fee scale. Dentists may hold more than one contract in order to treat patients with different insurance organisations.

As with general healthcare, approximately 99% of the population are entitled to receive dental care in this way, with the rest holding a certificate from the local authority.

There is no organisation entirely dedicated to children's dental care. However, some larger cities have dental clinics for children ("Jugendzahnkliniken"). Children are covered by the social sickness insurance of their parents and have the same rights to dental treatment as their parents. This means that parents have to pay the same percentages for the treatment of their children as for themselves.

There are institutions in every county ("Bundesland") which offer caries prevention programmes. These are mostly educational programmes (how to brush teeth, what healthy food to eat, etc.). In almost all counties children's teeth are examined regularly. A federal programme of oral health surveys began in 1997. Each year the oral status in a subgroup of the population (500 persons) is examined.

The dentists who work for the public dental service are only allowed to offer treatments within the scheme of the social security system. There are very few dentists working in hospitals, mainly practising oral maxillo-facial surgery, for emergency cases.

All payments to dentists are done by the way of fees for treatments. Normally re-examinations would be carried out annually. Domiciliary (home) Care is available in an emergency.

Private Care

For private patients who wish to pay the whole cost of care themselves, the levels of fees payable are decided by the individual dentist and are not regulated.

About 5% of the population use private insurance schemes to cover some of their dental care costs. All such schemes are personal, which supplement the public health system, and individuals insure themselves by paying premiums directly to an insurance company.

The private insurance policies which people can purchase may be dental-only or contracts which provide a range of medical benefits including dental care. Private insurance companies are regulated by insurance law only and thus accept all the financial risks involved. Generally the level of the premiums is linked to the age of the insured individuals, and the insurance company may refuse to provide cover if the risk of costly treatments is high.

The Quality of Care

The quality and standards of dental care are the responsibility of the Austrian Dental Chamber. Checks are made mainly on the quantity of care provided, and the correct and fair payment of fees, as recommended by the Dental Chamber (private services only).

There are regional variations in these monitoring arrangements but usually they concentrate on newly established dentists or those performing more than the expected number of particular treatments but random checks are carried out in some regions. Sometimes the quality of care is also monitored by dentists employed by the insurance schemes.

Another measure of the quality of care, and the only control for dentists providing care to private patients, is patient complaints.

The Dental Law requires the integration of a countrywide system of quality assurance by the end of 2009. This system will be organised by the Austrian Dental Chamber. First evaluations started in mid 2008.

Health Data

		Year	Source
DMFT at age 12	1.04	2002	OECD
DMFT zero at age 12	58%	2002	OECD
Edentulous at age 65	20%	2002	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no fluoridation schemes in Austria.

Education, Training and Registration

Undergraduate Training and Qualification

In the past, to practice as a dentist in Austria required a medical qualification (6 years' training), followed by specialist postgraduate training in dentistry. So, until 2004, in order to register as a dentist, a practitioner had to have the recognised primary degree [*Doctor of Medicine* (Dr. med. univ.) with the *Specialist Certificate* (*Facharzt für Zahn-, Mund-, und Kieferheilkunde*), needed to demonstrate Austrian or EU citizenship, and to provide evidence of professional indemnity.

However, in autumn 1998, to move progress towards mutual recognition under the EU Dental Directives, a separate curriculum for dentists was introduced. Since then all new dentists have had to study dental medicine. The study is divided into 3 sub-sections and lasts 6 years.

Year of data:	2008
Number of schools	3
Student intake	120
Number of graduates	119
Percentage female	65%

Graduation takes place at the three university dental schools: Graz, Innsbruck and Vienna.

Qualification and Vocational Training

Primary dental qualification

The first dentists under the new system graduated in 2004. The title upon qualification (from June 2004) is Dr. med. dent.

Quality assurance for the dental schools is provided by government regulators.

Vocational Training

There is no compulsory post-qualification vocational post-graduate training in Austria.

Registration

To achieve registration to practice in Austria applications must be made to the Austrian Dental Chamber (the competent authority for dentistry) via their regional organisations (Landeszahnaerztekammern). The annual fee for membership in the Austrian Dental Chamber is a certain percentage of the income of the dentist, which is different in every region. All dentists have to be a member of the Austrian Dental Chamber to be allowed to practise dentistry.

Until the end of 1998, non-Austrian dental degrees were not recognised. Since then all EU dental degrees have been accepted, but dentists from non-EU countries have to comply with the rules of Directive 2005/36/EG.

Language Requirements

Though there are no formal linguistic tests to register - the dental law requires a certain level of knowledge of the German language. In cases of doubt the Austrian Dental Chamber requires a certificate about knowledge of the German language (European level C1). Austrian citizenship is generally awarded on the condition that German can be spoken.

Continuing education

Legislation includes an obligation to participate in continuing education, but it is not proscribed as mandatory and a dentist is free to choose the activity he wants to join in.

There are several institutions which provide courses and training, including universities, scientific societies, medical or pharmaceutical companies, national and international medical congresses, on a regular basis. The dentist can apply for a diploma of education from the Austrian Dental Chamber, by submitting the approvals of the different types of training he/she has completed during this period.

Further Postgraduate and Specialist Training

In Austria no dental specialties are officially recognised, largely because dentistry itself was formally a specialist area of medicine, until 1998. However, it is possible to train in any of the 3 universities in the "subspecialty" of oral maxillo-facial surgery through a further 3 years education (officially, oral surgery still is a sub-speciality of medicine). There are no official guidelines as to whether the trainee is paid – this is a matter between the trainee and the university.

There are many associations and societies for dentists with special interests. These are most easily contacted via the Austrian Dental Chamber.
(www.zahnaerztekammer.at)

Workforce

Dentists

Year of data:	2008
Total Registered	4,501
In active practice	4,206
Dentist to population ratio*	1,980
Percentage female	39%
Qualified overseas	443

* this refers to the population per active dentist

There is a small increase of the dental workforce, with 150 dentists (including overseas dentists) entering into dentistry each year, so that the phenomenon of jobless dentists has commenced. However, there was a post-1945 population "bulge" (which included a bulge of dentists) and as a result many of these dentists will retire early in this century, leading to an expected reduction in the numbers.

Movement of dentists into and out of Austria

There is almost no movement of dentists out of Austria as far as can be established, but there are a considerable number of dentists, especially from Eastern Europe and Germany, moving into Austria. Approximately 17% of overseas dentists are from outside the EU/EEA.

Specialists

In Austria no dental specialties are officially recognised. Oral Maxillo-Facial surgeons are officially medical specialists (although we have included their approximate number of 120 within the data for dental specialists).

Auxiliaries

In Austria, other than dental chairside assistants (Zahnärztliche Assistentin), dental technicians (Zahntechniker) are the only other type of dental auxiliary. There are no clinical dental auxiliaries.

Year of data:	2008
Hygienists	0
Technicians	550
Denturists	0
Assistants (estimate)	7,100
Therapists	0
Other	0

Dental Technicians (Zahntechniker)

Education or training is over a 4-year period and is provided by qualified technicians and the dental practitioner confers the Diploma. As a "special profession" there is a registerable qualification which dental technicians must hold before they can practice. The register or list is administered by local trade federations, which also have federal and state groups.

The permitted acts of dental technicians are the production of prostheses (crowns, bridges, dentures and repairs), and they are not allowed to work in the mouth of a patient, or have direct contact with them.

90% of technicians work in dental laboratories separate from dental practices and invoice the dentist for work done. 10% work directly with the dentist.

Dental Chairside Assistants

Assistants are governed by the Kollektivvertrag, (the labour agreement between the union and the Austrian Dental Chamber) and follow 3 years training under the authority of the dentist.

They are paid by salary.

Officially there are no dental hygienists established in Austria, but there are some dental nurses specialised in oral prevention, who have obtained a diploma after 3 years professional practice and following the specific education determined by the Austrian Dental Chamber.

Practice in Austria

Oral health services are provided mainly in General Practice, both in the public and private sectors. Only a minority of dentists work solely in the private sector.

Year of data:	2008
General (private) practice	3,704
Public dental service	396
University	106
Hospital	120
Armed Forces	
General Practice as a proportion is	88%

In Austria, OMF surgeons are not registered as dentists but are listed in these numbers as Hospital dentists

Working in Liberal (General) Practice

Dentists who practice on their own or as small groups, outside hospitals or schools, and who provide a broad range of general treatments are in *General Practice*. Almost all are in single practice (this represents about 82% of all active dentists).

Dentists in general practice are self-employed. They claim fees from the public insurance organisations and directly from patients, as described above. Those who hold contracts with the insurance organisations are often called 'panel dentists'. About 22% of dentists in general practice do not hold a contract with any of the public compulsory insurance schemes (sick funds) and accept only private fee-paying patients. Most of the "private dentists" are concentrated in the cities.

Joining or establishing a practice

There are no rules which limit the size of a dental practice in terms of the number of associate dentists or other staff. Premises may be rented or owned, but only by dentists. There is no state assistance for establishing a new practice and dentists take out commercial loans from a bank. Local health insurance organisations may have a geographical plan of areas in need of more dentists (a *Stellenplan*) but 'private' dentists, who are not contracted with any public insurance scheme, may locate their practices anywhere. Generally there are very few places where additional contracted dentists are needed.

Normally dentists buy existing practices, mainly because that is the only way to become a 'panel dentist'. However, it is not possible to receive a list of patients. The only way the transfer of patients can be achieved is by the seller of the practice informing his patients about the new owner.

Dentists are not allowed to employ other dentists (but dental assistants only) in their single practices. Even the so called "*Wohnsitzzahnärzte*" (residence or locum dentists), who are practising in the absence of another dentist - for example, in case of illness, or maternity regulation - in a single practice are not employed by the original dentist during the absence. To determine the relationship of the dentist with their employees, the union for each type of auxiliary has a contract which is negotiated with the Chamber. A dentist's employees are also protected by the national and European laws on equal employment opportunities, maternity benefits, occupational health, and minimum wages.

Occupational health and safety regulations apply to all companies. There are no standard contractual arrangements prescribed for dental practitioners working in the same practice. However, dentists who are contracted with the local health insurance organisation cannot employ another dentist to carry out the work.

There is no available information regarding the size of a normal dental "list".

Working in the Public Service

The public insurance organisations also employ salaried dentists to provide care. This service takes place in dental clinics, health centres and hospitals – and competes with, and is subject to the same standards as the other dentists contracted with the insurance scheme. The care provided is therefore available to the same client groups, and provides the same range of treatments. Patients have a free choice to go to these clinics or a private dentist, but it was reported in 2003 that there is a political intention of the *Bundeskurie Zahnärzte* to increase the numbers of patients seen in general practice, rather than the public dental service. Subsequently, some of these institutions have been closed.

The public dental service employs dentists within 84 different institutions. There is no staff grade structure and no postgraduate training is required in order to work in the service.

Working in Hospitals

Dentists who work in hospitals are those who are employed to teach dentistry by the universities. Oral maxillo-facial surgeons are registered as doctors and work as salaried employees of the regional governments which own most hospitals, or earn income on a 'fee-for-service' basis for one of the few private hospitals. Usually there are no restrictions on seeing other patients outside the hospital. The titles are the same as those for hospital doctors; assistant (in training), *Oberarzt* and *Primarius* (head of department).

Working in Universities & Dental Faculties

Dentists working in universities and dental faculties are employees of the university. They are allowed to combine their work with part-time work elsewhere and, with the permission of the university, accept any amount of private practice work outside the faculty.

The main academic position within an Austrian dental faculty is that of head of department *Professor* and *Dozent* (chairside teaching only). There are no formal requirements for postgraduate training but most will have qualified by *habilitation*. This involves the submission of a thesis, and evidence of original research.

Working in the Armed Forces

There are no dentists working full time for the Armed Forces. Some dentists work part time in hospitals of the Armed Forces

Professional Matters

Professional associations

	Number	Year	Source
Österreichische Zahnärztekammer	4,501	2008	Chamber

Since 2006, the only organisation representing dentists in Austria has been the Austrian Dental Chamber (*Österreichische Zahnärztekammer*). The Chamber consists of 9 regional dental chambers and is self-financed through members' subscriptions, which are usually earnings-related and are deductible for the assessment of income tax. Membership by dentists is mandatory.

Ethics and Regulation

Ethical Code

The Dental Chamber does not have a specific code of ethics or any other guidelines of good or ethical practice. However, dentists in Austria have to work under Dental Law, and take the *Hippocratic Oath* before they can legally practice. The application of the law and the oath is primarily the responsibility of the Dental Chamber.

Fitness to Practise/Disciplinary Matters

Complaints by patients are administered at regional level by the Dental Chamber, and the Board of Arbitration is always convened before court action can be considered. The examining committee consists of dentists and of delegates of associations for consumer protection. If a complaint is upheld then the most likely form of sanction is a warning from the insurance company. In extreme cases the right of the dentist to practice can be removed by terminating their contract with the insurance company – although they could then still work without an insurance contract.

In cases of complaint against private dentists the Dental Chamber offers an arbitration service with experts, before the normal civil courts begin their proceedings. But neither patient nor dentists are obliged either to take part at the arbitration or to follow the rulings of the arbitration.

In cases of gross negligence a dentist may be suspended immediately or lose the licence to practise altogether.

Data Protection

Every dentist is bound to the duty not to disclose confidential information in any way to anybody, including health information on patients or any other data. The regulations of data protection are subject to Austrian federal law.

Advertising

Advertising is allowed in Austria although there are some legal limitations, as defined in a special code edited by the Austrian Medical Association - still valid also for the Dental Chamber. Limitations refer, for example, to the form of the advertisement in print media. Advertising on radio or TV is not allowed at all, except for commentary on medical and subject-specific issues.

Dentists are allowed to promote their practices through websites but they are required to respect the code of the Austrian Medical Association, which is more restrictive than the guidance of the Council of European Dentists.

Insurance and professional Indemnity

Liability insurance is not compulsory for dentists. However, insurance may be obtained from almost all private insurance companies and provides cover for compensation if negligence is proven. The cost of the premium depends on the maximum amount insured. Generally this insurance does not cover Austrian dentists working abroad.

Corporate Dentistry

Dentists are allowed to form a so called "Gruppenpraxis", which is a form of company, but these companies are only allowed to work outside of the social security system. A non-dentist cannot be a part-owner and/or on the board of such a company.

Tooth Whitening

Under the dental law of Austria tooth whitening can only be done legally by a dentist and an examination or diagnosis by a dentist is necessary anyway.

Tooth whitening is covered by medical regulations so there is no legal limit on the concentration of peroxide.

Health and Safety at Work

Workforce Inoculations are not compulsory and there are no authorities to survey compliance, but inoculations are recommended by the Austrian Dental Chamber, regarding possible liability of the dentist for any health damages.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	district government ("Bezirkshauptmannschaft")
Electrical installations	"Bezirkshauptmannschaft"
Infection control	"Bezirkshauptmannschaft"
Medical devices	"Bezirkshauptmannschaft"
Waste disposal	"Bezirkshauptmannschaft"

Ionising Radiation

Training in radiation protection is part of the undergraduate curriculum. The dentist in a practice would normally be the Radiation Protection Supervisor, having passed exams in the subject.

A dental assistant can also be trained and qualified to take radiographs and be a supervisor.

There is no mandatory continuing education and training requirement.

Hazardous Waste

The EU Hazardous Waste Directive (requiring amalgam waste to be collected as hazardous waste) has been incorporated into Austrian law. The law is actively enforced.

Amalgam separators have been legally required since 1995. There are regulations restricting who collects the waste to registered or licensed carriers.

Financial Matters

Retirement pensions and Healthcare

Retirement pension premiums are paid at varying levels at an average rate of 22.8% of earnings, half by employer, half by employee. Dentists are legally obliged to be members of two schemes: one organised by the *Österreichische Ärztekammer*, (although since 2006 the chambers of medical doctors and dentists have been separated, dentists are still obliged to be a member of the pension scheme of the Chamber of Medical Doctors); and one with a main public insurance company. Retirement pensions in Austria can be up to 80% of a person's average salary during the 15 years of highest-earnings. The normal retirement age in Austria is 65 years for men and 60 years for women, although dentists may practice beyond these ages.

For the majority of the Austrian population general health care is paid for at about 7.5% or less of annual earnings, half of which is paid by an individual's employer. At present this contribution is made up to a maximum assessment (*Höchstbemessung*).

Taxes

There is a national income tax: The highest rate of income tax is 50 % on earnings over about € 50,870 per annum

VAT

VAT at 20 % is payable on certain types of purchase, including most dental equipment and consumables.

Various Financial Comparators

Zurich = 100	Vienna 2003	Vienna 2008
Prices (excluding rent)	84.2	94.3
Prices (including rent)	85.2	90.4
Wage levels (net of taxes)	52.3	69.8
Domestic Purchasing Power	57.3	77.2

Source: UBS August 2003 & January 2008

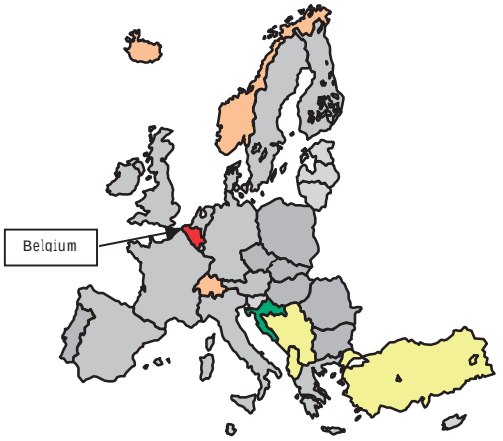
Other Useful Information

Main national associations and Information Centre:	
Österreichische Zahnärztekammer Kohlmarkt 11/6 1010 Wien AUSTRIA Tel: +43 505 11-0 Fax: +43 505 11-1167 Email: office@zahnaerztekammer.at Website: www.zahnaerztekammer.at	*Scientific Society of Dentists* Österreichische Gesellschaft für Zahn-, Mund- und Kieferheilkunde, Verein Österreichischer Zahnärzte Auenbruggerplatz 8036 Graz, AUSTRIA Tel: +43 316 385 2251 Fax: +43 316 385 3376 Email: dachverband@oegzmk.at Website: www.oegzmk.at
Competent Authority:	Publications:
Österreichische Zahnärztekammer Kohlmarkt 11/6 1010 Wien AUSTRIA Tel: +43 505 11-0 Fax: +43 505 11-1167 Email: office@zahnaerztekammer.at Website: www.zahnaerztekammer.at	Österreichische Zahnärzte-Zeitung Kohlmarkt 11/6 1010 Wien AUSTRIA Tel: +43 505 11-0 Fax: +43 505 11-1167 Email: koenig@zahnaerztekammer.at Website: www.zahnaerztekammer.at

Dental Schools:

Vienna	Innsbruck
Universitätsklinik fur ZMK Wien Währinger Strasse 25a, A-1090 Wien Tel: +43 1 4277 - 0 Fax: +43 1 4277 - 9670 E-mail: ik@univie.ac.at Website: www.univie.ac.at/uni-zahnklinik/ Dentists graduated 2007: 70 Number of students: 420	Universitätsklinik fur ZMK Innsbruck Anichstrasse 35, A-6020 Innsbruck Tel: +43 512 504 – 71 80 Fax: +43 512 504 – 71 84 E-mail: ilse.quaritsch@uibk.ac.at Website: www.uibk.ac.at Dentists graduated 2007: 25 Number of students: 150
Graz Universitätsklinik fur ZMK Graz Auenbruggerplatz 12 A-8036 Graz Tel: +43 316 385 – 22 48 Fax: + 43 316 385 – 33 76 E-mail: zahnklinik@email.kfunigraz.ac.at Website: www.kfunigraz.ac.at/zmkwww/ Dentists graduated 2007: 24 Number of students: 150	

Belgium



Date of last revision: 1st October 2008

In the EU/EC since	1957
Population (2008)	10,666,866
GDP PPP per capita (2007)	€28,972
Currency	Euro
Main languages	Dutch and French

General health care is mainly funded by deductions from salaries which also cover retirement pensions, and a supplementary child tax. The amount contributed depends on income.

Number of dentists:	8,423
Population to (active) dentist ratio:	1,408
Members of Dental Association:	Varies

Dentists may belong to one of 3 dental associations, depending upon their language. In 2007 membership was about 67% . The use of dental specialists is widespread but there has been no development of clinical dental auxiliaries. Continuing education for dentists is mandatory.

Government and healthcare in Belgium

Belgium has been independent, as a parliamentary monarchy, since 1830. The land area is just over 30,000 sq km. There is a well-established system of regional as well as national government. It is also a country with three languages (the main ones being Flemish, just under 60% and French just under 40%). This affects dentistry because there are Flemish and French Dental Schools and Dental Associations (see later).

The capital is Brussels. The bicameral Parliament consists of a Senate or *Senaat* in Dutch, *Senat* in French. As a result of the 1993 constitutional revision that furthered devolution into a federal state, there are now three levels of government (federal, regional, and linguistic community) with a complex division of responsibilities; this reality leaves six governments each with its own legislative assembly.

The *Institut National d'Assurance de Maladie et d'Invalidité* (INAMI)/*Rijksinstituut voor Ziekte en Invaliditeits Verzekering* (RIZIV) is the body responsible for managing the health system. The *Institut* acts as the adviser to the Minister of Social Affairs, who makes decisions on behalf of the King. The King is required to sign every application for new laws.

Healthcare is mainly funded by deductions from salaries which also cover retirement pensions, and a supplementary child tax. The amount contributed depends on income. There are two different schemes: one for employed which provides full cover, and another for the self-employed. Self-employed people only have to pay for high cost risks such as hospital care, but can elect to insure against lower cost treatments such as dentistry and general medicine.

Individuals can choose to belong to one of over a thousand sick funds, which operate in five major groups. For all sick funds central co-ordination ensures that the rules, fees and reimbursements are the same. Although the total budget for healthcare is decided by the government, it is divided between the five groups using a formula which takes into account social and economic factors, the number of people in each scheme, and occupational differences in health risk (eg the mine workers' fund receives more resources). Every three months the budget of all of the sectors are examined to determine what measures must be taken to control any expected overspend.

		Year	Source
% GDP spent on health	10.3%	2005	OECD
% of this spent by governm't	72.3%	2005	OECD

The health budget in 2007 was €19.6 billion. There is a legally approved increase of 3.5% per year in health care expenditure, with amounts above this having to be justified separately, for example by lobbying from the dental profession.

The following ministers are responsible for different aspects of health care:

- Minister of Social Affairs decides treatment tariffs and oversees relations with sick funds
- Minister of Health decides registration, and how many dentists are required
- Ministers of Education (2) control the basic education of dental students in each region

Oral healthcare

Oral health care is organised in the same way as general health care. All sectors of the population are able to access dental services, including the self-employed and unemployed people.

Almost all dental care is provided in private practice together with a very small amount in hospitals and universities - so small that it becomes irrelevant. Some free dental care is also available for homeless people in Brussels.

		Year	Source
% GDP spent on oral health	0.30%	2004	CECDO
% of OH expenditure private	40%	2004	CECDO

About 3.1% of all government spending on healthcare is spent on dentistry.

Public compulsory health insurance

There is an agreed scale of fees for dental treatments, called the *convention*. This is jointly agreed by the 3 dental associations and the sick funds working as a commission within the *Institut*. Dentists generally charge patients for each item of treatment, and then patients reclaim a proportion of the fees from their sick fund. However, a "third party payment system" also exists, where some dentists choose to receive reimbursement directly from the sick fund.

Almost the whole population is within a 15 minute bus access of a dentist. However, only approximately a third of the population attend a dentist regularly, one third when necessary and the remainder almost never or only in an emergency. The result is that many dentists work part-time, some for only a few hours a week. There is concern that this may lead to inadequate experience for some practitioners.

Patients normally attend for re-examinations every 6 months to the age of 18 years, then annually after then.

Private Insurance

There are a few private insurance schemes mainly in the form of group contracts for employees. The cover they offer is varied, as are the premiums charged.

Quality of Care

There are several ways in which standards of dental care are monitored.

The *Institut* has an administrative body which regulates the non-clinical administrative forms used in dentistry. It also has an independent control department staffed by medical doctors (not dentists) which checks that the treatment codes recorded agree with the actual treatment undertaken. The *Institut* may not comment on the quality of the dental treatments, but has the right to examine any patient. This usually happens only after a complaint (see Ethics).

Within the *convention* there are some quality standards. For example, a denture must include six stages of construction at a minimum of five visits. There is a possibility in the future that fees will be increased if more standards are included. As part of the convention a voluntary quality assurance accreditation system has been organised since 1998.

Health data

		Year	Source
DMFT at age 12	0.92	2006	VVT
DMFT zero at age 12	25%	2006	VVT
Edentulous at age 65	41%	2002	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no fluoridation schemes in Belgium. There is some naturally fluoridated water at an acceptable level (to the authorities).

Education, Training and Registration

Undergraduate Training

There are five dental schools, three French-speaking and two Flemish-speaking. Dental schools are part of the Faculties of Medicine in universities. There is a mix of Catholic (private) and State universities.

In Flanders there is an entry examination before entering the first year of training. In the French speaking universities there is a selection procedure after the first year of training.

Year of data:	2007
Number of schools	5
Student intake	230
Number of graduates	175
Percentage female	80%

Quality assurance for the dental schools is provided by the Ministry of Education.

Qualification and Vocational Training

Primary dental qualification

There are two titles awarded for clinical dentists graduating from Belgian dental schools, after a 5-year course:

- Flemish *Tandarts*
- French *Licencie en sciences dentaires*

Vocational Training (VT)

Students entering dental faculties since 2002 cannot practice as a generalist after their basic 5 years of education but have to follow vocational training after graduation - 1 year for general dentistry, 3 years for periodontology and 4 years for orthodontics.

Despite the absence of a *numerus clausus* (by the Department of Education) for the intake of students into the universities, a federal law has limited the number of places for vocational training to 155.

By 2008 the situation relating to the need for VT by overseas graduates was confused and awaiting a verdict of the Supreme Court. There are differences depending upon the country of graduation and the nature of the proposed work (whether within or outside the social security reimbursement scheme).

Registration

Before being able to practise a dentist must register with the Federal Ministry of Health.

Cost of registration 2008	€ 550

Language requirements

In 2008 new legislation meant that to register with the Ministry of Health a dentist should be able to communicate in at least one of the three national languages – Dutch, French or German. However, in view of the Professional Qualifications Directive (2005), whether the legislation contravened the PQD remained to be determined by the courts.

Further Postgraduate and Specialist Training

Continuing education

Since June 2002, continuing education spread over all aspects of the profession (general medicine, radiology, prevention, practice management, conservative dentistry, orthodontics, prosthodontics, ...) is mandatory in order to keep a title. The requirement is 60 hours over 6 years.

Specialist Training

The main degrees which may be included in the register are:

- Algemeen Tandarts, Dentiste Généraliste
- tandarts specialist in de Orthodontie, Dentiste Spécialiste en orthodontie
- tandarts Specialist in de Parodontologie / dentiste Spécialiste en Parodontologie.

Specialist training is undertaken at the universities - for general dentists 1 year, orthodontics 4 years, for periodontics 3 years (including the vocational training). Trainees are paid by the Ministry of Health.

Oral maxillo-facial surgery is a medical specialty, which requires 6 years basic training and qualification in medicine, a 2-year Master's degree in dentistry and then specialised training in oral maxillo-facial surgery for a further 4 years. This then is followed up by a one-year training in facial oncology.

Workforce

Dentists

Most dentists practice in general practice – although some also work in hospitals and dental faculties.

Year of data:	2007
Total Registered	8,423
In active practice	7,576
Dentist to population ratio*	1,408
Percentage female	48%
Qualified overseas**	118

* this refers to the population per active dentist
** CECDO estimate – there is no absolute way of determining this.

Movement of dentists across borders

There is a small, but insignificant movement of dentists from Belgium to its neighbouring countries (especially the Netherlands), and a small number from the Netherlands into Belgium.

Specialists

Three specialist titles are recognised in Belgium, orthodontics, periodontics and general practice. Maxillo-facial surgery is also recognised as a medical specialty.

Patients may go directly to a specialist, without referral.

Year of data:	2007
Orthodontics	380
Endodontics	
Paedodontics	
Periodontics	95
Prosthodontics	
OMFS	290
Dental Public Health	
Stomatology	320

All OMF surgeons are stomatologists. The 30 stomatologists, who are reducing in number may be undertaking general dentistry and are not specialists in the general way described in the EU.

Auxiliaries

There are two types of auxiliaries in Belgium, dental technicians and dental chairside assistants. There are no clinical dental auxiliaries.

Year of data:	2007
Hygienists	0
Technicians	2,250
Denturists	0
Assistants	1,500
Therapists	0

Dental technicians

Dental technicians have a protected title, under the governance of the Ministry of Economic Affairs, and receive undergraduate training in special schools (3 years) or in the dental laboratories (*"patronal training"*).

They are registered by the Ministry of Health.

There are illegal denturists who are pressing the government for legal status.

Chairside assistants

Dental chairside assistants are trained by and work to the direct instructions of dentists. There is no formal training, nor registration, for dental assistants. In 2000, FDI reported that there were 800 chairside assistants. There is no known later figure, but anecdotally it has been suggested that one in five dentists use a chairside assistant.

Practice in Belgium

Almost all patient care is undertaken in General Practice.

Year of data:	2007
General (private) practice	6,800
Public dental service	
University	200
Hospital	
Armed Forces	10
General Practice as a proportion is	90%

Working in General Practice

In Belgium, dentists who practice on their own or as small groups, outside hospitals or schools, and who provide a broad range of general treatments are said to be in *General Practice*. They represent almost all dentists actively practising in the country. Most dentists in general practice are self-employed and earn their living through charging patients fees.

Fee scales

All payments to dentists are by way of fees for treatments (Item of service). Dentists have a fee scale agreement known as the *convention* with the *social security*. The *convention* sets the level of reimbursement for patients for many types of dental care but crowns, bridges, inlays, implantology and periodontology are excluded. Equally Orthodontics is only included if treatment starts before the age of 14 years. Private fees can be set for all of these items in which case there is no reimbursement to the patient. These fees are only restricted by a professional ethic not to charge unreasonably high amounts.

As mentioned under *Oral Healthcare in Belgium* the *convention* is negotiated between the national dental associations and the sick funds working as a committee. It is re-negotiated every two years. Dentists then have to decide whether or not to participate in the convention, through elections which are held in each canton in the country. If an area votes 'no', then the Minister of Social Affairs can impose a fee scale on all dentists. However in some cantons where there has been a 'no' vote the Minister has not taken action.

If dentists are "in the convention" they are obliged to charge the appropriate fee and the patient claims a reimbursement. Outside the convention they can, in principle, charge any fee but the patient can still claim a reimbursement to the level allowed by the agreement. A dentist does not have to tell a patient whether or not he/she is in the *convention*, but sick funds hold a list of all dentists who are. The benefit to the dentist of being in the *convention* is related to pension rights on retirement.

Dentists use a five-point system for prioritising different types of treatment within the system. Generally preventive work is given a high priority, and extractions are a low priority. As there is insufficient funding to pay for all types of treatment, those with a lower ranking may not be reimbursed. Each year changes can be made either to the priority list, the size of the fee, or the level of reimbursement.

Prior approval for treatment is only required for orthodontics. There are also limits to the number of times patients can receive a subsidy for certain treatments, eg one panoramic radiograph per year, removable dentures every seven years, and once again for orthodontics there is a maximum of 36 monthly *forfaits*. A *forfait* is a fixed payment for a month in which treatment has been carried out, no matter how many visits are involved. Where active orthodontic treatment is suspended the dentist may receive a *contention* fee for monitoring the patient.

To overcome the above restrictions, the sick funds offer a supplementary insurance to meet the additional costs incurred.

Joining or establishing a practice

There are no rules which limit the number of associate dentists or other staff in a dental practice. Premises may be rented or owned, and there are no limitations as to where they may be opened. There is no state assistance for establishing a new practice, so dentists must negotiate commercial loans.

A practice must be registered at a specific address. Some health funds own polyclinics. A dentist may sell equipment and the practice buildings but cannot charge a premium for acquiring contact with existing patients. However there is a system where a vendor may charge 'for the doorstep' which is usually based on the practice income of the previous three years. No strict rules apply and a free market operates.

There are no specific contractual requirements between practitioners working in the same practice. However a dentist's employees are protected by the National and European laws on equal employment opportunities, maternity benefits, occupational health, minimum holiday entitlement and health and safety.

No domiciliary care is offered in Belgium.

Working in the Public Dental Service

There is no public dental service in Belgium. Some schools initiate a service directly with dentists for dental health surveillance. Health education is also part of the school curriculum, but in reality individual teachers decide how much dental health education is included.

Working in Hospitals

There are two types of hospitals in Belgium - private and university. A few dentists are employed full-time in university hospitals but most hospital dentists work part-time in private hospitals and part-tme in private general practice.

Dentists can either be paid a salary or, more usually, charge fees under the convention arrangements for their patients attending.

Working in Universities and Dental Faculties

Compared to other dentists, faculty members are not well paid. Very few dentists work full-time in universities and dental faculties, as employees of the university. They are free to combine their work in the dental faculty with part-time work elsewhere.

The main academic title within a Belgian university is gewoon hoogleraar/professeur ordinaire. Other titles include buitengewoon hoogleraar/professeur extraordinaire, hoogleraar/chargé de cours, docent/chargé d'enseignement and assistent/assistent. Professors generally qualify by a doctorate, aggregation and scientific experience and promotion depends upon the number of years of teaching and numbers of publications in international scientific publications.

Working in the Armed Forces

There are a few dentists working full time for the Armed Forces.

Professional Matters

Professional associations

There are 3 national dental associations recognised by the social security system (RIZIV-IMAMI):

- the *Chambres Syndicales Dentaires* (CSD) for French-speaking dentists
- the *Société de Médecine Dentaire* (SMD) also for French-speaking dentists and
- the *Verbond der Vlaamse Tandartsen* (VVT) for Dutch speaking dentists.

	Number	Year	Source
Chambres Syndicales Dentaires	1,260	2008	FDI
Société de Médecine Dentaire	1,057	2008	FDI
Verbond der Vlaamse Tandartsen	3,400	2008	VVT

Membership of a dental association is not compulsory.

Ethics and Regulation

Ethical Code

Dentists in Belgium have to work within one of two different but congruent ethical codes, depending on which dental association they belong to. Codes cover relationships and behaviour between dentists, the contract with the patient, consent and confidentiality, continuing education and advertising. They are administered by the associations.

Fitness to Practise/Disciplinary Matters

Patients may complain to the Provincial Medical Council. The disciplinary body comprises doctors, pharmacists, dentists, nurses and midwives. If a complaint is upheld, the Council can suspend the dentist from practice. There is also an appeals process.

Within the Dental Associations there is an ethical commission which also considers complaints. However this mostly handles disagreements between dentists and tries to mediate in these cases.

Data Protection

Belgium has implemented the EU Directive on Data Protection.

Advertising

Commercial advertising is strictly forbidden – Belgian legislation strictly forbids publicity for dentistry. This legislation was approved by the European Court in 2008 as not in contradiction with EU Regulations

Dentists' websites with purely information are accepted in Belgium. All VVT members can subscribe without cost to have a personal website on www.mijntandarts.be. Non members can subscribe for €25 a year. The Belgian ethical codes were also adapted in 2003 to include the CED guidelines on Electronic Commerce.

Insurance and professional indemnity

Liability insurance is compulsory for dentists. Professional liability insurance is provided by private insurance companies. Some dental associations also arrange group insurance, which provides cover to reflect the responsibilities of a dentist's individual contract. The cost of the insurance varies according to the cover, for example, providing implants approximately doubles the premium. Liability insurance covers dentists for working abroad.

Corporate Dentistry

Dentists are permitted to form companies in Belgium. These must be registered at a specific address. Non-dentists may be shareholders or fully own the company.

Tooth whitening

The CSD report that whitening products of greater than 6% peroxide must be used only in a dental office. The VVT have suggested that at this level such products must be classified as Medicinal.

Health and Safety at Work

Inoculations against Hepatitis B are compulsory for the workforce (administered by the Ministry of Health). A separate independent department of control inside the *Institut* monitors compliance.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Central government
Electrical installations	Central government
Infection control	Ministry of Health
Medical devices	Ministry of Health
Waste disposal	Regional government

Ionising Radiation

There are specific regulations about radiation protection. Training in radiation protection is mandatory for undergraduate dentists, who become the competent person in each practice. The dentist must undergo continuing training of at least 1.5 hours each 5 years.

The official authorities charge a one-off payment for the registration of radiation equipment, of about €275. In addition, there is an annual maintenance subscription of €160.

Hazardous waste

Regulations cover the disposal of clinical waste including the installation of amalgam separators. For waste disposal the Flemish Dental association has a group contract which cost €125 a year (2008). Approved collectors take the waste away in special containers.

Amalgam separators have been required by law since 2002.

Financial Matters

Retirement pensions and Healthcare

Normal retirement age is 65 for men and women, but is not compulsory. There is an official but very low retirement scheme for independent workers (€600 per month). There are many pension schemes on a voluntary basis.

Taxes

National income tax:

The highest rate of income tax is 55% on earnings over about €50,000.

VAT/sales tax

There is value added tax, payable at a rate of 21% on purchases, including dental equipment and materials. Dental services are not included in VAT.

Financial Comparators

Zurich = 100	Brussels 2003	Brussels 2008
Prices (excluding rent)	79.2	87.8
Prices (including rent)	75.7	83.6
Wage levels (net)	56.0	66.5
Domestic Purchasing Power	64.5	79.5

Source: UBS August 2003 January 2008

Other Useful Information

Competent Authority and Information Centre:

FOD Volksgezondheid/SPF Santé publique
Gezondheidszorg/Soins de santé
Victor Hortaplein 40 bus 10
1060 Brussel
BELGIUM
Tel: +32 2 524 98 33
Fax: +32 2 524 98 17
Email: Leona.Geudens@health.fgov.be
Website: www.health.fgov.be

Dental Associations:

Flemish (Dutch) language:

Verbond der Vlaamse Tandartsen (VVT)
Vrijheidslaan 61
1081 Brussel
BELGIUM
Tel: +32 2 413 00 13
Fax: +32 2 414 87 27
Email: verbond@tandarts.be
Website: www.tandarts.be

French language

Chambres Syndicales Dentaires (CSD)
Boulevard Tirou 25 bte 9
6000 Charleroi
BELGIUM
Tel: +32 71 31 05 42
Fax: +32 71 32 04 13
Email: administration.csd@incisif.org
Website: www.incisif.org

French language

Société de Médecine Dentaire (SMD)
Avenue de Fré 191
1180 Brussel
BELGIUM
Tel: +32 2 375 81 75
Fax: +32 2 375 86 12
EMail: info@dentiste.be
Website: www.dentiste.be

Publications:

VVT: *Contactpunt* (monthly)
Editor: Eric Delaeter
Vrijheidslaan 61
1081 Brussel
BELGIUM
Tel: +32 2 413 00 13
Fax:
Email: eric.delaeter@tandarts.be

CSD: *L'Incisif* (monthly)
Boulevard Tirou 25 bte 9
6000 Charleroi
BELGIUM

SMD: *Le Point* (monthly)
Editor: Olivier Custers
Avenue de Fré 191
1180 Brussel
Tel: +32 2 375 81 75
Fax: +32 2 375 86 12
EMail: info@dentiste.be

Dental Schools:

Brussels Université Libre de Bruxelles Hôpital Universitaire Saint-Pierre Rue Haute 322 1000 Bruxelles BELGIUM Tel: +32 2 538 00 00 Fax: Email: website: http://www.ulb.ac.be Dentists graduating each year: 23 Number of students: 100	Brussels (French) Univerisité Lible de Bruxelles Hôpital Universitaire Erasme Route de Lennik 808 1070 Bruxelles BELGIUM Tel: +32 2 555 31 11 Fax: +32 2 555 34 66 Email: Website: www.ulb.be Dentists graduating each year: 25-30 Number of students:
Gent (Flemish) Universiteit Gent Dienst voor Mond-Tand-en Kaakziekten De Pintelaan 185 B-9000 Gent BELGIUM Tel: +32 9 240 40 01 Fax: Email: Website: http://www.rug.ac.be Dentists graduating each year: 25 Number of students:	Liège (French) Université de Liège Institut de Dentisterie Espace Bavière Boulevard de la Constitution B-4020 Liège BELGIUM Tel: +32 4 343 43 3 Fax: Email: Website: http://www.ulg.ac.be Dentists graduating each year: 30-35 Number of students:
Leuven (French) School voor tandheelkunde Pathologie Buccale et Chirurgie Maxillo-Faciale KU Leuven Kapucijnenvoer 7 3000 Leuven BELGIUM Tel: +32 16 33 24 07 Fax: +32 16 33 24 84 Email: Website: www.kuleuven.ac.be Dentists graduating: 48 Number of students:	

Bulgaria

Date of last revision: 1st October 2008

In the EU/EEA since	2004
Population (2008)	7,640,238
GDP PPP per capita (2007)	€9,802
Currency	Bulgarian Leva (BGN) 1.95 BGN = €1.00 (2008)
Main languages	Bulgarian

General health care is mainly funded by deductions from salaries.
The system is designed as a state monopoly although voluntary health insurance which is at its initial stage. It operates through a National Health Insurance Fund.

Number of dentists:	7,987
Population to (active) dentist ratio:	957
Members of Dental Association:	100%

The use of specialists is widespread but there has been no development of dental auxiliaries.
Continuing education for dentists is mandatory.

Government and healthcare in Bulgaria

Bulgaria is in South-Eastern Europe, bordering the Black Sea to the East, Romania to the North, Serbia and FYROM to the West, and Turkey and Greece to the South. The land area is 110,550 sq km. The capital is Sofia. The country is divided into 28 districts.

The head of state is the President and the head of government the Prime Minister. The Council of Ministers is nominated by the prime minister and elected by the National Assembly. The President of the Republic is elected by direct popular vote for a term of four years.

There is a unicameral National Assembly or Narodno Sybranie (240 seats; members elected by popular vote to serve four-year terms)

The minimum age for voting and standing for election is currently 18.

Healthcare in Bulgaria is based on mandatory health insurance, governed by the Health Insurance Act (1998, State Gazette #70), also encompassing the voluntary health insurance which is at its initial stage. It creates legislative framework for the organisation of the mandatory health insurance.

The mandatory health insurance system is designed as a state monopoly. It has the exclusive right to grant mandatory health insurance and to guarantee the observance of the insurance rights in respect of all nationals, following a public contract model. A National Framework Contract is to be signed every year between the National Health Insurance Fund (NHIF) on one side, and the Bulgarian Medical and Dental Associations – on the other. The Contract comes into force upon sanction of the Minister of Health. The contracted annual package of activities in dental medicine varies according to the age.

		Year	Source
% GDP spent on health	8.0%	2004	OECD
% of this spent by governm't	57.6%	2004	OECD

The Bulgarian Dental Association (BgDA) reports that in 2007, the proportion of public resources spent on general healthcare, including dental medicine, was 4% of GDP (2.3 billion BGN or €1.2 billion).

The total budget for the mandatory health insurance system for 2008, adopted by the Parliament, amounted to 1.68 billion BGN (€850 million).

Oral healthcare

The proportion of the total budget for the mandatory health insurance that was spent on dental medicine in 2008 was 4%.

		Year	Source
% GDP spent on oral health	0.16%	2008	BgDA
% OH expenditure private	No data		

The Bulgarian Dental Association (BgDA) has drafted a National programme for prevention of oral diseases in children 0-18 (see section *Quality of Care*). The Programme comprises a national epidemiological survey of oral health which has not been conducted since the 1980s. Some partial data have been summarised in 2002 in a report by the Expert Committee of the Bulgarian Dental Association.

Here is a link to the Bulgarian text of the report: http://www.bzs.bg/REPORT%20EXPERT%20COMMITTEE.pdf

About 98% of dentists in Bulgaria work in general (liberal) practices. Thus, the dental services are delivered on this basis, either through the National Health Insurance Fund (NHIF) or privately. Among all Bulgarian dentists, over 5,500 have contracts with the NHIF.

The dental procedures in the mandatory health insurance sector are on a co-payment and fee-for-service base. The scope and the extent of co-payment are different for children and adolescents on one hand, and adults on the other.

The Bulgarian Dental Association has drafted a National programme for prevention of oral diseases in children 0-18. The draft has been discussed in the Ministry of Health and the Parliament, and informally endorsed. The Minister of Health has established a working group with representatives of both the Ministry and the Bulgarian Dental Association in order to finalise the Programme during 2008. The final draft will be presented to the Council of Ministers.

There is no available information about domiciliary care, "list" sizes and frequency of patient re-examination periods in Bulgaria.

Quality of Care

The NHIF monitors the quality of dental care in the system of mandatory insurance, according to criteria negotiated with the BgDA and included in the National Framework Contract.

The quality of dental care in private practice is not actively monitored. Some control is being carried out by BgDA on the base of the Ethical Code and the Rules of Good Medical Practice in Dental Medicine.

Patient complaints are generally managed by the Ministry of Health, and the regional and national Ethical Committees of BgDA.

Health Data

		Year	Source
DMFT at age 12	3.03	2002	OECD
DMFT zero at age 12		2002	OECD
Edentulous at age 65		2002	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth.

There are no later figures available.

Fluoridation

Milk fluoridation schemes for prevention of dental caries in children are being implemented in kindergartens in 8 Bulgarian cities (Plovdiv, Varna, Shumen, Veliko Tarnovo, Stara Zagora, Burgas, Sevlievo and Drianovo). Over 30,000 children are covered by these schemes. The schemes are based on joint protocols of WHO, the Bulgarian Ministry of Health, the respective municipalities, local NGOs, and the Borrow Foundation (a UK registered charity, a non-profit making organisation, actively involved in promoting milk as a vehicle for fluoride for the benefit of children's oral health).

Education, Training and Registration

Undergraduate Training

To enter a faculty of dental medicine of the university, a student has to have completed secondary school (usually at the age of 18). There is an entrance examination, which is similar to that of medical students. The undergraduate course lasts for 5.5 years and was fully "EU compliant" on Bulgarian accession to the EU in 2007.

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The following table shows the official number of students ordered by the Ministry of Education and Science.

Year of data:	2008
Number of schools	3
Student intake	170
Number of graduates	126
Percentage female	50%

The school in Varna is new, having been opened in 2005. By 2008 there had been no graduates, but the other two schools historically graduate 90% of their students, so the total number of graduates will increase from 2010, when the first students in Varna graduate.

Qualification and Vocational Training

Primary dental qualification

The primary degree in Bulgaria is *Physician of Dental Medicine with a Master Degree (Лекар по дентална медицина с образователна степен Магистър).*

Vocational Training (VT)

Dental graduates in Bulgaria are entitled to registration immediately upon graduation. There is no postgraduate vocational training. There is a 6 months mandatory pre-graduate practical training in the faculties of dental medicine.

Quality assurance for the dental schools is provided by the Ministry of Education.

Registration

Cost of registration (2008)	€ 51

The prerequisite for registration in Bulgaria is a primary degree in dental medicine. The registration of *dental practitioners* is administered by the Bulgarian Dental Association by means of its Regional Colleges.

The registration of the *dental practices* as medical institutions is administered by the Ministry of Health by means of its regional bodies – the Regional Centres of Healthcare.

Diplomas from other EU countries are recognised without the need for vocational training.

Language requirements

According to the *Law of Health*, the Ministry of Health shall assist EU citizens in acquiring the necessary knowledge of Bulgarian language and professional terminology.

Non-EU foreign citizens are required to have a command of Bulgarian language and professional terminology.

Further Postgraduate and Specialist Training

Continuing education

Continuing education is mandatory. A credit system has been introduced and administered by BgDA. A minimum of 30 points is to be covered in 3 years. The CE is delivered by BgDA, or by other institutions, accredited by BgDA.

Specialist Training

Specialists train in the faculties of dental medicine, and in accredited medical institutions. Specialisation is administered by the Ministry of Health, with the support of BgDA.

Training lasts for 3 years and concludes with a State examination

The types of specialist are:

- General dental medicine
- Orthodontics
- Oral Surgery
- Paediatric dental medicine
- Operative dental medicine and endodontics
- Periodontology and oral mucosa diseases
- Prosthetic dental medicine
- Dental image diagnostics
- Social medicine and dental health organization
- Dental clinical allergology

The titles obtained by specialists in orthodontics and oral surgery, the two specialities recognised by the EU, are:

- Специалист по ортодонтия (Specialist in Orthodontics)
- Специалист по орална хирургия (Specialist in Oral surgery)

Workforce

Dentists

Most dentists practice in general practice – although some also work in hospitals and dental faculties.

Year of data:	2005
Total Registered	7,987
In active practice	7,987
Dentist to population ratio*	957
Percentage female	66%
Qualified overseas	66

* this refers to the population per active dentist

There is a significant ratio discrepancy between the big cities (with an excess of dental practitioners), and the rural areas (where there is a deficiency of dental practitioners).

Therefore, under the pressure of BgDA, in the last few years the National Framework Contract with NHIF stipulates special incentives for contractors practising in remote and deprived areas.

There is no reported information about unemployment amongst Bulgarian dentists.

Movement of dentists across borders

There is no distinct movement into Bulgaria by overseas dentists. In 2008, 85% of the overseas dentists working in Bulgaria were citizens of non-EU countries.

As at July 2008, and since the beginning of 2007, approximately 120 Certificates of Good standing had been issued to dentists by the BgDA (these are for registration with other EU regulatory bodies).

Specialists

Patients have free access to specialists.

Year of data:	2005
Orthodontics	35
Oral Surgery	226
Endo & Restorative	417
Paedodontics	577
Periodontics	31
Prosthodontics	115
Oral Radiology	2
OMFS	45
Dental Public Health	17
Dental Clinical Allergy	1
General Dental Medicine	2,264

The "Specialty" of General Dental Medicine is unique to Bulgaria and stems from an earlier era – being an automatic analogue with the medical system. It was a mandatory pre-requisite to train and qualify for this "specialty" to open a dental practice. The law has now been amended to abolish this duty.

Auxiliaries

There is no system of use of dental auxiliaries in Bulgaria, other than dental technicians.

Year of data:	2005
Hygienists	0
Technicians	1,200
Denturists	0
Assistants	No data
Therapists	0
Other	0

Dental technicians

Dental technicians in Bulgaria graduate from a 3 years' special education with a degree *Professional Bachelor*. The training is 3,240 hours, including 1,275 hours theoretical training, 1,365 hours practical training and 600 hours pre-graduate practice.

The dental laboratories are 100% private and must register with Ministry of Health. The scope of their activities comprises elaboration of dental and orthodontic appliances. Dental technicians are not entitled to undertake any form of clinical work.

Denturists

Denturism is unknown in Bulgaria and there are no reports of (illegal) denturists.

Dental Chairside Assistants

After 1989, no specific training has been available for dental assistants (dental nurses). Currently, general care nurses are being registered by the respective professional association, and an unknown number of them are working in the field of dental medicine.

In 1989 there were about 6,000 dental assistants, but there were very many fewer by 2008 – the number in dental clinics is very small.

Practice in Bulgaria

Oral health services are provided on the base of general (liberal) practice in the mandatory health insurance system or privately.

Year of data:	2005
General (private) practice	7,700
Public dental service	
University	258
Hospital	35
Armed Forces & Police	48
Police	70
General Practice as a proportion is	98%

Working in General Practice

Virtually all Bulgarian dentists are working in the private sector on a self-employment base, ie in general (liberal) practice; most of them are in individual practices for primary care. A small amount of group practices are also registered.

Most specialists practice in specialised centres of dental medicine; there are also a few in individual or group specialised practices.

Among general practitioners, over 5,500 (2008) have contracts with the National Health Insurance Fund (NHIF). Insured patients are entitled to a specific package and volume of dental procedures, covered by the Fund. The additional dental services are fully paid by the patients.

Fee scales

As stated earlier, dental procedures in the mandatory health insurance sector are based on co-payments and fee-for-service base. In 2008, the annual scope for children and adolescents comprised 1 extensive check + 4 curative procedures (incl. fillings, endodontics and extractions). The annual scope for adults comprises 1 extensive check + 2 curative procedures (incl. fillings and extractions).

BgDA does not regulate or recommend any fees in the fully private sector, and prices are set by the market.

Joining or establishing a practice

There are no rules which limit the size of a dental practice or the number of associate dentists or other staff working there.

The practice has to be registered with the Regional Centre of Healthcare – a division of the Ministry of Health. The location, size, structure etc, of the premises, are regulated by Bulgarian law.

The state offers no assistance for establishing a new practice, and generally dentists rely on their own investments, or bank credits.

The dentists work on self-employed basis, and (rarely) may be employed. Their auxiliaries are always employed.

Working in the Public Dental Service

There is no public dental service in Bulgaria.

No special home care system exists. Physicians in dental medicine may provide home care at their discretion, by patient request.

Working in Hospitals

A very small number of dentists work in hospitals as employees, salaried by the Ministry of Health. They undertake mostly surgical treatments.

These dentists are entitled to treat other patients outside the hospital.

Working in Universities and Dental Faculties

Dentists working in faculties of dental medicine are salaried employees of the university. They are allowed to combine their work in the faculty with private practice.

The academic titles in the faculties of dental medicine are Professor, Associate Professor, and Assistant Professor.

The faculties of dental medicine are involved in graduate education, as well as postgraduate special education.

Working in the Armed Forces

There are physicians in dental medicine working in the Armed Forces, and in the Police Forces.

Professional Matters

Professional associations

	Number	Year	Source
Bulgarian Dental Association	7,987	2008	FDI
Association Médicale Scientifique Républicaine de Stomatologie	150	2007	FDI

The Bulgarian Dental Association was among the first dental professional organisations in Europe: it was founded on December 20th 1905, and for more than 40 years has been a powerful and authoritative representative of the interests of the profession.

However, the communist regime banned the medical and dental associations in 1947, and replaced them with what are now described as "obedient and toothless trade-unions", uniting artificially the alleged interests of the so-called "health workers" – doctors and auxiliary staff together. The centralised healthcare system transformed the doctors from independent specialists to salaried state employees, with no real responsibility and stimulus. Private practice was prohibited from 1971.

All this lasted until 1989, when the government regime ceased. The Bulgarian Dental Association was "resurrected" on March 11th 1990 in the city of Plovdiv, by a widely drawn national conference of Bulgarian dentists, which actually turned out to be the constituent assembly of the renewed organisation. The Association quickly gained popularity and new members, although membership was voluntary. Highly intensive activities were immediately undertaken in several directions: *reestablishment of private practice, cost evaluation of dental procedures, professional ethical standards, defence of the profession, information and qualification of the members*.

This initial period was characterised by the co-existence of the old, discredited public system and the renewed private dental care, which was quickly gaining power and overtaking the modern standards. This co-existence raised some specific problems: *disloyal competition, price dumping, dual standards* etc.

In 1999 the *Law of the Professional Organisations of Physicians and Stomatologists* (Later: *Physicians in Dental Medicine*) established the new professional organisation: The Association of Stomatologists in Bulgaria (ASB). After the accession of Bulgaria in the EU, the Association regained the title *Bulgarian Dental Association* (*BgDA*).

The law entrusts to the Association functions, typical of the similar professional organisations in the democratic world:

- To negotiate and contract with the National Health Insurance Fund.
- To keep and update the register of the profession. Registering with the Association is a compulsory prerequisite for practising dental medicine in Bulgaria.
- To enforce the ethic principles of the profession and penalize their infringement.
- To inform and qualify its members.
- To defend its members, etc.

The Constituent Congress adopted the Constitution of BgDA, which develops further the stipulations of the law in the spirit of the professional self-government.

The Constitution introduced the "functional field" principle in the central management of the Association, via the establishment of 7 Standing Working Committees (SWC), intended to perform its basic functions. Each Chairman of a SWC is elected by the Congress, and holds also the office of a Vice-President of the Association.

The Constitution stipulates a territorial representation in the Managing Board by including in the Board representatives of all the 28 Regional Colleges of BgDA.

The Law of the Professional Organisations and the Constitution of BgDA constitute also the control bodies of the Association as independent commissions:

- The *Commission of Professional Ethics* supervises the moral, ethical and deontological issues in practising the dental profession.
- The *Control Commission* controls the decisions of the Managing Board, as well as their implementation, in terms of their adherence to the law and the Constitution of BgDA.

The English text of the Constitution of BgDA is available at: http://www.bzs.bg/site/index.php?option=com_content&task=view&id=84&Itemid=105

Ethics and Regulation

Ethical Code

Bulgarian dental practitioners are subject to the *"Code of professional ethics of the physicians in dental medicine in the Republic of Bulgaria"*, adopted by the Congress of BgDA, signed by the Minister of Health and published in the State Gazette.

The Code contains the duties of the physicians in dental medicine ensuing from the practicing of the dental profession. It reflects the moral principles and criteria of professional conduct of the members of the dental profession.

The Code contains regulations on:

- The duties of the members of the dental profession during practice;
- Promotion of the dental services;
- Relationships with the patients;
- Patients' referral;
- Medical documentation and professional secrecy;
- Payment of the dental services;
- Qualification;
- Infringements and penalties.

The English text of the Code is available at: http://www.bzs.bg/site/index.php?option=com_content&task=view&id=85&Itemid=106

Fitness to Practise/Disciplinary Matters

The Commission of Professional Ethics has 9 members, all dentists.

The penalties for infringement of the Ethical Code vary in severity, from censure, financial penalty to erasure from the register (for a term from three months to two years).

Data Protection

In 2002, two laws came into force: the *Law on Protection of Personal Data*, and the *Law on Protection of Classified Information*.

In 2006, the *Law on Consumer's Protection* was been adopted. These laws stipulate the use of personal and classified data.

Advertising

According to Bulgarian law, no commercial advertising is permitted in healthcare activities. Dental practitioners are permitted to promote their services in accordance to the law and the Ethical Code.

Websites can be used provided they are absolutely factual and contain no commercial elements.

Insurance and professional indemnity

Professional indemnity insurance is mandatory according to the *Law of Health*, and the Regional Colleges of BgDA cover the insurance of their members. It does not cover for Bulgarian dentists working overseas.

Corporate Dentistry

Individual and group dental practices may be owned and managed only by physicians in dental medicine. Dental and Medico-dental centres may be owned by any person, but has to be managed by a specialist in the respective field, either physician or physician in dental medicine with an additional specialty in Health Management or Business Administration.

There are no limited companies owning Bulgarian dental practices.

Tooth whitening

Tooth whitening is being practiced in the last few years by some physicians in dental medicine.

The BgDA was propagating changes on the issue of tooth whitening in 2008.

Health and Safety at Work

This issue is regulated by the *Law of Health*, and secondary legislation. There are no mandatory vaccinations.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Government Agency of Nuclear Regulation
Electrical installations	Government agency
Infection control	Ministry of Health – Inspectorate of Preservation and Control of Public Health
Medical devices	Ministry of Health – Executive Agency on Drugs
Waste disposal	Ministry of Environment and Water Supplies and Ministry of Health

Ionising Radiation

Ionising radiation is regulated by the *Law of Health* and the *Law of the Safe Use of Nuclear Energy*, plus secondary legislation.

During their dental education, physicians in dental medicine take examinations in radiology, with an emphasis on dental diagnostics. Those who would like to have x-ray equipment in their offices, have to acquire a corresponding certificate issued by the Ministry of Health, according to the Medical Standard "Image Diagnostics", following a specialised education and a successful exam. The certificate has 5 years' validity.

All x-ray equipment has to be licensed by the Agency of Nuclear Regulation. The Regional Inspection for Preservation and Control of Public Health issues a certificate for entry in the Register of establishments with public function, according to the Law of Health.

The equipment is inspected annually. The maintaining services perform an annual prophylaxis and technical examination.

Hazardous waste

The disposal of hazardous waste is regulated by the *Law of Waste Management*, plus secondary legislation.

Amalgam separators are only advised and they are not yet mandatory.

Financial Matters

Retirement pensions and Healthcare

The retirement ages in Bulgaria are 63 for men and 60 for women. There are no restrictions for the physicians in dental medicine to continue practicing after this age.

Health care in the mandatory health insurance system is funded by mandatory health insurance payments amounting to 6% of the income due by all Bulgarian citizens.

Taxes

National income tax:

Since the beginning of 2008, a flat income tax has been introduced amounting to 10% of incomes.

VAT/sales tax

VAT in Bulgaria is 20%, and does not apply to healthcare services; however, it applies to drugs, medical devices, instruments, equipment, consumables and other products used in medicine and dental medicine

Various Financial Comparators

Zurich = 100	Sofia 2008
Prices (excluding rent)	55.2
Prices (including rent)	54.0
Wage levels (net)	7.3
Domestic Purchasing Power	17.7

Source: UBS January 2008

Other Useful Information

Important Contacts::

Bulgarian Dental Association (BgDA)
49, Kniaz Dondukov Blvd.
1000 Sofia, Bulgaria
Tel.: +35 929874797
Fax: +35 929888724
Gateway: +359888407226
E-mail: ssbcentur@abv.bg
Website: www.bzs.bg

Ministry of Health:
5, Sveta Nedelya Square
1000 Sofia, Bulgaria
Tel.: +35 929301152
Tel./Fax: +35 929811820
E-mail: press@mh.government.bg
Website: www.mh.government.bg

National Health Insurance Fund
1, Krichim Str.
1407 Sofia, Bulgaria
Tel: +35 929659130
Tel./Fax: +35 929659124
EU integration: +35929659130
Email: ivatkova@nhif.bg
Website: www.nhif.bg

Dental Schools:

Sofia

Medical University
Faculty of Dental Medicine
1, Sveti G. Sofiiski Blvd.
1432 Sofia, Bulgaria
Tel: +35 929522818; +35 929541247;
+35 929523548
E-mail: info@stomfac.org
E-mail: d_ziya@abv.bg

Numbers of annual intake: 80
Dentists graduating each year: about 90%

Plovdiv

Medical University
Faculty of Dental Medicine
3, Hristo Botev Blvd.
4002 Plovdiv, Bulgaria
Tel: +35 9896610286
E-mail: doz_kukleva@abv.bg

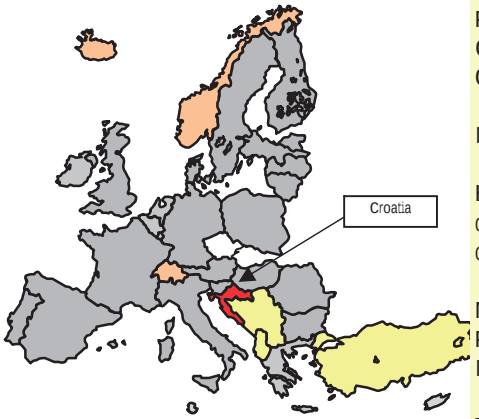
Numbers of annual intake: 60
Dentists graduating each year: about 90%

Varna (established in 2005)

Medical University
Faculty of Dental Medicine
55, Marin Drinov Str.
9002 Varna, Bulgaria
Tel: +35 9888226863
E-mail: svechtarov@yahoo.co.uk

Numbers of annual intake: 30
Dentists graduating each year: not yet know

Croatia



Date of last revision: 1st October 2008

In the EU/EEA expected	2009
Population (2008)	4,435,383
GDP PPP per capita (2007)	€13,230
Currency	Croatian Kuna (HRK)
	7.26 HRK = €1.00 (2008)
Main languages	Croatian

Healthcare is funded through general taxation and an additional "health contribution" which is paid by everyone receiving any kind of wage, compensation or pension.

Number of dentists:	4,137
Population to (active) dentist ratio:	1,267
Members of Dental Chamber:	100%

The use of specialists is widespread but there has been no development of dental auxiliaries.
Continuing education for dentists is mandatory.

Government and healthcare in Croatia

Croatia is located in South-eastern Europe, bordering the Adriatic Sea (and Italy), between Bosnia and Herzegovina, Slovenia, Hungary, Montenegro and Serbia. The land area is 56,542 sq km. The capital is Zagreb.

The lands that today comprise Croatia were part of the Austro-Hungarian Empire until the close of World War I. In 1918, the Croats, Serbs, and Slovenes formed a kingdom known after 1929 as Yugoslavia. Following World War II, Yugoslavia became a federal independent Communist state under Marshal Tito. Although Croatia declared its independence from Yugoslavia in 1991, it took four years before the occupying Yugoslav army was mostly cleared from Croatian lands. Under UN supervision, the last YU army-held enclave in eastern Slavonia was returned to Croatia in 1998.

The political system is a parliamentary democracy. The chief of state is the President and the head of government is the Prime Minister. The cabinet is the Council of Ministers, named by the prime minister and approved by the parliamentary Assembly. There is a unicameral Assembly or Hrvatski Sabor (152 seats; members elected from party lists by popular vote to serve four-year terms).

Elections: the President is elected by popular vote for a five-year term (eligible for a second term); the leader of the majority party or the leader of the majority coalition is usually appointed Prime Minister by the President and then approved by the Assembly.

The minimum age for voting and standing for election is currently 18.

Administratively Croatia is split into 21 counties (zupanije, zupanija - singular) among which is a capital - city (grad - singular).

A few Basic Laws are the regulatory frame of Croatian healthcare system (Law of healthcare protection, Law of obligatory healthcare insurance, Law of voluntary healthcare protection, Law of dentistry). The system is basically social and a basic range of medical, dental, radiology, laboratory services are free and available for all citizens of Republic of Croatia.

In Croatia healthcare is funded through general taxation and an additional "health insurance contribution" which is paid by everyone receiving any kind of wage, compensation or pension.

		Year	Source
% GDP spent on health	7.7%	2004	OECD
% of this spent by governm't	81.0%	2004	OECD

Oral healthcare

The Croatian healthcare system (including dental healthcare) is contribution based (similar to taxation) and financed from the State Budget.

The responsibility for planning oral healthcare lies with the Ministry of Health, which through the state owned insurance agency the Hrvatski Zavod za zdravstveno osiguranje (HZZO) finances and provides all services in paying for healthcare under the strategic direction of the Ministry. The agency is self-regulating and ultimately under the supervision of the Croatian Parliament (Hrvatski Sabor).

		Year	Source
% GDP spent on oral health	No data	2007	Chamber
% OH expenditure private	No data	2007	Chamber

At the time of publication there was no available data for this table.

Branches of the HZZO are in the municipalities.

The dental services are delivered through the network of dental offices throughout the state. Some of the offices are private but about half have contracts with the HZZO. The network of dental services is defined and a ratio of 2,200 patients per dentist is the prescribed standard. A small proportion of offices remain in former public health centres and work for the HZZO. A proportion of dental care is delivered by totally private dental offices. The patients may be covered by private dental insurance for reimbursement.

Formally and practically all citizens of Croatia have the right to elect their doctor of dental medicine – a contractor of the HZZO and receive dental care. However, not all citizens use this right, despite the fact that they are paying for it through their contributions. They have made a decision to receive care from privately run dental offices.

State and private companies often offer their employees the additional benefit to their salaries of a contract with private health insurance companies for the delivery of private care.

The basic package of dental services provided by the state through HZZO ensures almost all basic dental procedures (restorative, endodontic, basic periodontal, oral surgery, oral diseases, orthodontics up to 18 years, prosthodontics partially) and emergency dental care are available and have to be provided immediately when requested. If the contractor is not able to perform the required procedure he has the right to direct the patient to a specialist, who is again a contractor with the HZZO.

There is no available data about what proportion of the population receive oral healthcare regularly (in a two-year period) and how often oral examinations would normally be undertaken.

The Quality of Care

The state authorities provide rules about the space, equipment and the qualifications needed to provide dental care. The state insurance company (HZZO) provides a list of services, contents and worth of each service provided by the state. The Croatian Dental Chamber (see later) describes the standards needed to perform these services. All services are listed. Billing is actively checked by HZZO to ensure that bills reflect the amount of work done.

Radiology, laboratories and their equipment are strictly monitored by the authorities.

Patient rights are protected by the Patient Rights Protection Law (2004).

The Croatian Chamber (see later) has an expert committee with a system to supervise the quality of the clinical dentistry provided, whether in the private sector or through the HZZO.

Patient complaints should be managed initially by the dentist. Patients' rights are protected by law and if dissatisfied they can complain to the Chamber. Proven complaints are reimbursed by the insurance company having a contract with the Chamber. This reimbursement covers all treatments in both sectors.

Health Data

		Year	Source
DMFT at age 12	3.03	2002	OECD
DMFT zero at age 12	No data		
Edentulous at age 65	No data		

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no mass fluoridation schemes (such as water, milk or salt)) but dentists routinely undertake fluoride treatments of deciduous and permanent teeth in children.

Education, Training and Registration

Undergraduate Training and Qualification

To enter dental school a student has to have completed secondary school (cca. age 18). There is an entrance examination which consists of scoring from secondary school grades, scoring from a written exam and scoring from a manual skills exam.

Year of data:	2008
Number of schools	3
Student intake	160
Number of graduates	80
Percentage female	67%

The undergraduate course lasts for 5 (Split and Rijeka) or 6 years (Zagreb), depending on which school is chosen.

The oldest dental school is in Zagreb, founded in 1962; the school in Rijeka was founded 1973. The dental school of Split was founded in 2006 and is privately funded. By 2008 there had been no graduates.

All curricula are tailored according to the *Bologna Declaration*.

Quality assurance for the dental schools is provided by the Ministry of Education.

Qualification and Vocational Training

Primary dental qualification

The primary degree which is included in the register is:

doktor stomatologije (dr.stom.) or
Doctor of Dental Medicine (DMD) in English

Vocational Training (VT)

There is no post-qualification VT, other than as below.

Registration

To register in Croatia, a dentist must have a recognised degree or diploma awarded by the university and have completed one year of mandatory training or "residence," under the supervision of experienced dentists. At least 6 months of this training must be undertaken in dental school and 6 months in one of the experienced private or contractor dental offices. There is practical and theoretical training. The trainees are salaried as non-dentists, without a licence with maximum salaries of €7000 (gross) a year.

After that the trainee dentist must pass the state exam held at the Ministry of Health and organised by the staff of the school of dentistry and Ministry. After this exam has been passed, the dentist obtains a Licence from the Croatian Dental Chamber.

Only then a dentist is licensed to work independently.

Language Requirements

There is a formal need to understand and speak the Croatian language to register.

Further Postgraduate and Specialist Training

Continuing education

Continuing education is mandatory and the rules are set in law. The requirement is 7 hours of formal training each year. CE is organised by the Chamber (the number of courses and standards). Courses are given by dental school staff and private organisers.

Specialist Training

Specialist training is organised by the dental schools of Zagreb and Rijeka. Training lasts for 3 years and includes a University examination and written specialist thesis.

Specialist education leads also to a degree, for example: *"Specialist in Endodontics"*

There is training in 8 main specialties:

- Pedodontics
- Endodontics and Restorative dentistry
- Family dentistry
- Oral surgery
- Oral medicine
- Orthodontics
- Periodontics
- Prosthetics

There is also a medical specialty of Oral Maxillo-facial surgery.

The specialist title is issued by the competent authority - the Ministry of Health but a list that the public may consult is not kept.

Workforce

Dentists

Year of data:	2008
Total Registered	4,137
In active practice	3,500
Dentist to population ratio*	1,267
Percentage female	65%
Qualified overseas	No data

* this refers to the population per active dentist

There is an increase in workforce as demand rises. However, the dentist unemployment rate is reported by the Chamber as "high" (315 unemployed and registered at the Croatian employment service on Jan. 31st, 2008). There are some overseas qualified dentists working in Croatia but the actual numbers are unknown.

Movement of dentists across borders

In 2008, the Chamber reported: "There is an increased interest to come to Croatia and work as dentist".

Until Croatia becomes a member of the EU the unemployed dentists may not be able to go overseas to find employment.

Specialists

A patient has the right to go to a specialist but has to be referred by his contracted dentist. Patients can also go without referral, but then this is fully private and the patient has to pay for the service.

Year of data:	2008
Orthodontics	160
Oral Surgery	98
Endo & Restorative	93
Paedodontics	145
Periodontics	94
Prosthodontics	145
Oral Medicine	81
OMFS	30
Family Dental Medicine	2

Family Dental Medicine is unique to Croatia. It is an amalgam of dentistry focused on all dental problems related to family from birth to death – "Family dental doctor".

Auxiliaries

There is no system of use of dental auxiliaries in Croatia other than dental technicians. Medical auxiliaries are used by some dentists as Chairside Assistants but training is strictly informal and there is no qualification or registration. There is no guide to numbers.

Year of data:	2008
Hygienists	0
Technicians*	1200
Denturists	0
Assistants	No data
Therapists	0
Other	0

* there are an unknown number of unregistered technicians

Dental Technicians

Dental technicians train for 4 years in respective secondary schools (6 schools in Croatia), and they receive a diploma on qualification, for dental technicians. All dental technicians have to undertake one-year of vocational training after secondary school, after which they have to pass state examination of the Ministry of Health, in order to be free to work.

Technicians are not obliged to register, although most of them are registered with one of two existing Dental Techicians Associations in Croatia. By 2008 there was some activity towards the organisation of unique organisation, which could become a "Chamber for Dental Technicians", but details were not yet available. The numbers registered have been identified by how many receive the professional journal, but because registration is not mandatory it is concluded that there may be many unregistered but working.

It is not compulsory to undertake continuing education, but most technicinans do, due to competition and demands in everyday practice, especially those in private sector.

Technicians normally work in independent commercial laboratories or laboratories within national health service institututions, or in the laboratories which are part of private polyclinics. Nobody knows exactly, but it is thought that most are employed within the private sector. They are not able to treat patients at all directly.

Practice in Croatia

Oral health services are provided mainly in General Practice, both in the public and private sectors with about half of dentists in each sector.

Year of data:	2008
General practice (owners)	2,512
General practice (employees)	419
Public dental service	446
University/Hospital	137
Hospital	No data
Armed Forces	No data
Others	33
General Practice as a proportion is:	85%

"Others" refers to dentists working in incorporated dental offices. The number is included in the final row, "General Practice as a proportion of all dentists".

In Croatia the hospital dentists are also academics, hence the combined total. Also, many dentists practise in more than one sphere of practice.

In 2008, just over half of general practitioners were in purely private practice and just under half were in mixed practice (private and HZZO).

Working in General Practice

In Croatia, dentists who practice on their own, or as group practice, or in so called "polyclinic" institutions or incorporated dental practice are said to be in "private practice". The numbers working this way include contractors with HZZO who are providing primary public oral health care but also have the right to provide private services not included in the package of primary dental care.

Most doctors of dental medicine in practices are self-employed but additionally there were over 400 employees of private dental offices in 2008.

Most dentists in private practice earn their living through charging fees for treatments. Patients pay for the service when it exceeds their right given by the state included in the package (in offices having a contract with HZZO).

Patients without any contract with insurance companies pay for the full service in offices.

Fee scales

There are two levels of insurance: *obligatory* oral healthcare and *additional* oral healthcare. However, from 2008 additional healthcare is also obligatory but still has the name of additional and will depend on a person's salary/income.

The package of obligatory oral healthcare includes paedodontics, restorative dentistry, endodontics, oral diseases, (partially) periodontics, minor oral surgery and prosthetics, orthodontics (until the age of 18). For anything not included the patient pays a bill.

Additional oral healthcare includes what is not included in basic package and it is the remainder of periodontics, major oral surgery and advanced prosthetics. Not included in the additional oral healthcare is most of fixed prosthetics and orthodontics after 18.

The Dental Chamber recommends fees but these are not obligatory for their members.

Joining or establishing a practice

There is a book of regulations that regulates the size of dental practices, what should be included in the practice, the size of entrance door, the entrance for disabled persons etc. The same applies to group practices, polyclinic institutions and other practices.

Regarding location, a private practice can be established wherever the entrepreneur – dental doctor - finds appropriate space that suits the requirements of an Act about the minimum office space conditions (about 40 sq. m, requiring dental chair office, waiting room, two restrooms, and an entrance for disabled persons). But, most contractors who rent formerly state owned dental offices, situated in state buildings - "Public health homes" – are said (by the Chamber) not to have working conditions that answer the requirements of the "Act".

To start the dental practice a location permit is needed first from the municipality. After that several documents are needed in order to proceed:

1. Degree certificate;
2. State exam certificate;
3. Croatian residency;
4. Confirmation of not being prosecuted.

After submitting all requested documents the Ministry of Health asks the Chamber for their opinion, included in the letter of confirmation. When the dental office is ready to function a three member commission from the Ministry checks it from the legal and clinical point of view and formally approves the start. Only after that a permit to start the dental practice (or joint dental practice, or polyclinic) is issued.

Working in the Public Dental Service

A small number of offices remain in former public health centres and work only for the HZZO.

Children (until 15 years of age) have to be registered to a dentist contracted with the HZZO if they want free service. Disabled and bed ridden persons also have to be registered to the contracted dental office to receive primary dental care.

Working in Hospitals

Those dentists working in hospitals also work for the Dental Schools of Zagreb or Rijeka, so they are numbered in the University group. Indeed, almost all dentists teaching in

these dental schools are at the same time members of hospital clinics at the University hospital clinical centres of Zagreb and Rijeka.

There are restrictions on these dentists seeing other patients outside hospital. It is obligatory for the staff member to obtain the permit to work outside hospital, from the Director of the Clinical institution and additionally amounting to no more than 20% of working time.

Patients requiring oral surgery would either receive it from an oral surgeon in a primary care setting (in a general practice) or for more serious procedures would go to the hospitals in the bigger cities.

The complaints procedures are the same as those for dentists working in other settings.

Working in Universities and Dental Faculties

Dentists working in dental schools are salaried employees of the University (and University Clinics). Until the early 2000s they were not allowed to work elsewhere but now they have that possibility – but only after the Director's permit (see above).

The academic titles are: Assistant, Assistant Professor, Associate Professor and Professor.

To become an Assistant Professor or higher one must obtain first the Ph.D. level and also finish a specialist clinical training.

The quality of clinical care, teaching and research in dental faculties is performed by its staff and through students working in teams under the direction of experienced teaching and academic staff.

Epidemiological surveying in Croatia would normally be done by academic dentists.

The complaints procedures are the same as those for dentists working in other settings.

Working in the Armed Forces

There are dentists working in the Armed forces but data are not obtainable.

Professional Matters

Professional associations

The Croatian Dental Chamber is an independent, professional, non-political association, founded in 1995 in Zagreb as an organisation of doctors of dental medicine. It is a legal entity empowered to represent the rights and professional common interest of dentists, as well as to care about reputation and advancement of the dental profession in the Republic of Croatia.

	Number	Year	Source
Dental Chamber	4,137	2008	Chamber
Dental Society	1,748	2008	FDI

Membership of the Chamber is obligatory by Statute. There are full-time staff based in Zagreb and also regional offices without full-time staff. The Chamber organises Continuing Education and is responsible for monitoring its uptake by dentists.

Patient complaints which have not been satisfied by the individual dental practice's complaints procedure are investigated and settled by the Chamber.

Ethics and Regulation

Doctors of dental medicine have to swear to Hippocrates' Oath, follow all medical and human standards and, above all, rightful action towards patients and colleagues. This includes using scientifically based and proven techniques and materials; this also includes a protection of patients' rights (which are also protected by the Law).

Fitness to Practise/Disciplinary Matters

Supervision of the practise of dentistry is by the Dental Chamber and by the Ministry of Health. There were about 17 complaints made against dentists in 2007.

Based on the decision of the Chamber's Committee for a misdemeanour or proven mistake, the Committee can impose an Admonition, a Public Admonition, a Financial Penalty, Amending damages, and temporary or permanent withdrawal of the licence to practise.

Data Protection

There is a Data Protection Law which ensures that no data can be issued or printed without the patient's and/or an employer's consent.

Advertising

Advertising is permitted only when a doctor opens an office, or when moving from one address to another, otherwise no advertising is permitted.

Website promotion is permitted and not under any control.

Insurance and professional indemnity

Patient indemnity insurance is not compulsory for doctors of dental medicine, but voluntary. However, the Croatian Dental Chamber includes in its annual subscription professional indemnity insurance. This provides coverage for all patient injuries caused during dental care, up to a limit of €1,500.

The compensation covers medical and dental treatment expenses, other necessary expenses caused by the injury, loss of income, pain and suffering, permanent functional defect and permanent cosmetic injuries. Claims for compensation have to be presented to the Dental Chamber's Committee.

In theory the insurance should cover for work done by Croatian dentists outside Croatia, but there is no information available about whether this has actually applied.

Corporate Dentistry

Doctors of Dental Medicine can own other non-dentist companies and non–dentists can own or part own incorporated companies and share in any profits.

Tooth Whitening

Tooth whitening in Croatia comes under the Cosmetic Directive.

Health and Safety at Work

Employees are protected by the "Law of Safety at Work". Hepatitis B vaccination is mandatory (with rare medically documented exclusions).

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Ministry of Health
Electrical installations	Ministry of Health
Infection control	Ministry of Health
Medical devices	Ministry of Health
Waste disposal	Ministry of Environment Protection

Ionising Radiation

There are specific regulations about radiation protection. Training in radiation protection is mandatory for the competent person in each practice – in Croatia, the dentist. The dentist must undergo continuing training, within the general requirements for continuing education.

Hazardous Waste

The EU Hazardous Waste Directive is incorporated into law and actively enforced. Amalgam separators are legally required.

Financial Matters

Retirement pensions and Healthcare

The national obligatory pension income contribution is:

a) I pillar : 15% of gross earnings
b) II pillar: 5 % of gross earnings.

The national voluntary income pension contribution is:

III pillar (voluntary amount)

Retirement pensions in Croatia are 60% of all working time average to a maximum of €900 per month. The official retirement age in Croatia is 65 – male, 60 – female.

Taxes

There is a national income tax (dependent on salary), a municipal tax (which varies according to municipality: in capital Zagreb 18%)

National income tax:

National income tax: 15%; 25%; 35% and 45% (on a monthly gross income over €6,000)

In addition to taxes there are retirement and health insurance contributions.

VAT/sales tax

There is a value added tax payable at a rate of 22% on purchases. Dental and medical services are excluded.

Various Financial Comparators:

No data available

Other Useful Information

Main national associations and Information Centre:

Hrvatska stomatološka komora
Kurelceva 3, 10000 Zagreb
Tel: +3851 488 6710
Fax: +3851 481 6540
Website: hsk@hsk.hr

Specialist associations and societies:
Dentists' scientific organisation:

Hrvatsko stomatološko društvo
Hrvatski lijecnicki zbor,
Šubiceva 9, 10000 Zagreb
Avenija Gojka Šuška 6, 10040 Zagreb
Tel: +385 1290 3067
Fax: +385 1286 4250

Website: hsd@kbd.hr

Competent Authority:

Ministry of Health and Social Care
Ksaver 200a, 10 000 Zagreb

- Tel: +385 1 4607 555
- Tel: +385 1 4677 005
- Tel: +385 1 4698 300

Prisavlje 14, 10 000 Zagreb

- Tel: +385 1 6169 111
- Web : http://www.mzss.hr

Publications:

Hrvatski stomatološki vjesnik

Dental Schools:

Zagreb

Stomatološki fakultet Sveucilišta u Zagrebu
Gunduliceva 5, 10000 Zagreb
Tel: +385 1480 2111
Fax: +385 1480 2158
Web: sfzg@sfzg.hr

Dentists graduating each year: 60
Number of students: 450

Rijeka

Stomatološki fakultet Sveucilišta u Rijeci
Brace Branchetta 20 + 51 000 Rijeka
Tel: + 385 5165 1111
Fax: + 385 5167 5806
Web: www.medri.hr/studiji/stomatologija

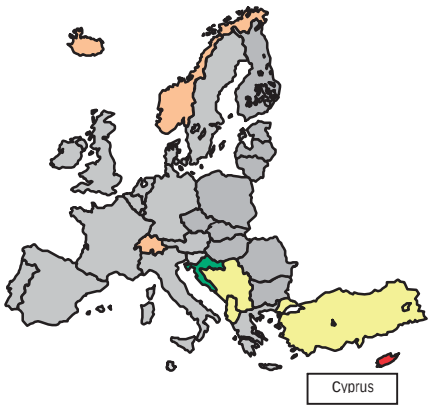
Dentists graduating each year: 20
Number of students: 150

Split

Stomatološki fakultet u Splitu
Benkovacka 10/a - Split
Tel: +385 2150 2600; 502 491
Fax: +385 2150 2490; 501 141
Mob. +385 9111 11455
www.dentalcentarmarusic.com
E-mail: dental.marusic@dentalcentarmarusic.com

Number of students: 120
(the School was only founded in 2006, so by 2008 there were no graduates)

Cyprus



Date of last revision: 1st October 2008

In the EU/EEA since	2004
Population (2008)	794,580
GDP PPP per capita (2007)	€22,938
Currency	Euro
Main languages	Greek, Turkish & English

In Cyprus oral healthcare is provided largely through fully liberal, private general practice, as the public sector is very small. The amount contributed depends on income.

Number of dentists:	1,018
Population to (active) dentist ratio:	1,091
Members of Dental Association:	100%

The use of dental specialists is restricted as is the development of clinical dental auxiliaries.
Continuing education for dentists is not mandatory.

Government and healthcare in Cyprus

The Republic of Cyprus is on an island in the eastern Mediterranean Sea. Turkey lies to the north and Syria to the East. The land area of the island is 9,250 sq km, which makes it the third largest island in the Mediterranean. The highest point on the island (Mt Olympus) is 1,951 m. The capital, Nicosia is near the geographical centre of the island.

Independence from the UK was approved in 1960 with constitutional guarantees by the Greek, Turkish and UK governments.

However, following military intervention by Turkey in 1974, the island has been *de facto* divided, with a northern 37% being controlled as "Turkish Republic of Northern Cyprus", declared in 1983, recognised only by Turkey, and unaccepted as a legal entity by the rest of the world. There have been UN-led direct talks between the two sides to reach a comprehensive settlement to the division of the island from time to time but no progress has been made. The Republic of Cyprus became a member of the EU in 2004. The *Acquis Communautaire* will not be applied in the north part, for the time being.

The Republic is governed as a presidential democracy. The legislative power is administered through the House of Representatives and the judicial power is executed by the Supreme Court and the District Courts. There are six administrative districts.

About 81% of the population are Greek-Cypriots (including about 9,000 Maronites, Armenians and Latins), 11.0% Turkish-Cypriots and 8% foreign residents and workers.

In Cyprus, a National Health System had not yet been established by 2008. Health care is provided by the government (public sector), the private health care sector, and some schemes covering specific population groups. According to Cypriot national legislation, health care in the public sector is provided by the Government Medical and Dental Services and is governed by the Government Medical Institutions and Services General Regulations of 2002.

The introduction of a General Health Insurance Scheme (GHIS) is scheduled for 2009. The GHIS will:

1. Provide general medical services, specialised in medical services, inpatient care, diagnostic tests, drugs, rehabilitation services and preventive dental care for children up to 16 years old and medical treatment abroad.
2. Change the structure of health care services, as well as the way providers are remunerated for their services. Primary care Physicians will be paid on a combined manner, 3-tiered approach (capitation rate, quality assurance, reward right referral pattern); specialists will be paid on a fee schedule. Hospital services payment will be paid on the Diagnostic Related Groups (DRGs) system.
3. Introduce elements of competition between the private ant the public sector to stipulate greater efficiency, quality and effectiveness in the provision of health care services.

Improved institutional capacity, organisational structure and human resources through changes are expected to take place in order to provide the necessary infrastructure for the implementation of the GHIS.

Current legislation in Cyprus stipulates that financial criteria must be taken into account to define eligibility for receiving health care by the public sector.

		Year	Source
% GDP spent on health	6.0%	2007	CSS
% of this spent by governm't	45.0%	2007	CSS

The CSS is the Cyprus Statistical Service

Public healthcare expenditure is regulated by Parliament, on an annual basis.

Oral healthcare

Oral health care in Cyprus is provided by dentists and dental auxiliaries employed by the government (Dental Services of the Ministry of Health) and by private (non-governmental) dentists and dental auxiliaries financed by payments by patients or a source other than the government. Some dentists have contracts with workers´ unions or other semi-governmental organisations, as well as insurance companies. They would normally be paid on an item of service system.

		Year	Source
% GDP spent on oral health	0.06%	2007	CSS
% of OH expenditure private	97%	2007	CSS

As mentioned earlier, access to public oral healthcare depends on income. Primary school children receive free preventive treatment from the public sector. The services provided by the public sector also include conservative and surgical items, but not orthodontics or fixed prosthetics. These items have to be paid for by the patients. Special groups (such a poorer adults and children with special needs) are exempted from charges, or pay a reduced amount, for their dental treatment offered by the public sector.

For the rest, there is a set rate for the oral healthcare provided by the public sector, depending on the income and status of the patients (for example, civil servants are entitled to reduced fees). However, different levels of contribution do not affect the level of entitlement to care.

For the public sector the Law governing the provision of Dental Services is applied. There are fixed prices for the specific items offered, but depending on the income of the patient, as mentioned above. For the private sector, the patient pays directly and the price is not regulated. In the case of insurance company involvement, the fees are agreed between the dentist and the company.

With the implementation of a new General Health Insurance System (GHIS), the Ministry of Health has recommended the following adjustments related to dental services:

- Primary/preventive dental care up to the age of 16;
- Provision of dental services in Foundations (in mobile dental units);
- Public Dental Health;
- Dental Treatment for pupils aged 10 from private sector dentists - after the student's reference by dentists from the public sector;
- Dental Treatment for schools (in mobile dental units);
- Second degree dental care (Dental Surgery, Paedodontics, Periodontology) for special groups;
- Third Degree dental care services (Removable prosthetics and Oral/Maxillofacial Surgery - local and general anaesthesia) for special groups.

The proportion of the population receiving oral healthcare regularly (in a two-year period) is not known, but there is data for the public sector.

Oral examinations would normally be undertaken annually, or more frequently where active disease is present. There is an uneven distribution of dentists in Cyprus, but as the roads are in a very good condition and Cyprus is a small place, there is no actual problem of access.

Domiciliary care is normally provided by the Public Service, in certain cases.

Private Insurance

Only a very small proportion of the population is covered by private insurance companies.

Quality of Care

A committee at the level of the Ministry of Health is becoming involved with issues concerning quality. However, there are no routine checks and they rely on someone making a complaint.

Health data

		Year	Source
DMFT at age 12	1.14	2005	Min of Health
DMFT zero at age 12	No data		
Edentulous at age 65	No data		

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There is no fluoride adjusted water scheme in Cyprus, although a very small proportion of the population receives fluoridated water at or above optimal levels (naturally fluoridated).

Education, Training and Registration

Undergraduate Training

There are no dental schools in Cyprus. The majority – about 75% - of dentists practicing in Cyprus have graduated from EU/EEA universities - mainly Greek Universities (Athens and Thessaloniki). To study in Greece, a student has to pass the entry exams organised by the Ministry of Education of Cyprus - there are usually 15 posts allocated for Cypriot citizens each year. If a student wishes to study in other countries he/she has to fulfil the requirements imposed by the country concerned.

Qualification and Vocational Training

Vocational Training (VT)

There is no post-qualification training in Cyprus.

Registration

According to the Articles 19A (1) and (2) of the amended Dentists' Registration Law 2004:

(1) A dentist national of a Member State who holds one of the titles referred to in Annex V and is a resident of an EU Member State has the right to provide services in the Cyprus Republic without being registered with the Dental Council. (In this case he/she is registered in a record kept by the Dental Council)

(2) In accordance with this Article, the Dental Council keeps a record of the names of dental practitioners who provide services.

According to the amended Dentists' Registration Law 2004 Article 4(1) the following persons shall be entitled to be registered as a dentist, if the Dental Council's requirements are met:

a. Any person whose age is 21 years old and above.
b. Any person who is a national of the Republic of Cyprus or is married to or is a child of a national of the Republic of Cyprus who has his permanent place of residence in, or is a national of a Member State.
c. Any person who holds a diploma, certificate or other title applied to Annex III or holds a diploma or title which is not applied to Annex III but complies with the requirements at Annex IV, which is recognised by KYSATS and approved by the Dental Council or covered by the provisions in Article 4A.
d. Is a person of good character presenting a certificate of the "judicial record" or, in the case of nationals of Member States, an equivalent document issued by a competent authority in the Member State of origin or the Member State from which the foreign national comes, given that this is updated (not more than three months since the date of issue up to the date of its presentation).
e. Any person who has not ceased to practice because of professional misconduct.

In order to be allowed to practice Dentistry in Cyprus, registration with the Cyprus Dental Council is mandatory for recognition of his/her title and then in order to practice the dental profession he/she has to be registered with the Cyprus Dental Association (professional body) so all dentists are members.

Exempted from the registration with the Cyprus Dental Association are the dentists who would like to provide services according to the relevant sectoral Directives. If an EU dentist wants to be established in Cyprus he/she also has to be registered with both CDC and CDA, but for a dentist who wants to provide services for a limited time period, registration with the CDC only is necessary. Nevertheless, with the new PQD Directive, the new harmonised legislation will state that if a dentist wishes to provide services, she/he will have to have a pro forma registration with the professional association.

Language requirements

Language requirements are going to be imposed with the new amended legislation (harmonisation with the EU Directive 2005/36) as regards license to practice.

Cost of registration CDC (2008)	€ 34.17
Cost of registration CDA (2008)	€ 120

Further Postgraduate and Specialist Training

Continuing education

Continuing education is not mandatory. The Dental Services of the Ministry of Health, with the collaboration of the Cyprus Dental Association, organises seminars and workshops on contemporary dental topics in Cyprus, with instructors from EU countries (mainly from Greek Universities).

Specialist Training

There is no specialist training in Cyprus. All specialists train overseas.

Workforce

Dentists

All dentists practising in Cyprus qualified overseas. In 2001 about 66% qualified in EU/ EEA countries, with the remainder qualified in third countries.

Year of data:	2008
Total Registered	1,018
In active practice	728
Dentist to population ratio*	1,091
Percentage female	47%
Qualified overseas	1,018

There is no reported unemployment amongst dentists in Cyprus.

Movement of dentists across borders

There is no significant movement of dentists from and to Cyprus. Dentists from the UK mainly come to get established in Cyprus, but not in large numbers. Cypriot dentists move to other EU/EEA countries (mostly the UK) to get postgraduate education and to work.

Specialists

Since 2004, when new laws were enacted, the recognised specialties are:

- Orthodontists who have received at least 3 years' training, and
- Oral Surgeons, who have received at least 3 years' training, and
- Oral Maxillo-facial surgeons, after basic medical and dental training plus at least 4 years' specialist training, and
- Dento-alveolar surgery, after at least 4 years' training

Year of data:	2008
Orthodontics	40
Endodontics	
Paedodontics	
Periodontics	
Prosthodontics	
Oral Surgery	1
Dental Public Health	
Dento-alveolar Surgery	12
OMFS	2

Specialists usually practice in the towns but as Cyprus is small there is no actual problem for patients to access them. About two thirds of the Oral surgeons have had dental training only and the remainder have received medical and dental training. The specialty of Oral-Maxillofacial Surgery is also recognised by the Cyprus Medical Council.

Auxiliaries

There are two kinds of clinical dental auxiliaries in Cyprus, Dental Hygienists and Technicians:

Year of data:	2008
Hygienists	7
Technicians	200
Denturists	0
Assistants	340
Therapists	0

Dental Hygienists

Dental hygienists are trained abroad as there are no dental schools in Cyprus. They are not registered nor regulated in Cyprus. Dental hygienists are paid a set fee for every patient who is seen.

Dental Technicians

Technicians are trained in Greece, the UK, other European countries, or the USA. The minimum requirement, for a dental technician to be registered, is 3 years study, after the completion of the secondary school studies. They normally work in separate dental laboratories and invoice the dentist for work done.

They have to be registered with the Dental Technicians' Council, comprised of 7 members, 1 public dental technician, 1 public dentist, 1 private dentist and 4 private dental technicians. There is no reported illegal practice.

Dental Chairside Assistants

Dental assistants working for the public sector are salaried. There are approximately 40 (unqualified). The others, in the private sector, are salaried or have an agreement with the dentist to work on commission.

There is no formal education, but dental assistants working for the public sector undergo on the job training.

Practice in Cyprus

Only a small proportion of dentists work for the Public Health Services in the Dental Services of the Ministry of Health, and in the Armed Forces - these dentists cannot practice privately. The others are private practitioners.

There is no data available for the private sector relating to how many patients would normally see in a day, but in the public sector a dentist can treat about 15 patients daily.

Year of data:	2008
General (private) practice	681
Public dental service	40
University	
Hospital	
Armed Forces	7
General Practice as a proportion is	94%

Working in General Practice

Most dentists practice in private practice. They work in a completely liberal, private fees-for-service system. However, there is a minimum price list set by the Cyprus Dental Association.

Joining or establishing a practice

There are no specific rules about the location of a practice, for the time being.
There is no government assistance to set up new practices, and these are usually funded through bank loans.

Most dental practices in Cyprus are solo practices. Only a small percentage of general dental practitioners work as assistants or associates. There are no specific regulations for the time being but in 2008 it is expected that new special regulations will apply at some future time.

Working in Hospitals (the Public Dental Service)

There are 5 public district hospitals in Cyprus. The Public Health Service Dentists work in these urban and rural health centres, owned by the state. They are all salaried and are not permitted to undertake private practice. The treatment they may provide includes oral surgery, oral maxillofacial surgery, endodontics, restorative dentistry, paedodontics, removable prosthetics and dental public health.

There are also a few small private hospitals, but only 3 or 4 clinicians provide services there, mostly oral maxillofacial surgery.

Working in the Armed Forces

There are a handful of dentists working full time for the Armed Forces, including one female.

Professional Matters

Professional associations

	Number	Year	Source
Cyprus Dental Association	728	2007	CDA

There is a single main national association, the Cyprus Dental Association. The Association was founded and was established by law in 1968 - with five local Dental Associations also. These are Nicosia-Keryneia, Limassol, Larnaka, Pafos and Famagusta Local Dental Association one in each District of Cyprus. Each dentist, under the Dentists Registration Law should be registered with the local Dental Association where he/she practises dentistry.

There are 23 members of the council of the Association and they elect the President, Vice-President, Secretary and Treasurer. Also, there is a scientific committee and executive committee. They have their regular meetings every two months and the elections for the new members of the council every three years.

The Association represents private and public dentists and combines this role by trying to emphasize to common professional matters.

The local dental associations have representatives in the Board of the CDA.

The CDA has owned a new building since 2007 and has one full-time secretary.

The Dental Council is made up of 4 dentists from the private sector and 3 from the public sector. The Council is appointed by the Council of Ministers. It is the competent authority for the registration of dentists in Cyprus and for the recognition of dental specialities.

Ethics and Regulation

Ethical Code

Dentists work under an ethical code which covers relationships and behaviour between dentists, the contract with the patient. The ethical code is administered by the Cyprus Dental Association.

Fitness to Practise/Disciplinary Matters

Complaints from patients are presented to the Cyprus Dental Association and to the Court, depending on the nature of the complaint. The Disciplinary Committee of the Cyprus Dental Association judges the complaints. Dentists from both the public and private sectors sit as members of the committee. A complaint may be referred to the courts, depending on its severity.

Usually the remedies have to do with monetary compensation. The final sanction of the professional body could be the withdrawal of the licence for a specific duration of time. The final sanction of the court could be a sum of money to be paid to the patient as penalty. The right of appeal is based on the National Law.

Data Protection

Cyprus has been harmonised with EU Legislation in regard to data protection.

Advertising

Advertising is not generally allowed. A dentist can display the title he/she bears, if this title is recognised by the Dental Council. However, when a young dentist is starting practice he or she may put an advertisement in a newspaper.

Dentists may use websites to inform the patients on general dental issues or inform their colleagues on a special kind of service they provide. There were plans to integrate the CED Code in the new dentists' code of ethics legislation, hopefully later in 2008.

Insurance and professional indemnity

There is no mandatory professional indemnity cover in Cyprus. However, discussions were being held in the Parliament and in the CDA on this topic in 2008.

Corporate Dentistry

This is permitted in Cyprus. Non-dentists may wholly or partly own the company, but in all cases at least one dentist must be employed

Tooth whitening

There is no specific legislation about this in Cyprus.

Health and Safety at Work

Most members of the dental workforce have been vaccinated with Hepatitis B vaccine, but this is not mandatory.

Ionising Radiation

There are specific regulations about radiation protection, according to the relevant EU Directives. Licensing of ionising radiation equipment is regulated through legislation and there are licensed users of ionising radiation, dentists are included.

There is no mandatory continuing education for ionising radiation. Dentists can attend seminars organised on this issue by the Ministry of Labour and Ministry of Health.

Hazardous waste

Cyprus adopted the European legislation on waste disposal in 2005. The disposal of clinical and hazardous waste including the installation of amalgam separators is governed by legislation. Each producer and holder of waste is responsible for its safe disposal.

The Public Dental Service has a contract with a private company for clinical and hazardous waste. Amalgam separators are installed in the dental units of the public dental service. Private practices are not obliged by law to have amalgam separators. Dental equipment is governed by legislation as regards the CE conformity marking.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	The Ministry of Labour and the Ministry of Health
Electrical installations	The Ministry of Communication & Works in collaboration with the Electricity Authority of Cyprus
Infection control	The Ministry of Health
Medical devices	The Ministry of Health and the Ministry of Commerce, Industry and Tourism
Waste disposal	The Ministry of Agriculture, Natural Resources and Environment.

Financial Matters

Retirement pensions and Healthcare

Pensions for the dentists in the public sector are monitored through the Pensions Law of the civil servants (retirement at 60 years of age). Public health workers receive a pension based on the years of service they have had in the civil service and on their final salary.

Dentists in the private sector can work past this retirement age. They claim their pension according to their contributions to the Social Insurance fund during their working life. In 2008 a new legislation was being enacted to establish a "Dentists´ Pension Fund" combined with the "Doctors´ Pension Fund". The Dental Association was working towards enabling dentists to join this scheme.

Taxes

National income tax:

The highest rate of income tax is 30% on earnings over about €25,500.

In addition to income tax, social insurance premiums are paid as a percentage of salary, a 6.3% contribution each by the employer and employee. However, civil servants are entitled to a reduced health care provision to the fund.

VAT/sales tax

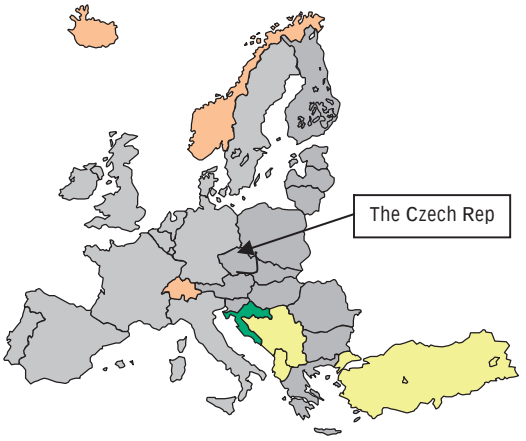
There is a value added tax, payable at a rate of 15% on purchases. Medical and dental services are not included

Other Useful Information

Main national association and Information Centre:	*Main information Centre:*
Cyprus Dental Association 1, 28 Octovriou Str., 2414 Nicosia, Cyprus or P.O. Box 22063, 1517 Nicosia, Cyprus Tel: +357 22 819 819 Fax: +357 22 819 815 Email: cda@cytanet.com.cy Website: www.dental.org.cy	Dental Services Nicosia General Hospital 1450 Nicosia Cyprus Tel; +357 22 801511, +357 99 685190 Fax +357 22 669148, +357 22 592606 Email: Plambrou@ds.moh.gov.cy Website: www.moh.gov.cy
Main Professional Journal	*Competent Authority:*
Dental Revue (ODONTIATRIKO VIMA) 1, 28 Octovriou Str., 2414 Nicosia, CYPRUS or P.O. Box 22063, 1517 Nicosia, CYPRUS Tel: +357 22 819 819 Fax: +357 22 819 815 Email: cda@cytanet.com.cy Website: www.dental.org.cy	Cyprus Dental Council 1, 28 Octovriou Str., 2414 Nicosia, CYPRUS or PO.Box 22063, 1517 Nicosia, CYPRUS Tel: +357 22 819 819 or +357 24 654 525 Fax: +357 22 819 815 or +357 24 625 516 Email: www.dental.org.cy Website: cdcouncil@dental.org.cy

There are no dental schools in Cyprus

The Czech Republic



In the EU/EEA since	2004
Population (2008)	10,381,130
GDP PPP per capita (2006)	€20,612
Currency	Czech Crown (CZK)
	23.4 CZK = €1.00 (2008)
Main languages	Czech

There is compulsory membership of all citizens in the health insurance system. This is provided by 9 (state-approved) health insurance companies. Around 6% of the public healthcare budget is spent on dentistry. About 70% of dental care is paid from the state system and the balance is through fully liberal practice.

Number of dentists:	8,146
Population to (active) dentist ratio:	1,473
Members of Dental Association:	100%

Specialists are available and the use of clinical auxiliaries is limited to dental hygienists. Continuing education for dentists is mandatory, but participation can lead to Certificates of Proficiency and higher fees for dental practitioners.

Date of last revision: 1st October 2008

Government and healthcare in the Czech Republic

The Czech Republic is a small country in terms of population and land area coverage (78,864 sq km).

The Czech Republic is a sovereign, united and democratic country. Its government is divided into three branches - the legislative, represented by Parliament, the executive, represented mainly by the President and the government, and the judicial branch, represented by courts at various levels. The country is administered as 13 regions. Praha, the capital, has regional status, too.

Czech healthcare is founded on the following principles of solidarity ("spreading the risk"), a high level of autonomy, multi-source financing by predominantly public health insurance, the free choice of physician and health care facility, the free choice of health insurer in the framework of public health insurance, and equal accessibility to services provided for all insured.

Healthcare is provided predominantly on the basis of obligatory public health insurance. The public health insurance system is provided by 10 (state-approved) health insurance companies. The system (sick fund) provides a legally prescribed standard package of healthcare. Contractual health insurance is only of a supplementary nature.

Persons participating in public insurance are required to pay premiums regularly. Public health insurance payers are various and include: employees, employers, self-employed individuals and the State.

If the participant in the system of public health insurance is an employee, then both the employer and employee share in the payment of premiums, where the employee pays one third of the whole amount and the employer the remaining two-thirds - 4.5% and 9% of income respectively, in total 13.5% of the gross wage. Self-employed individuals participating in the public health insurance pay premiums themselves in the form of a monthly deposit, and following end-of-year accounting.

The State is the premium payer for some individuals who are participants in public health insurance, by transferring the legally required amounts from the State budget to the insurer. This group includes for children not otherwise provided for (up to 18 years or up to 26 years old by studying), pensioners – receiving pension from the Czech pension insurance scheme, mothers on maternity leave or those who take full-time care of at least one child up to 7 years old or two children up to 15 years old, national servicemen, persons in custody or serving their sentence, and others.

Persons with permanent residence in the CR but who are neither employees nor self-employed persons, nor persons for whom the state pays the premiums, are required to pay the due premium deposit payments to their insurer.

		Year	Source
% GDP spent on health	6.8%	2006	OECD
% of this spent by governm't	87.9%	2006	OECD

Oral healthcare

About 5% of the public healthcare budget is spent on dentistry. The healthcare budget is annually estimated according to the expected amount of money in the insurance fund.

		Year	Source
% GDP spent on oral health	0.36%	2006	Chamber
% OH expenditure private	No data		

Oral healthcare is coordinated by the Czech Dental Chamber (Ceská stomatologická komora – CSK).

Public compulsory health insurance

The insurance fund is the compulsory public health insurance system mentioned above. The system of money distribution is limited by government health policy.

Up to 80% of dental care is paid from the health insurance system and the balance is through fully liberal practice. The Sick Funds are self-regulating under national legislation.

The dental services are delivered through a system of university clinics, or by private dentists and dental laboratories. In 2007, about 90% of dental care was delivered by private dentists.

The insurance system provides cover for all standard conservative items such as amalgam fillings, basic endodontic treatment (canal filling using any suitable paste material), surgical and periodontal items and for a few basic prosthodontic items. There is no co-payment by the patient for the standard items (the list of items and their description is presented in the Collection of Laws. There is no annual limit of treatment range, for an individual patient.

Cosmetic fillings and non-basic endodontic treatment (methods of lateral or vertical condensation of gutta-percha points or Thermofil-type systems), implants and fixed orthodontic appliances in adults have to be paid for completely by patients. Crowns and bridges, partial dentures and removable orthodontic appliances are paid partly from sick funds and partly by the patient. The percentage is different for various prosthodontic items, for example:

- metallo-ceramic crown = 15-20% sick fund, 80-85% patient,
- partial dentures with casting framework = 30-60% sick fund, 40-70% patient.

There is no prior approval for treatment and no provision for domiciliary (home) care.

Children under 18 years receive health insurance system cover for the higher cost - the adult patient self-payment part of their dental care (for all types of fillings, all types of endodontic treatment, and the higher cover element of prosthodontic items).
Less than 1% of dentists (mainly in Praha and in the other larger cities) work completely outside the system of health insurance, in fully liberal practice. The prices of dental care in their practices are contractual and their patients must pay the full cost of their dental care, directly negotiated with the dentist. So the fees are totally unregulated (according to a feedback of the market).

A full-time working dentist would normally have 1,650 patients regularly attending. Oral re-examinations normally would be carried out for most adult patients at a period of 6 months.

In some parts of Czech Republic there is a shortage of orthodontists and specialists for oral surgery, periodontology or paediatric dentistry.

The Quality of Care

The Dental Chamber becomes involved when a patient complains about the quality of care. The complaint may be made:

- to the health insurance company
- to the Dental Chamber

By law, the CSK is empowered to access and examine complaints filed against dentists. Final complaints are processed by the regional, professional board of examination – Regional Dental Chambers´ Auditing Boards. The authority to examine a dentist's professional malpractice or ethical misjudgement is carried by the relevant professional disciplinary bodies – the Regional Dental Chambers' Honorary Councils and the Czech Dental Chamber's Honorary Council.

Health data

		Year	Source
DMFT at age 12	2.50	2006	Chamber
DMFT zero at age 12	29.5%	2006	Chamber
Edentulous at age 65	18.2%	2003	Chamber

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There is no fluoridation of the water supplies in the Czech Republic. There is some fluoridation of salt on a voluntary basis. Dentists recommend the use of fluoride toothpaste or other local fluoride agents individually, according to age and dental status of the patient.

Education, Training and Registration

Undergraduate Training

To enter dental school students must successfully finish high school, with a school-leaving certificate. They must successfully pass a theoretical entrance examination. No other vocational entry is needed.

Year of data:	2007
Number of schools	5
Student intake	260
Number of graduates	250
Percentage female	38%

Dental schools are known as *Stomatologická klinika Lékarské fakulty*, of a university (Stomatological Clinic of the Faculty of Medicine of the University).

Until the undergraduate intake of students in 2003 the course of study was different in the five Czech dental schools: 5 years, 5.5 years, or 6 years. Since 2004 dental studies have been under a new a curriculum, according to the standards of the EU – and the courses are all 5 years

The responsibility for quality assurance in the faculties is by the Ministry of Education, the Chancellor of the University and the Dean of the Faculty.

Qualification and Vocational Training

Primary dental qualification

Until 2003, the title on qualification was MUDr., the same title as for a doctor in general medicine, but the text on the diploma is specified: *"Medicinae universae doctor in disciplina medicinae stomatologicae"*. The legislation for a change of title was subsequently changed and the title for a dentist is now "MDDr" *Diplom o ukonceni studia ve studijnim programmeu zubní lékarství (doktor zubního lékarství, MDDr.* This change of title is in relation to the newly formed study of dentistry has been from the year 2004.

Vocational Training (VT)

Upon qualification, there is a programme of vocational postgraduate training for 36 months, under the guidance of skilled dentists (with a certificate of the Dental Chamber). The training is not completed by examination – the certificate of completion of training is given by the tutor and only then is the dentist able to be fully licensed and to own a dental practice. During the training the dentist is a salaried employee. This post-qualification training has a practical part (the participant has to fulfil a list of prophylactic, diagnostic and treatment items) and a theoretical part of training (compulsory attendance on recommended courses and lectures).

This system of vocational training is likely to continue until the first *MDDr* graduates are produced in 2009, when the graduates will have had comparable education and training with the rest of the EU – and they will be able to work in other EU countries immediately upon qualification.

In 2009 it is expected that a new Czech law will be introduced, so that all graduates (MUDr. and MDDr.) are able to be fully licensed immediately upon qualification.

Czech vocational training is not compulsory for graduates of other EU countries' dental schools.

Registration

Dentists must register with the Ministry of Health, the Czech Dental Chamber (CSK) and the Regional Authority. To register, a dentist must have a recognised qualification, permission for permanent residence in the Czech Republic, a work permit, and knowledge of Czech language by test.

However, for Czech dentists there is no registration in the Ministry of Health, so no registration fees. For foreign dentists (non-Czech) the Ministry of Health recognises the qualification and this process is free of charge.

The CSK statutorily maintains a register containing the dentists´ data, including qualifications and professional performance data.

Requirements for foreigners to practice dentistry in the Czech Republic:

1. Recognition of a university diploma under the authority of the Ministry of Health
2. Adequate knowledge of the Czech language – successful completion of a test of qualification in the Czech language
3. Permission for long-term or permanent residence
4. The qualification achieved in any EU country is accepted. Authorisation for the practice of dentistry on the territory of the Czech Republic is under the authority of the Ministry of Health and is necessary for the dentists from non-EU countries. It consists of a professional written and oral examination
5. Membership in the Czech Dental Chamber (CSK).
   The CSK registers all who:
   - have duly completed studies at a school of medicine at a Czech or foreign university and successfully completed a final examination in dentistry
   – are authorised to practice dentistry on the territory of the Czech Republic.

- The fulfilment of the requirements stated above leads to authorisation to practice.
- In order to begin private practice, it is subsequently necessary to fulfil the requirements of the CSK for the issuance of a licence for the practice of practical dentistry.

Further Postgraduate and Specialist Training

Continuing education

Participation in continuing education has been obligatory since 2004.The system is delivered mainly by CSK, but also other providers can take part in the system. There are organised theoretical and practical lectures.

The result of the CSK continuing postgraduate education cycle is a Certificate of Proficiency, issued by the CSK;

- Dentist Practitioner with Certificate of Proficiency
- Dentist Practitioner with a Certificate of Proficiency in Periodontology
- Dentist Practitioner with a Certificate of Proficiency in Oral Surgery
- Dentist Practitioner with a Certificate of Proficiency in Paediatric dentistry

- Dentist holding a Certificate of Proficiency in Orthodontics

The Certificate of Proficiency is evidence of the education of the dentist, for patients. The attendance of dentists on recommended practice-oriented courses or theoretical lectures is evaluated by credits. The participant in continuing postgraduate education can receive the Certificate if the required amount of credits and the prescribed spectrum of educational actions, during two years, is fulfilled. The Certificate is valid usually for 3 to 5 years – it can be then repeated, if the conditions of postgraduate education are fulfilled. The holder of a Certificate has higher settlements for some dental care issues (about 10% higher) from the system of health insurance - the patient does not pay more.

Specialist training

There is specialist training in two recognised dental specialties: orthodontics and oral-maxillo-facial surgery. To enter specialist training a dentist must have completed 36 months in general dental practice (or, for oral surgery, medical practice is acceptable). Then to complete the specialist training of orthodontics it takes 3 years and of oral-maxillo-facial surgery 6 years and it is finished by examination.

Training takes place in clinics in universities and is undertaken by university teachers who have been accredited for specialist training.

The titles a specialist receives on gaining their diploma are:

- Orthodontics: attestation in maxillo-facial orthopaedics *Diplom o specializaci (v oboru ortodoncie*)
- Oral Surgery: attestation in oral and maxillofacial surgery *Diplom o specializaci (v oboru orální a maxilofaciálníChirurgie*))

The responsibility for registration of specialists lies with the Chamber under the State Educational System in healthcare. The dentists in specialist training are usually salaried employees (or part-time employees) of the universities where the training is held.

Workforce

Dentists

Year of data:	2007
Total Registered	8,146
In active practice	7,048
Dentist to population ratio*	1,468
Percentage female	65%
Qualified outside the CR or Slovakia	221

The "dentist to population ratio" means the figure of active dentists including specialists to the figure of population.

It was reported by the Chamber that there were no unemployed dentists in 2007.

The Chamber expects that the active dental workforce will decrease after 2008. About 63% of active dentists are older than 50 years, and it is presumed that in the following years more dentists will leave their practices due to reaching retirement age than will join the profession.

Movement of dentists across borders

There is no significant movement of dentists from the CR to its neighbouring countries. The figure of leaving dentists is similar to the figure of dentists coming from abroad - approximately 22 dentists a year enter from other countries and a similar number of Czech dentists receive a "good-standing" certificate for working abroad.

Specialists

Year of data:	2007
Orthodontics*	299
OMFS*	70

*In 2007, 28% of orthodontists were male, and 88% of OMFSs were male.

Additionally, about 75% of dentists hold a Certificate of Proficiency, which entitles them to higher fees – see below. This includes practitioners with a General Dental proficiency.

Certificates of Proficiency	
Year of data:	2007
Paedodontics	22
Periodontics	405
Prosthodontics	
Oral Surgery	434
Dental Public Health	

Whilst a referral by a generalist to a specialist is the norm, patients are not precluded from making direct access to specialists (or dentists with the certificates of proficiency).

Auxiliaries

There are two kinds of clinical auxiliaries, Dental Hygienists and Dental Technicians. Additionally, there are dental nurses and receptionists.

Year of data:	2007
Hygienists	200
Technicians	4,500
Denturists	0
Assistants	7,000
Therapists	0
Other	0

all figures approximate

There is no obligatory registration of dental hygienists, dental technicians and dental assistants in Czech Republic.

Dental Hygienists

Hygienists are permitted to work in the Czech Republic, provided they have a diploma (DiS). They train in a special higher school specifically for dental hygienists (3 years), following 4 years in any high school. In 2008 a Bachelor degree study (BSc) for 3 years for dental hygienists started.

Hygienists work under the supervision of a dentist only, and their duties include scaling, cleaning and polishing, removal of excess filling material, local application of fluoride agents, the insertion of preventive sealants and Oral Health Education.

They do not need to be registered if they work as an employee. Hygienists would normally be salaried. In 2007 no hygienists were unemployed – the demand is higher than supply.

Dental Technicians

There are different ways of training for dental technicians: 4 years study in a high school specifically for dental technicians (assistant of the dental technician, he/she can work as employee only), or study in a higher school specifically for dental technicians (3 years of study following 4 years in any high school) – those with a higher degree of education also receive a DiS. In 2008 a Bachelor degree study (BSc) for 3 years for dental technicians started.

Dental technicians construct prostheses for insertion by dentists. They normally work in commercial laboratories, only a few are employees of dentists or of clinics. Technicians can be owners of the laboratory and than they are self-employed or they are normally salaried (the employees).

The Chamber has no reports about illegal dental practice by dental technicians.

Dental Assistants (Nurses)

Dental assistants must have appropriate education:

- accredited specialised course for dental assistants
- or 2 years of study at the school for dental assistants
- or dental assistants can be general nurses with training by the dentist. They are educated in high school for nurses, for 4 years, with a leaving examination.

They are permitted to undertake oral health education.

Practice in the Czech Republic

Year of data:	2007
General (private) practice	6,206
Public dental service	0
University	309
Hospital	30
Armed Forces	35
General Practice as a proportion is	87%

Working in Liberal (General) Practice

Fee scales

For dentists working within the system of health insurance it is obligatory (by law) that they complete a price list of items partially covered by the insurance system, or items which are fully covered by the patient. The prices are calculated in each practice independently and they are not regulated. For those items partially covered by the scheme, the insurance element is taken out of the calculated price.

So, the rate varies in each practice (for example, the common range of price for metallo-ceramic crown is between 2,500 – 4,000 Czech Crowns, (about €100- €160). Control of the price-lists is maintained by the financial authority and is checked routinely, by audit of bills and documentation, or as a result of a complaint by a patient.

The prices of items fully covered from insurance system are in fact the same in all health insurance companies and are valid for a year. The new prices can be scheduled as a result of negotiation between health insurances, delegates of dentists (usually the President and Vice-president of the CSK).

For payment, the contracted dentist sends an invoice with the list of patients and the provided dental care, to the health insurance company (usually monthly and on a floppy disk or stick) – payment by the insurance company follows in 30 days.

Joining or establishing a practice

There are no stated regulations which specifically aim to control the location of dental practices. There are also no other regulations or factors which effectively restrict where dentists may locate. Any type of building may be used which fulfils the legislative claims to dental practice. But rules exist which define, for example, the minimum size of rooms for dental practice, disabled facilities, etc. There is no limit to the maximum number of partners etc.

The law does not allow the selling of a list of patients. The state offers no assistance for establishing a new practice, and generally dentists must take out commercial loans from a bank.

To establish a new practice private dentists have to complete the registration of local health state authorities. If the applicant fulfils all the necessary conditions (qualification, lack of disciplinary convictions, hygienic bylaws, equipment of the practice) there is no ground to refuse his application. There is a one-off registration fee to the Regional Authority, which was 1,000 CZK (€40) in 2008. A new practice has no claim for a contract with any health insurance company – it depends on the will and demand of the health insurance companies.

Just less than 500 graduates work as assistants in private practices.

Working in the Public Clinics

There are no public dental clinics in the Czech Republic.

Working in Hospitals

Dentists who work in hospitals (university or big regional hospitals) are normally salaried employees. Hospitals are usually owned by state (university hospitals) or privately (joint stock companies), and the dental services provided are usually full scale and oral surgery.

These dentists will also assist in the education and training of dental undergraduates.

About a half the dentists working in hospitals are specialists, the others in training. They can be either fully or partially employed – some of them work concurrently in private practice.

Working in Universities and Dental Faculties

These dentists are normally full-time salaried employees of the University. Some of them are allowed the combination of part-time teaching employment and private practice (with permission of university).

All the dentists in Universities are "MUDr." or "MDDr." The additional titles of university teachers are: assistant (title As.) docent (Doc.), or professor (Prof.).

For the positions of docent and professor it is necessary to pass "habilitation" - this involves a further degree (publication activities and a record of original research) and a public lecture in front of the Scientific Council of University. The study for a PhD is also required (earlier it was adequate to have a CSc., leading to the PhD). The CSc. – candidatus scientiarum, was a scientific degree used in the Czech Republic until 1990. The study for obtaining of a CSc. was similar to a PhD. The PhD has been used in the Czech Republic since the 1990s.

Epidemiological studies are undertaken by the Czech Statistical Institute and the Institute of Health Information and Statistics of the Czech Republic.

Working in the Armed Forces

About 60% of dentists serving in the Armed Forces are female.

Professional Matters

Professional associations

The Czech Dental Chamber (Ceská stomatologická komora – CSK) was established in law in 1991. The CSK is a regular member of the FDI World Dental Federation.

	Number	Year	Source
Czech Dental Chamber	8,146	2007	Chamber

To work a dentist must be registered with the Chamber (see *Registration* - earlier), however inactive dentists do not need to be members of the Chamber. It is an independent, self-governing, non-political, professional organisation, forming an association of dentists with the purpose of protecting common interest, maintaining a professional level and ethics. The CSK resolves complaints and executes disciplinary powers toward its members. It defines requirements on operating a dental practice and confirms compliance with the dentists´ professional performance requirements.

The CSK is organised on territorial basis with Regional Dental Chambers (61) forming the basic organisational units. The supreme body of the Chamber is the CSK Assembly consisting of 92 members elected by Regional Dental Chambers. The Assembly elects the President, Vice-President, the Board (15 members), the Auditing Board (7 members), and the Honorary Council (9 members). All bodies' persons are elected for a 4-year term.

The CSK is engaged in life-long learning programmes for dentists. The CSK confirms compliance with life-long learning requirements by issuing the Certificates of Proficiency.

Ethics and Regulation

Ethical Code

There is an ethical code in the Czech Republic, which is administered by the Czech Dental Chamber. Breaches of the ethical code are administered by Regional Auditing Boards of Czech Dental Chamber and Honorary Councils of Czech Dental Chamber.

Fitness to Practise/Disciplinary Matters

A rightful complaint is submitted to the regional Honorary Council of the Czech Dental Chamber and the outcome of a complaint may be a reprimand, a penalty or even the loss of licence (the dentist cannot be suspended immediately). Any serious break of the law can be referred to court and even result in imprisonment. The complaint is heard by the professional body – the regional Auditing Board of the Czech Dental Chamber. An appeal is possible to the higher disciplinary body of the Czech Dental Chamber.

Advertising

Advertising is permitted under the framework of the ethical code, but this does not include the use of advertisements on the TV or radio.

Czech dentists may use websites, within the ethical code – although the code does not include a specific section on the issue. The ethical code has been adapted according to the CED ethical guidelines.

Data Protection

Data Protection is regulated by the law which follows the EU Directives.

Indemnity Insurance

Liability insurance is compulsory (by the law) for all dentists in the Czech Republic – the amount of cover is not pre-determined. Dentists usually choose the range from 1,000,000 to 5,000,000 CZK (€32,000 - €160,000). Costs are up to €200 per year for this insurance. For work abroad is necessary to make a special supplement to the contract.

Corporate Dentistry

Anyone can own a dental practice (non-dentists need a dentist present, as a warranty of proficiency), and there is also provision for them to be run as companies. In 2008, there were 244 non-state (private) health companies in the Czech Republic.

The parties for a company have to prepare and present a report (settlement) about their activities, about relations inside the company etc. and then they need to request judgement for registration in the Companies Register.

Tooth whitening

Tooth whitening is provided by dentists only, although hygienists may provide this under the dentist's supervision. Whitening procedures are under Cosmetic rules and are not covered within the health insurance system.

Agents with a peroxide concentration lower than 6% are offered in drug stores as Cosmetic products.

Health and Safety at Work

By ministerial regulation, dentists and those who work for them have to be inoculated against Hepatitis B and later be checked regularly for sero-conversion. The employer usually pays for inoculation of the dental staff.

Ionising Radiation

Training in radiation protection is mandatory for undergraduate dentists (it is part of the curriculum).

The undergraduate education in radiation protection is not sufficient for independent work with dental X-ray apparatus or with orthopantomographs – the dentist has to pass an examination by State office for Nuclear Security every 10 years.

Radiation equipment is registered by the State office for Nuclear Security and the function of this equipment must be under control of an accredited company (with revision every year).

Hazardous waste

Amalgam separators are obligatory (since 2004) as part of the dental unit. The dental office must have the contract with an accredited company for the disposal of amalgam and exchange of the separators.

The disposal of clinical hazardous waste must be ensured by an accredited company.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	State office for Nuclear Security
Electrical installations	The State accredits electrical technicians
Waste disposal	Local government
Medical devices	Ministry of Health
Infection control	Ministry of Health and local authorities

Financial Matters

Retirement pensions and Healthcare

The normal age for retirement is 63, although dentists and staff can work past then.

There is a state-funded system of pensions, of which dentists and their staff are a normal part. The pension would be about 50% of last declared income. This is the same for employed and self-employed dentists. Any additional insurance pension depends on the individual contract and the amount insured.

Taxes

There is a national income tax (*25 CZK - €1 at 1/4/08*)

Total annual income	Annual tax (Czech Crowns = CZK)
0 – 121,200 121,200 – 218,400 218,400 – 331,200 331,200 + (and more)	12% 14,544 - CZK + 19 % 33,012 - CZK + 25 % 61,212 - CZK + 32 %

VAT

In Czech Republic there are two VAT rates: 9% and 19%.

The main dental materials (filling materials, impression materials, instruments) have 9% VAT, disinfection solutions, examination gloves and auxiliary materials, such as radiographic materials have 19% VAT. The cost of dental health care (and other health care too) is VAT free.

Various Financial Comparators

Zurich = 100	Prague 2003	Prague 2008
Prices (excluding rent)	40.5	58.7
Prices (including rent)	41.8	57.2
Wage levels (net)	12.4	24.7
Domestic Purchasing Power	32.0	43.2

Source: UBS August 2003 & January 2008

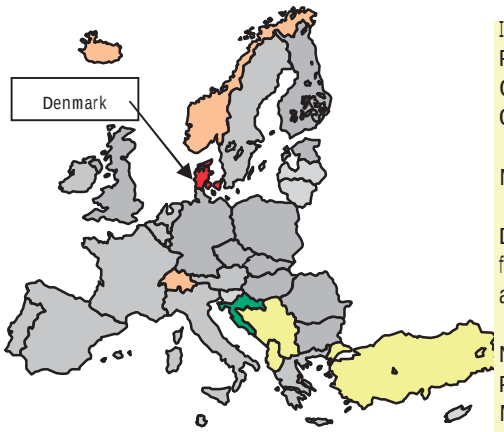
Other Useful Information

Main national association:	*Competent Authority:*
Czech Dental Chamber Ceska Stomatologická Komora Slavojova 22, Praha 2 128 00 Czech Republic Tel: +420 234 709 610 Fax: +420 234 709 616 E-mail: csk@dent.cz Website: www.dent.cz	Contact Name: doc. MUDr. Jiri Zemen, Ph.D. Tel: +420 603 927 134 Fax: +420 234 709 616 E-mail: j.zemen@gmail.com or j.zemen@volny.cz Website: www.dent.cz
Details of information centres:	
Name: Ústav zdravotnických informací a statistiky CR Tel: +42 022 497 2243 Fax: +42 022 491 5982 E-mail: sekretariat@uzis.cz Website: www.uzis.cz	Name: Ministerstvo zdravotnictví CR (Ministry of Health) Palackeho nam. 4, 128 01, Praha Tel: +42 022 497 1111 Fax: +420 2 2497 2111 E-mail: mzcr@mzcr.cz Website: www.mzcr.cz
Details of indemnity organisations:	
Name: Kooperativa pojišťovna, a.s. Tel: +420 800 105 105 Fax: E-mail: info@koop.cz Website: www.koop.cz	Name: Ceská pojišťovna, a.s. Tel: +420 800 133 666 Fax: E-mail: info@cpoj.cz Website: www.cpoj.cz

Dental Schools:

City: Plzen Name of University: Lékarská fakulta Karlovy univerzity v Plzni Tel: +42 377 593 400 Fax: +42 377 593 449 E-mail: Jana.Vlnasova@lfp.cuni.cz Website: www.lfp.cuni.cz Dentists graduating each year: cca 50-60 Number of students: cca 280	City:Praha Name of University: 1. lékarská fakulta Karlovy univerzity Tel: +42 224 961 111 Fax: +42 224 915 413 E-mail: info@lf1.cuni.cz Website: www.lf1.cuni.cz Dentists graduating each year: cca 50-60 Number of students: cca 290
City:Hradec Králové Name of University: Lékarská fakulta Karlovy university v Hradci Králové Tel: +42 495 816 111 Fax: +42 495 513 597 E-mail: dekanats@lfhk.cuni.cz Website: www.lfhk.cuni.cz Dentists graduating each year: cca 50-60 Number of students: cca 280	City:Olomouc Name of University: Lékarská fakulta univerzity Palackého Tel: +42 585 632 010 Fax: +42 585 223 907 E-mail: pilikova@tunw.upol.cz Website: www.upol.cz Dentists graduating each year: 50 - 60 Number of students: cca 290
City: Brno Name of University: Lékarská fakulta Masarykovy university Tel: +42 542 126 111 Fax: +42 542 213 996 E-mail: dekan@med.muni.cz Website: www.muni.cz Dentists graduating each year: cca 40 Number of students: cca 250	

Denmark



Date of last revision: 1st October 2008

In the EU/EEA since	1973
Population (2008)	5,475,791
GDP PPP per capita (2006)	€30,771
Currency	Kroner (DKK)
	7.46 DKK = €1 (2008)
Main language	Danish

Denmark has a highly decentralised National Health Service, largely funded by general taxation. Oral healthcare is free for children (0-18) and subsidised for adults.

Number of dentists:	7,298
Population to (active) dentist ratio:	1,141
Members of Danish Dental Association:	90%

There are two specialist degrees in Denmark – oral surgery and orthodontics – and there is a well-developed system of dental auxiliary support for dentists. Continuing education for dentists is not mandatory, except for members of the Dental Association

Government and healthcare in Denmark

Denmark is a very well developed country despite its small size in regards to both land area (43,094 sq km) and population.

It is governed as a constitutional monarchy with a unicameral parliament (Folketing) of 179 seats, whose members are elected for 4-year terms under a proportional representation system. The country is administered as 5 regions and 98 municipalities.

Denmark has two dependencies; Greenland and the Faeroe Islands. They are both independent in health matters – but follow the Danish national legislation. Information about them can be found later.

Denmark has a national health service funded by general taxation. There are no additional special taxes or private insurance contributions involved. The management of health care is highly decentralised, with the individual regions running most services and the municipalities responsible for some public health commitments.

Dental care for adults is only partly subsidised by the government. The amount paid by the patients is dependent on the treatment – but in general the patients pay most of the treatment costs themselves. There are no private insurance schemes.

The National Board of Health (NBH) is responsible for the legislation concerning dentistry, and is based in Copenhagen.

		Year	Source
% GDP spent on health	9.5%	2006	OECD
% of this spent by governm't	84.1%	2005	OECD

Oral healthcare

In Denmark oral healthcare is provided in one of two ways. For children under the age of eighteen all care is free of charge and is usually provided at school. For adults a system of government subsidies is available through private dental practitioners for most common types of treatment.

		Year	Source
% GDP spent on oral health	0.19%	2006	DDA
% of OH expenditure private	80%	2008	DDA

Governmental spending on healthcare (2006): €11,213m
Public dental service (children 0-18): €253m
Spending on adult care: €160m

Spending on oral healthcare represents just above 9% of the total public healthcare spend.

Public dental health care

Dental services for children

Dental services for those aged 0 to 18 are organised by the municipals (or the *kommuner)* and is free of charge. There are 98 *kommuner* in Denmark and more than 97 of them employ their own dentists and have their own premises for examining and treating children.

Since January 2004 children have been able to choose to receive dental care from a private practitioner instead of the service provided by the *Kommune* – but have to pay 35% of the costs. At the age of 16 children may change to a private practitioner with the full cost of treatment still being met by municipalities until they are 18 years old.

In several *kommuner*, in more rural areas, the *Kommune* contracts with local private practitioners to treat the children. Within these services all treatment is free, including orthodontic care.

Dental services for adults

For adults, a system of subsidies for dental healthcare is operated by an agreement between the regions (regioner), in collaboration with the Danish Dental Association (*Tandlægeforeningen*). Under this system the patient pays a part of the fee to the dentist. The other part is claimed through the region.

On average patients pay around 80% of costs and the public about 20%. In general the subsidy is higher for preventive care and essential treatments, and for expensive treatments such as oral surgery it is lower. Subsidies for the 18 to 25 year-olds are also higher.

The main treatments for which subsidies are paid include examination and diagnosis, fillings, oral surgery, periodontology, and endodontics. For most adults, orthodontics, crowns and bridges, and removable prosthodontics have to be paid for in full by the patient.

Free dental care is only available for adults if the treatment needs to be carried out in a hospital or if the patient belongs to special groups. These are disabled patients and those of low economic status, and for some elderly. People receiving social security may have their expenses for dental care paid by the municipality and those who do not receive unemployment benefits (*Bistandsklient*), such as the homeless or victims of drug and alcohol abuse, usually receive free care.

For adult patients who have all their dental costs paid by the state (*Bistandsklient*) there is a requirement to seek prior approval to provide treatment from the municipal rule.

Payments to dentists

All payments to dentists are by way of "item of service" fees. Adult patients would normally receive oral examinations at an average of every 8 - 9 months and about 2/3 of the population visit a dentist annually.

In 1994 another objective to the public dental care system was added. Dental care for the elderly living in nursing homes and for mentally and physically handicapped living in their own homes but who are not able to use the normal dental care system is now part of the objective of the municipal dental care service.

Private dental care

A substantial number of Danish adults (about 30%) buy private health insurance. There is a single scheme, "Health Insurance Denmark" (*Sygeforsikringen Danmark*) which is a personal scheme with the premium paid by the individuals concerned. Cover may be obtained within one of three groups depending on the items of care included. About 62% of all oral healthcare spending is on private dentistry.

The government introduced regulations in 2003 making it mandatory to publish on the internet and/or inside practices information about the cost of treatment which is not covered by the state scheme, and therefore receives no subsidy.

The Quality of Care

The County Society of the region monitors standards of oral health services. This is mainly done by auditing the treatment figures which every dentist has to submit in order to claim public subsidy. Any dentist who carries out particular treatments by more or less than 40% of the regional average has to provide an explanation.

Apart from this screening, no other quality assessment is compulsory in Danish healthcare.

The Danish Health Care Quality Assessment Programme

The programme is a joint Danish system intended to support continuous quality improvement of the Danish health care services as a whole. In principle, the Quality Programme comprises all patient pathways in the health care services.

The Quality Programme will be developed in successive versions over a number of years.

The first version will comprise all Danish public hospitals, including their cooperation with and relations to other institutions and sectors. The intention is that subsequent versions of the Quality Programme will gradually be extended to include the remaining sectors of the health care

services, including private health care institutions and vendors entering into agreements with the public health care services.

Health data

		Year	Source
DMFT at age 12	0.70	2007	NBH
DMFT zero at age 12	72%	2007	NBH
Edentulous at age 65	18%	2005	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth. NBH = National Board for Health.

Fluoridation

There is no fluoridation scheme in Denmark. Some parts of the country have naturally occurring fluoridated water.

Education, Training and Registration

Undergraduate Training

To enter dental school a student needs to be a secondary school graduate, as "Student" or similar. There is no vocational entry, such as being a qualified dental auxiliary.

Year of data:	2008
Number of schools	2
Student intake	160
Number of graduates	135
Percentage female	71%

Dental education is state-funded. There are no tuition fees. The education lasts 5 years (with a bachelor degree after 3 years).

The quality of the training is monitored by the Council of the Faculty.

Qualification and Vocational Training

Primary dental qualification

After graduation from the dental schools the students have authorisation as a dentist. The *Sundhedsstyrelsen* (National Board of Health) issues the certificate.

The authorisation gives the right to work as an employed dentist but if one wishes to own a practice, the dentist needs to have a permission from the National Board of Health to practice independently. The permission can be obtained if the dentist has worked 1,440 hours. In that period of time, the dentist must have treated both adult patients and children for at least 360 hours. There is no annual registration fee, but to receive permission to practice independently the dentist must pay approximately €147 to the National Board of Health.

Vocational Training (VT)

There is no formal post-qualification vocational training as such. EU qualified dentists can work in Denmark but if they would like to own a practice they need a permission to practice independently from the National Board of Health.

Diplomas from other EU countries are recognised according to the Professional Qualifications Directive.

Registration

Although the National Board of Health administers an initial national register of dentists, it is primarily a list of those who have received degrees from Danish universities, or have had other qualifications recognised.

In order to be a principal in private practice and receive government subsidy payments dentists must also register with the regional branch of the Danish Dental Association (DDA) and with the *Sundhedsstyrelsen* (National Board of Health) who certify that he/she has worked as an employed dentist for a required length of time - currently one year.

Dentists who work in the public dental service are not required to register with the DDA. Directors of public clinics must be authorised by the National Board of Health.

To be registered with the DDA or the APHD a dentist must first hold a recognised primary degree or diploma in dentistry. The membership fee is one quarter at registration.

For all dentists who qualified outside the European Union the National Board of Health has the right to require further courses to be taken.

Language requirements

There is no language requirements other than all records should be written in Danish. Every dentist should practice carefully and conscientiously. To comply with this provision, dentists are required to be capable of responsible communication with patients, relatives, other hospital staff, etc.

Non-EU nationals may have to have an oral and written language test in Danish, conducted by the National Board of Health before registration.

Further Postgraduate and Specialist Training

Continuing education

Continuing education (CE) is usually organised by the dental associations, dental schools or private companies. CE is not compulsory in Denmark.

From January 2009 members of the DDA have to register 25 hours of CE annually.

Specialist Training

To undertake specialist training a graduate must have had at least two years of working experience. Trainees are paid by the hospital or dental school. There is formal training in two specialties:

- Orthodontics
- Oral Maxilla Facial Surgery (OMFS)

For specialists in OMFS, 5 years of specialised training is required. The experience must be gained in departments of Oral Surgery, Oral Pathology and Medicine, Ear, Nose and Throat, and Anaesthetics.

For specialists in Orthodontics, 3 years of specialised training is required. The experience must be gained within a Department of Orthodontics. During the training period the trainee is paid by the hospital or university. There is no particular specialist degree.

Workforce

Dentists

Year of data:	2008
Total Registered	7,298
In active practice	4,800
Dentist to population ratio*	1,141
Percentage female	50%
Qualified overseas	No data

* active dentists only

The workforce was stable in 2008 – but the DDA believe that it will decrease the following years as more Danish dentists will retire than new dentists trained. The expectation is about 80 to 100 dentists less each year.

Movement of dentists across borders

There is little movement of dentists in and out of Denmark.

Specialists

Year of data:	2008
Orthodontics	258
Endodontics	
Paedodontics	
Periodontics	
Prosthodontics	
Oral Surgery	
Dental Public Health	
OMFS	91

Most specialists in Oral Maxilla Facial Surgery in Denmark work in hospitals. Oral MF surgeons and orthodontists may run their own practices. But most orthodontic specialists are employed in the Public Health System.

Usually a dental practitioner refers a patient to a specialist for selected treatments. Patients are also able to consult a specialist without a referral and have free choice both of the dentist and specialist that they wish to visit. No formal extra fee is given to specialist treatment.

There are many societies which represent special interests in dentistry, especially at the regional level. The Danish Dental Association is the best initial point of contact for questions about these societies.

Auxiliaries

There are 3 classes of dental auxiliaries in Denmark, besides dental assistants – hygienists, technicians and clinical dental technicians.

Year of data:	2008
Hygienists	800
Technicians*	1,100
Denturists/Clinical Dental Techs	565
Assistants**	4,400
Therapists	0

* estimate by DDA

** 800 Student assistants

Dental Hygienists

Dental hygienists undertake 2.5 years training at dental school in Denmark. Upon qualification they must be authorised by the National Board of Health.

They may work in practice after graduation, but they must register to be able to own their practice, without supervision of a dentist, which is permitted in Denmark. Hygienists can undertake basic diagnostics. Hygienists are mainly found in the fields of Oral Health Promotion and Disease Prevention. Hygienists are allowed to administer local anaesthetics.

Dental Technicians

Training for dental technicians is for up to two years at special dental technician schools. There is theoretical and practical training. There is no registerable qualification for dental technicians, so there is no list of registered dental technicians. Dental laboratory technicians work mostly in laboratories, hospitals or dental faculties and are salaried, but some are employed by dentists in private practice.

All of their work may be carried out without the supervision of a dentist.

Clinical Dental technicians

Clinical dental technicians/denturists must undertake a 4-year training period in a special dental technician school and there is some time spent in practice. They need a licence from the National Board of Health to be allowed to practice independently. They may provide full removable dentures without the patient being seen by a dentist. However for partial dentures, a treatment plan from a practitioner is required, and a patient presenting any pathological changes must be referred to a dentist.

They may take payment from a patient, and be part of the NHS.

Dental Assistants (Nurses)

These may provide any kind of assistance to the dentist at the chairside. Training is carried out either on the School for Dental Assistants, Hygienists and Technicians (SKT) or in Technical Schools in several municipalities.

Practice in Denmark

Year of data:	2008
General (private) practice	3,336
Public dental service	1,200
University	142
Hospital	63
Armed Forces	55
General Practice as a proportion is	70%
Number of general practices	2,300

Working in Private Practice

Dentists who practice on their own, in small groups, or employed by other dentists outside hospitals or schools, and who provide a broad range of general rather than specialist care are said to be in *private practice*.

All dentists in private practice are self-employed or employed by the owner of the practice and earn their living partly through charging fees for treatments and partly by claiming government subsidies for adult care. The government pays for all dental treatment of children, up to the age of eighteen. Very few (less than 1%) dentists in private practice accept only fee-paying patients. In more rural areas where it may be uneconomic to organise a separate public dental service for children some practitioners may be contracted by the *kommune*/*municipality* to provide this service.

Once registered with the region a dentist in private practice may generate two-column bills, one column to be paid directly by the patient, the other to be claimed by the dentist from the government. The dentist may present a bill to the patient after each visit or after a complete course of treatment, depending on what has been agreed.

Fee scales

For preventive care and essential treatments the subsidy is higher (around 40 %), and for expensive treatments such as oral surgery it is lower. The main treatments for which subsidies are paid include examination and diagnosis, fillings, oral surgery, periodontology, and endodontics. For most adults, orthodontics, crowns and bridges, and removable prosthodontics have to be paid for in full by the patient. Subsidies are also higher for 18 to 25 year-olds.

The fee is defined in a departmental order, but the agreement parties (Danish Regions and the DDA) typically supply the government with recommendations.

Joining or establishing a practice

Before dentists may establish their own practice they must gain permission to practice independently from the National Board of Health. There are no rules which limit the size of a dental practice and the number of associate or employed dentists or other staff. Premises may be rented or owned and there is no state assistance for establishing a new practice. Generally dentists must take out commercial loans from a bank to finance new developments.

Other than for reclaiming Government subsidy payments there is no additional requirement to register when working in private practice. There are no standard contractual arrangements prescribed, although the ethical code of the Danish Dental Association provides some guidelines. Dentists who employ staff, must comply with minimum wages and salaries regulations, and must meet occupational health and safety regulations. Maternity benefit is payable four weeks before and 14 weeks after birth. In addition to that it is possible to get benefit from the local authorities. Once a dentist employs more than four employees strict rules on occupational security will apply.

Monitoring the standards of private dental practice is the responsibility of the Society of the 5 regional bodies with the Danish Dental Association. The monitoring consists of statistical checks and official procedures for dealing with patient complaints (see below).

Working in the Public Dental Health Service

Of the 98 *kommuner*/*municipalities* in Denmark, 97 employ dentists. These dentists are working in universities, the armed forces, hospitals and public dental healths services / schools. People who are unable to take care of their own oral health are also treated within the public dental health service.

Dentists within the public dental health service may apart from the clinical work carry out administrative tasks.

There are no further official requirements for working as a dentist in the public dental health service. However, orthodontists must be qualified in this specialty.

In general within the public dental health service it is possible to work full or part-time as a dentist.

Working in Hospitals

Dentists who work in hospitals are mostly specialists in oral surgery. All dentists are the employees of the hospitals, which are owned and run by regional government. Dentists working in hospitals will also often combine treating patients with administrative tasks.

Working in University

Dentists working in dental faculties are all employed by the university. Whilst they all have teaching responsibilities, they may have additional responsibilities to treat patients in university clinics (*Clinical teacher*), undertake research (*Lecturer*), or have a mixture of management, research and student supervisory responsibilities (*Professor*, or *Assistant Professor*/*Senior Lecturer*). There are also *External Teachers* who provide teaching in specialties.

Clinical teachers usually work part-time and spend their remaining time in practice.

Although there are no official requirements, dentists at the grade of *Assistant Professor*/*Senior Lecturer* or above will generally have a PhD, a Doctorate or other postgraduate scientific qualifications.

The two universities undertake epidemiological studies.

Working in the Armed Forces

28 dentists and 25 dental assistants work in the armed forces. Dentists are trained to treat patients in periods of peace and war. Furthermore dentists in the armed forces are working with quality monitoring and educational work.

Professional Matters

Professional associations

The national dental association is called *Tandlægeforeningen*, (Danish Dental Association). About 90% of Danish dentists are members, just over half being male.

	Number	Year	Source
Association of PH Dentists	1,263	2008	FDI
Danish Dental Association	6,115	2008	DDA

Many of the members of the APHD are also members of the DDA. Most of the other members of the DDA work in general practice. In 2008 membership included 433 students and 1,224 retired members. So, about 4,500 were active members.

The Danish Dental Association is the professional association and trade union for dentists in Denmark. The association was established in 1873 and is the oldest dental association in the Nordic countries and indeed one of the oldest in the world.

The main goals of the association are:

- to look out for the interests of all dentists in all aspects of the profession
- to promote oral health within the Danish society
- and further develop all aspects of dental care to the Danish population

For the address of the DDA see later.

There is also a Public Health Dentists Association (APHD) called *Tandægernes Nye Landsforening* with over 1,200 members.

The APHD organises dentists employed in municipal health care services. It was founded in 1985 and works for better pay and employment conditions and the Association has declared health care policy goals.

Ethics and Regulation

Ethical Code

The practice of dentistry is mainly governed by an ethical code. This applies to all dentists, but with slight variations between dental services. Other laws and regulations exist which relate to negotiating the system of subsidies, monitoring the billing of patients and dealing with patient complaints. These are described where appropriate in the relevant sections.

The clauses of the *The Code of Ethics and Professional Statutes of the Danish Dental Association* describe:

1. Purpose of the code
2. The position of the dentist within society
3. The dentist's relationships with the patient
4. The dentist's relationship with the public, public authorities etc.
5. The dentist's relationship with colleagues
6. The dentist's relationship with his staff
7. The dentist's relationship to the association and profession
8. Special provisions

Apart from the ethical requirement that all care should "preserve and improve the health of his patients" there are few restrictions on the treatments which a dentist may provide. A dentist should not however carry out any care to which the patient has not consented, or for which the dentist does not possess the necessary specialist knowledge.

Fitness to Practise/Disciplinary Matters

There are two systems dealing with complaints. One relates to complaints against dentists working with "the agreement of adult dental care" - (*Tandlægeoverenskomsten*) and the other to all other complaints (*Sundhedsvæsenets Patientklagenævn*).

The complaint system under the *Tandlægeoverenskomst* is managed in the regions, by committees served by regional politicians and members of the DDA. The sanctions can vary from a reprimand to a recommendation to the NBH to take away the authorisation to practise. The decisions can be appealed to a national committee.

The system under *Tandlægeoverenskomsten* also deals with the money issue, but it is a compulsory patient insurance that gives the patients compensation when they are entitled.

The *Sundhedsvæsenets Patientklagenævn* deal with complaints about other dentists and auxiliaries.

Protection of Data and information

The rules for data protection follow the EU Directive.

Advertising

Advertising must be matter-of-fact, sober and adequate and it is illegal to promote oneself or one's practice at the expense of others. Sponsorship is also permitted and the use of radio and websites. However the use of television is not permitted.

The DDA believe that the Directive on Electronic Commerce is of no direct concern to the members, as the DDA are not aware of dentists in Denmark who are involved in E-

commerce. However, it is permissible for a dentist to set up and have a website for his/her practice and many dentists have one. There is a website (www.sundhed.dk) which is owned by the public, where the dentists in private practice are all published – together with all other health personnel (in private practice).

Indemnity Insurance

Liability insurance is provided by the Danish Dental Association, and is compulsory for private dental practitioner members. It provides cover for occupational injuries for owners and staff, legal expenses insurance, patient injuries and damage to patients' belongings and HIV infection. A dental practitioner pays approximately €100 annually (2003) for legal expenses insurance; for the other elements health insurance companies deduct a percentage from income.

This indemnity based insurance only covers for work undertaken in Denmark.

Corporate Dentistry

Dentists are allowed to form companies, and non-dentists may be on the board of such a company. Non-dentists can not have the majority on the Board – nor indeed comprise the whole Board.

Tooth whitening

For tooth whitening supplied for the home or in beauty clinics (by non-authorised persons), hydrogen peroxide with a concentration of more than 0.1 % is not permitted.

Dentists may use tooth whitening products with a stronger concentration of hydrogen peroxide. Those products used by dentists are categorised as chemical products.

Health and Safety at Work

Workforce Inoculations, such as Hepatitis B are not compulsory in Denmark.

Ionising Radiation

There are specific regulations about radiation protection and It is mandatory for undergraduate dentists to take training in radio protection. Continuing education in ionising radiation is not mandatory.

All new x-ray equipment must be registered by the National Board of Health.

Hazardous waste

The Hazardous Materials Act is very strict – and amalgam is on the list. Only approved companies or individuals are allowed to collect amalgam. The dentist must have written documentation for their disposal and to whom.

The municipality *(kommune)* provides guidance.

Amalgam separators are not generally mandatory although some municipalities insist that they are installed.

Regulations for Health and Safety

For	*administered by*
Ionising radiation	Radiation Institute, (National Board of Health)
Electrical installations	Kommuner /Municipality government
Infection control	DS2451-12 and Statens Serums Institut
Occupational Health Safety Administration (OHSA)	Danish Ministry of Labour, Arbejdstilsynet
Waste disposal	Kommuner/Municipality government
Arrangement of working places and staff security	Danish Ministry of Labour, Arbejdstilsynet

Greenland and the Faroe Islands

In Greenland all dental care is provided as a free public service, to children and adults. All dentists, except one private practitioner, are employed by the Greenland government and there is a constant need for more staff. The demand for dentists in Greenland is likely to increase as old arrangements for free flights to Denmark for Danish nationals are phased out. However, new arrangements, including short-term contracts of three or six months, free accommodation and a free return flight should make working in Greenland more attractive to non-Danish dentists. Nearly all dentists work with Inuit staff, who act as Inuit interpreters also.

The Faroe Islands are governed as a single Danish municipality. Until recently, as in Greenland, all dental services were provided as a free public service. Today the system in the Faroe Islands is the same as in Denmark as a whole.

Financial Matters

Retirement pensions and Healthcare

National pension insurance premiums are paid at about 10% of earnings.

While the government pays approximately 85% of the national costs of healthcare, 15% comes from individuals through co-payments for treatment. For dental care this ratio is reversed since the national cost of caring for adults' dental health is 20% government-funded, with the remaining 80% paid by patients.

Normal retirement age is 65 but dentists may practice beyond this age.

Taxes

National income tax:

There is a national income tax (dependent on salary). The lowest rate is 28% and the maximum is 55.3% for income over about €65,000 per year.

VAT/sales tax

VAT is also payable on certain goods and services at 23%. Dental treatment is excluded from VAT. However, costs related to purchase of dental equipment, instruments and materials are subject to VAT and will be reflected in the prices

Various Financial Comparators

Zurich = 100	Copenhagen 2003	Copenhagen 2008
Prices (excluding rent)	98.9	108.0
Prices (including rent)	97.9	105.0
Wage levels (net)	74.8	81.3
Domestic Purchasing Power	68.3	77.5

Source: UBS August 2003 & January 2008

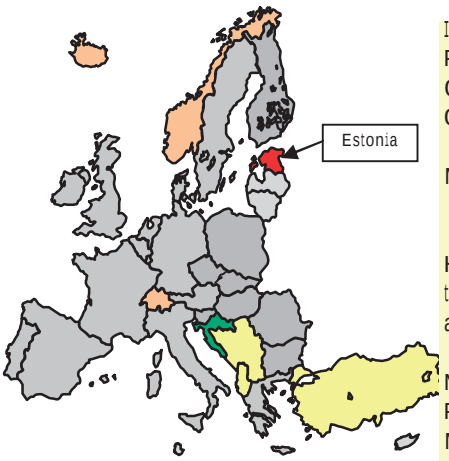
Other Useful Information

Main national associations and Information Centre:	*Competent Authority:*
The Danish Dental Association Tandlægeforeningen Amaliegade 17 Postboks 143 DK 1004 Copenhagen K, DENMARK Tel: +45 70 25 77 11 Fax: +45 70 25 16 37 E-mail: info@tandlaegeforeningen.dk, Website: www.tandlaegeforeningen.dk Association of Public Health Dentists in Denmark Emdrupvej 28A DK 2100 Copenhagen Ø DENMARK Tel: +45 33 14 00 65 Fax: +45 38 71 03 22 Email: tnl@tnl.dk Website: www.tnl.dk	Sundhedsstyrelsen (National Board of Health) Islandsbrygge 67 DK 2300 Copenhagen S Tel: +45 72 22 74 00 Fax: +45 72 22 74 11 Email: sst@sst.dk Website: www.sst.dk *Ministry of the Interior and Health Information website:* www.sundhed.dk *Publications:* The Danish Dental Journal *Tandlægebladet* c/oThe Danish Dental Association/ *Tandlægeforeningen* and The Danish Journal of Public Health Dentistry, from the APHD

Dental Schools:

Copenhagen	Århus
School of Dentistry Faculty of Health Sciences University of Copenhagen Nørre Alle 20, 2200 Copenhagen N Tel: +45 35 32 67 00 Fax: +45 35 32 65 05 Email: kl@odont.ku.dk Website: www.odont.ku.dk Dentists graduating each year: 85 Number of students: 450 approx	Royal Dental College Faculty of Health Sciences University of Århus Vennelyst Boulevard, 8000 Århus C Tel: +45 89 42 40 00 Fax: +45 86 19 60 29 Email: odontologi@au.dk Website: www.odont.au.dk Dentists graduating each year: 50 Number of students: 300 approx

Estonia



Date of last revision: 1st October 2008

In the EU/EEA since	2004
Population (2008)	1,340,935
GDP PPP per capita (2007)	€17,764
Currency	Krooni (EEK)
	15.65 EKK = €1 (2008)
Main language	Estonian (65%)
	Russian (28%)

Healthcare is funded through general taxation, with an additional special tax for health, which is paid by employer at 13% of salaries. Much is also funded by patients as 96% is private.

Number of dentists:	1,358
Population to (active) dentist ratio:	1,178
Members of Estonian Dental Association	50%

There are two specialist degrees – oral surgery and orthodontics, with orthodontics – and there is a well-developed system of dental auxiliary just two other specilaists. The use of auxiliaries is very limited. Continuing education is not mandatory, but there is a general requirement to keep skills updated.

Government and healthcare in Estonia

The Republic of Estonia, *Eesti Vabariik* in Estonian, lies on the eastern shores of the Baltic Sea. The name *Eesti* is apparently derived from the word *Aisti*, the name given by the ancient Germans to the people living northeast of Visla. Estonia is situated on the level north-western part of the East-European platform, on which there are only slight variations in elevation. The average elevation is only about 50m and the highest point (Suur Munamägi) is only 318m above sea level.

With the Gulf of Finland in the north, and the Baltic Sea in the west, Estonia shares land borders with Russia to the east and Latvia to the south. Estonia comprises an area of 45,215 sq. km., making it larger than, for instance Denmark, Switzerland, the Netherlands, Belgium and Albania in Europe.

The capital, Tallinn, is on the Northern shore.

In 1991 Estonia gained its independence as a state. The new Constitution of 1992 established the principles of the State, setting Estonia as a democratic parliamentary republic – with a President, Prime Minister and Cabinet and a State assembly known as the *Riigikogu*. Elections to the *Riigikogu* take place every 4 years. Local governments, separated from the central power, are based on 15 counties.

Since 1989, the population in Estonia has been dropping, by 13% between 1990 and 2003, due to emigration and negative natural growth.

Healthcare delivery in Estonia is provided through private practice and a statutory health insurance system (Sick Funds). The membership of the system is appointed by the Parliament. Local governments can also provide support. The source of income of the health insurance is 13% of the social tax or 13% of the employee's gross salary paid by the employer.

Health insurance is based on the solidarity principle: health service is not dependent on the amount of social tax paid for the specific person. The health insurance fund pays the cost of health services to the medical institution for the insured person.

In Estonia all persons are entitled to receive emergency care regardless of having health insurance or not.

		Year	Source
% GDP spent on health	5.0%	2006	Ministry
% of this spent by government	73.7%	2006	Ministry

"Ministry" refers to the Ministry for Social Affairs

Oral healthcare

		Year	Source
% of GDP spent on oral healtl	0.39%	2006	Ministry
% of OH expenditure private	66%	2006	Ministry

Public dental care

About 90% of oral healthcare in Estonia is provided through general (private) practice. Dental care services for adult patients (over 19) are paid by patients and reimbursed by the sick fund although emergency care (traumas, infections) is actually paid by the sick fund, but only for those who are members of it. Patients who do not have insurance can have only first aid.

Since October 1st 2002 the Sick Funds have provided this limited financial support for oral healthcare. Treatment is provided and is free for children under 19 years of age, provided they visit a dentist with a contract with the Sick Fund. Other patients may receive a reimbursement for the fees they have paid, up to €10. The health insurance provides this cover for 41 conservative and surgical items but crowns and bridges, implants, and other complex or cosmetic treatments have to be paid for fully by the patient. Orthodontic treatment is free to children under 19 years - with severe malocclusion - with all kinds of appliances

Pregnant women, or nursing mothers whose child is less than one year of age, can receive reimbursement of up to €19. Pensioners (over the age of 63) may receive reimbursement of up to €96 once in a 3-year period, for one prosthodontic appliance – all these reimbursements at 2008 prices.

Oral examinations would normally be undertaken every 6 to 12 months, more frequently for patients with periodontal conditions. There is no prior approval system for treatment. The Estonian Dental Association reports that they believe that most of the population visit a dentist within any 2-year period. This is what dentists ask from patients.

In some private clinics dentists give a guarantee for the technicians work only if the patient visits the dentist every 6 months for two years.

Access to oral healthcare may be difficult for patients who live in some urban areas, as well as all those in rural areas, as salaries there are generally too low for what is almost private care, with the low reimbursements. Indeed, there may be difficulties for patients, all over Estonia, obtaining prosthetic treatment under the scheme.

Private dental care

About two thirds of all adult dental treatment is provided under fully (liberal) private contract between patients and their dentists. There is no regulation of private fees and there are no dental insurance schemes in Estonia.

The Quality of Care

There are no routine quality checks, so the system relies on a complaint from a patient, for monitoring purposes.

Health data

		Year	Source
DMFT at age 12	2.80	2003	OECD
DMFT zero at age 12	25%	2003	OECD
Edentulous at age 65	No data		

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no specific community fluoridation schemes in Estonia.

Education, Training and Registration

Undergraduate Training

To enter dental school a student has to have completed secondary school (usually at the age of 18). There is an entrance examination.

Year of data:	2008
Number of schools	1
Student intake	30
Number of graduates	30
Percentage female	87%

Until 2003 the student intake was higher (40) so the number of graduates until 2008 will be around 40, also.

The dental school is situated within the Faculty of Medicine in the University of Tartu. It is publicly funded. Undergraduate training lasts 5 years. The dental course has been "EU-compliant" for some years, so most Estonian graduates have been able to work elsewhere in the EU from May 1st 2004.

Quality assurance for the dental school is provided by the Ministry of Education and Social Affairs.

Qualification and Vocational Training

Primary dental qualification

The primary degree which may be included in the register is "DDS Dentist".

Vocational Training (VT)

There is no vocational training for dentists in Estonia.

Registration

Cost of registration (2008)	€ 65

To register in Estonia, a dentist must have a recognised degree or diploma awarded by the university, or from another EU country. The register is administered by the Healthcare Board/General Dental Council, within the Commission for Licence (the competent authority). There is full information available at:

http://www.tervishoiuamet.ee/index.php?page=158

Language requirements

There are no formal linguistic tests in order to register, although dentists from outside the EU are expected to speak and understand Estonian.

Further Postgraduate and Specialist Training

Continuing education

Continuing education is not mandatory, but under Estonian legislation there is a general requirement to keep skills updated. Postgraduate education is delivered through the Tartu University Postgraduate Training Centre and the Estonian Dental Association.

Specialist Training

There is training in 3 specialties:

- Orthodontics
- Oral Maxillofacial Surgery
- Clinical Dentistry

Specialists train in the University. There is no minimum of years pre-training (working as a dentist after basic education), before entering specialist training. Training lasts for 3 years for Orthodontics and Clinical Dentistry and 5 years for Oral Maxillofacial Surgery. All postgraduates must pass a university examination. The specialist education and training leads to a degree, "Specialist in Orthodontics", "Maxillofacial Surgeon" or "Specialist in Clinical Dentistry". Specialists in Clinical Dentistry undertake training in endodontics, periodontics and prosthodontics.

Only orthodontics is recognised by the Healthcare Board/General Dental Council and registered as a specialty, in addition to Oral Maxillo-facial surgery, which officially is a dental specialty under a law introduced in 2002. It is anticipated that Specialists in Clinical Dentistry will be recognised and will need to register, after 2004.

Workforce

Dentists

Year of data:	2008
Total Registered	1,358
In active practice	1,220
Dentist to population ratio*	1,097
Percentage female	87%
Qualified overseas	4

* active dentists only

There is no reported unemployment amongst dentists in Estonia.

Some dentists practice in more than one sphere of practice.

Movement of dentists across borders

There is only small movement of overseas dentists into Estonia and little outwards.

Specialists

Specialists work mainly in private practice and patients access them by referral from other dentists.

Year of data:	2008
Orthodontics	52
Paedodontics	
Clinical dentistry	2
includes Periodontics,	
Prosthodontics & Endo	
Oral Surgery	
Dental Public Health	
OMFS	22

Auxiliaries

The system of use of dental auxiliaries is developing in Estonia. However, in 2008 the only type of dental auxiliary is a medical nurse trained by dentist as an assistant.

Hygienists

In 2002, it was reported that there were 2 hygienists in Estonia, who had been trained outside the country, but they were only permitted to work as dental assistants. In the new register of medical specialities in 2008, there was no such dental auxiliary specified as "hygienist".

Year of data:	2006
Hygienists	2
Technicians	137
Denturists	0
Assistants	1,644
Therapists	0
Other	26

Dental Technicians

The title is legally protected and there is a registerable qualification which dental technicians must obtain before they can practice. They train in the country's special technicians' school, for a period of 3.5 years. The register is held by the Healthcare Board.

Their duties are to prepare dental prosthetic and orthodontic appliances to the prescription of a dentist and they may not work independently, except for the provision of repairs to prostheses.

Individual technicians are normally salaried and work in commercial laboratories which bill the dentist for work done.

There is no reported illegal activity.

Dental Nurses

Nurses follow 3.5 years training of *Medical Nurse*, and then are trained in dentistry by the dentist, with institutional support. They receive a diploma, which they must register with the Healthcare Board. Their duties are to assist the dentist, including the cross infection control. They are paid by salary by their employers.

Dental Therapists

In the 1950s, when all professionals currently known as dentists were doctors trained as stomatologists, some school dental therapists were trained in Vocational Training School (and were actually called "dentists" at the time) in parallel with nurses and midwives. Some came from the (former) Soviet Union. Whilst they have permission to work until the end of their active practices, their position relating to "Acquired Rights" in the EU is unclear.

In 2008, there were about 26 still practising.

Practice in Estonia

Year of data:	2008
General (private) practice	1,150
Public dental service	
University	35
Hospital	35
Armed Forces	0
General Practice as a proportion is	94%

Working in General (Private) Practice

Dentists who practice on their own, or as small groups, outside hospitals or health centres, and who provide a broad range of general treatments are said to be in *private practice*. Many only work part-time in private practice. About 50% of private dentists provide some kind of publicly funded or assisted oral healthcare, mainly for children, as adult subsidies are very restricted (see Oral Healthcare, above). About 90% of private practitioners work in single dentist practices.

Most dentists in private practice are self-employed and earn their living through charging fees for treatments. The patient pays the dentist in full and some then reclaim partial or full reimbursement from the local office of the sick fund.

Fee scales

Since September 2003, there has been a partnership for the negotiations on fee scales between the Sick Fund Price Commission and the Estonian Dental Association.

Joining or establishing a practice

There are no rules which limit where a practice may open, but this has led to problems, as most dentists want to work in either Tallinn or Tartu, where the dentist to population ratio has fallen to 1:750. The opening of a practice is subject to the approval by the local health department. Existing practices are also bought and sold on the open market.

Practices can be found in all types of accommodation. Within practices, there is a minimum limit to the size of rooms and the facilities supplied. The state offers no assistance for establishing a new practice, and generally dentists must take out commercial loans from a bank. There are no rules relating to the numbers of dentists or partners in the practice.

Working in Public Dental Service

Public Dentistry ceased to exist from the beginning of 2004. The last dental clinic was privatised. Local government can partly own clinics or support them financially.

Working in Hospitals

Hospitals in Estonia are all publicly owned. All the hospital dentists are Oral maxillo-facial surgeons who work as salaried employees. They undertake mostly surgical treatments.

There are generally no restrictions on these dentists seeing other patients outside the hospital, in private practice. The quality of dental care is assured through dentists working in teams under the direction of experienced specialists. The complaints procedures are the same as those for dentists working in other settings.

Working in Universities and Dental Faculties

Dentists who work in the dental school are salaried employees of the university. About half work part-time - they are allowed to combine their work in the faculty with part-time employment in private practice, elsewhere.

The senior academic title within the Estonian dental faculty is that of university professor, who since 2002 must be DDS. Other titles include docents and teachers. There are no formal requirements for postgraduate training but docents and professors will have completed a PhD, and most will also have received a specialist clinical training. To be elected to the post of professor a dentist must have published scientific research of at least 3 dissertations. Apart from these there are no other regulations or restrictions on promotion.

The quality of clinical care, teaching and research in the dental faculty is assured through the old traditions of Tartu University (formed in 1632) and a Ministry of Education curriculum which has been accredited by the international commission 2002, following a DentEd visit in 2001.

Any epidemiological studies are local – being undertaken by enthusiastic teachers only.

Working in the Armed Forces

There are no dentists working full time for the Armed Forces.

Professional Matters

Professional associations

There is one professional association, the Estonian Dental Association (EDA) - *Eesti Hambaarstide Liit*.

	Number	Year	Source
Estonian Dental Association	666	2008	Association

The Association represents private and public health dentists and combines this role by trying to emphasise common, professional matters. The EDA represents Estonia at international meetings.

The EDA is run by a Board, secretary and 40 (elected) council members. It is established to protect dentists as liberal professionals, and represent members in negotiations with local authorities, ministries and legal bodies. It provides members information about changes in legislation and offers advice to dentists on legal affairs. Together with the Society, the EDA arranges lectures and conferences.

The ESS was first founded in 1921. Annual dental meetings are organised by the ESS.

There is also an Estonian Dentistry Students Association.

Ethics and Regulation

Ethical Code

Dentists are subject to an ethical code which is based on the Council of European Dentists Ethical Code.

Supervision of this is by the Estonian Dental Association. However, the Ethical Code is not mandatory, it is only recommended, so dentists may receive only a written warning, on non-compliance, or removal as a member of the Association.

Fitness to Practise/Disciplinary Matters

If this is unsatisfactory for patients then they may make a claim to the Consumer Protection Bureau. For disciplinary purposes a complaint by a patient is investigated by a "Treatment Quality Commission", which is appointed by the Ministry of Social Affairs, Health Department's Supervision Department. Patients may also write an application to the Consumer Protection Service, but they send their complaint to the Health Department's Supervision Department first.

In the Treatment Quality Commission there is one dentist, who is appointed by the Ministry of Social Affairs Health Department, as a dental councillor. A patient will be examined, if it is necessary, by a commission appointed by the dental councillor. If it is reported to the Treatment Quality Commission that quality is below standard, then they may call to order the dentist and demand that he undertakes and passes courses, or they may suspend temporarily the working permit, until the reported deficiency is removed. The Dental Councillor is a member of the board of the Estonian Dental Association.

For appeals against what they consider an adverse decision the patient or the doctor/dentist may complain to the Court.

Data Protection

Estonia has a Data Protection Law and all dentists who apply for the permission to work, have to first have permission from the Data Protection Service. The EU Directive has been adopted by Estonia.

Advertising

Advertising is permitted, provided that it is legal, decent, honest and fair – and may take place in any of the mediums such as TV, radio and the press. However, comparison of skills with another dentist is not permitted.

Dentists are allowed to promote their practices through websites subject to the usual rules of "legal, decent, honest and fair", but they are required to respect the legislation on Electronic Commerce, and the data protection law.

Insurance and professional indemnity

Estonian dentists have a "Responsibility Insurance", but this is voluntary.

Corporate Dentistry

Dentists are allowed to form "limited companies" and non-dentists may be part or full owners of such companies.

Tooth whitening

Tooth whitening comes under cosmetic legislation if the hydrogen peroxide is up to 5.5%. However, with greater concentrations, medical devices legislation applies and only dentists may use this on patients.

Health and Safety at Work

Hepatitis B vaccinations for dentists and their staff are not mandatory, and the practice owner must pay for any voluntary inoculations undertaken.

Ionising Radiation

There are specific regulations relating to radio protection. Training is mandatory for undergraduate dentists and then they become the competent person to direct radiation. They must undertake continuing education every five years.

The Radiation Protection Centre registers and controls radiation equipment.

Hazardous waste

Amalgam separators are not required by law, although they are advised.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Radiation Protection Centre
Electrical installations	Health Protection Bureau
Infection control	Health Protection Bureau
Medical devices	Heath Protection Service
Waste disposal	Health Protection Bureau

Financial Matters

Retirement pensions and Healthcare

The national retirement age is 65 but (liberal) dental practitioners may work until any age. The national insurance premiums include a contribution to the national pension scheme. Retirement pensions in Estonia are typically €224 a month, but private pensions would depend on a person's contributions.

Taxes

National income tax:

The rate of income tax is 21%

VAT/sales tax

There is a value added tax, payable at a rate of 18% on purchases, including dental materials. Medical and dental services are not included.

Various Financial Comparators

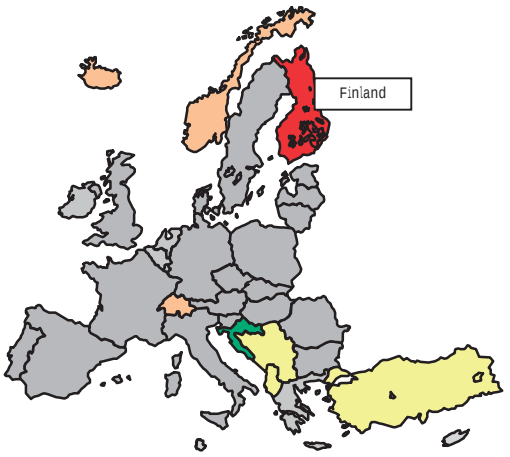
Zurich = 100	Tallin 2003	Tallin 2008
Prices (excluding rent)	50.0	66.8
Prices (including rent)	46.1	64.5
Wage levels (net)	11.9	20.9
Domestic Purchasing Power	15.6	32.3

Source: UBS August 2003 & January 2008

Other Useful Information

Dental associations and information centres:		
Estonian Dental Association: 1) Ravi 27-250, 10138 Tallinn ESTONIA Tel: +372 64 59 001 Fax: +372 64 59 001 2) Raekoja Plats 6 51003 Tartu ESTONIA Tel: +372 7319 855 Fax: +372 7428 608 Email: ehleda@online.ee Website: www.ehl.ee		Estonian Dentistry Students Association Raekoja plats 6 50013 Tartu ESTONIA Office: Nooruse 7-901 50408 Tartu ESTONIA Tel: +372 7 381 241 Fax: Email: info@ehyl.ee Website: www.ehyl.ee
Competent authorities:		*Tartu Dental school:*
Healthcare Board Gonsiori 29 Tallinn 15157 Estonia Tel: +372 650 9840 Fax: +372 650 9844 Email: info@tervishoiuamet.ee Website: www.tervishoiuamet.ee	The General Dental Council 29 Gonsiori Str, Tallinn 15157 Estonia Tel: +372 6509840 Fax: +372 6509844 Email: info@tervishoiuamet.ee Website: www.tervishoiuamet.ee	The Dean Docent Mare Saag Clinic of Stomatology, Tartu University Raekoja Platz 6 51003 Tartu ESTONIA Tel: +372 7319 855 Fax: +372 7428 608 Email: mare.saag@kliinikum.ee Website: http://www.med.ut.ee/stom

Finland



Date of last revision: 1st October 2008

In the EU/EEA since	1995
Population (2008)	5,300,484
GDP PPP per capita (2007)	€29,421
Currency	Euro
Main language	Finnish 95% Swedish 5%

Healthcare is funded largely through general taxation, with an additional special tax for health which is paid by everyone including those who have retired.

Number of dentists:	5,866
Population to (active) dentist ratio:	1,178
Members of Finnish Dental Association:	98%

The use of dental specialists and the development of dental auxiliaries are both well advanced.
Continuing education for dentists is not mandatory.

Government and healthcare in Finland

Finland is a Nordic country. The land area is 2,628 sq km and the country has Norway, Sweden and Russia as adjacent neighbours. The capital is Helsinki (the northernmost capital in Europe).

Finland was a province and then a grand duchy under Sweden from the 12th to the 19th centuries, and an autonomous grand duchy of Russia after 1809. It won its complete independence in 1917.

The national parliament has 200 members, elected under a system of proportional representation. The President of the Republic is elected by direct popular vote. In the regular course of events, a Presidential election takes place every six years. Finland has a unicameral Parliament with 200 seats. The minimum age for voting and standing for election is currently 18. The Prime Minister is elected by Parliament and thereafter formally appointed to office by the President of the Republic. The President appoints the other ministers in accordance with a proposal from the Prime Minister. In 2008 there were 20 ministers in the Cabinet.

Regional government is organised through 6 provinces, and 432 municipalities (or *Kunta*).

In Finland healthcare is funded largely through general taxation, with an additional special tax for health which is paid by everyone including those who have retired.

The Primary Health Care Act (PHC Act) of 1972 reformed the planning of primary health services by establishing a network of health centres funded by the municipalities. These provide a range of local public services, including medical services, radiology, laboratory and dental services - although the latter varies between health centres.

		Year	Source
% GDP spent on health	8.3%	2005	FDA
% of this spent by governm't	77.8%	2005	OECD

Oral healthcare

A comprehensive survey of oral health in adults was conducted as part of a nationwide study of health status in Finns in year 2000. Over 6000 persons attended in the study, which included clinical and radiological oral examination. The results are published by the National Public Health Institute, (Health and Functional capacity in Finland 2004) in pdf-form:

http://www.ktl.fi/attachments/suomi/julkaisut/julkaisusarja_b/2004b12.pdf

The responsibility for planning oral healthcare lies with the Ministry of Social Affairs and Health, but the actual service is usually provided by municipalities. The government social insurance agency (the Kansaneläkelaitos or KELA), also provides some assistance in paying for healthcare, again under the strategic direction of the Ministry. The agency is self-regulating, under the supervision of the Finnish parliament, has its own budget, and 263 branch offices in municipalities. However if the KELA has a budget deficit the government is obliged by law to make up the total spent, from taxation.

		Year	Source
% GDP spent on oral health	0.42%	2005	FDA
% of OH expenditure private	62%	2005	FDA

About 70% of the population receive oral healthcare regularly (in a two-year period) and oral examinations would normally be undertaken every 1-2 years.

The dental services are delivered either through the system of public health centres, or by private dentists, denturists and dental laboratories. About 36% of dental care is state-funded (half by the municipalities, half by central government) and 56% is paid for directly by households. 7% of the balance is paid by KELA and 1% by employers.

There has been a major change in Finland affecting all healthcare from the beginning of March 2005. A new Act imposed new requirements on municipalities, which must organise their health care so that patients will receive an assessment of their need for non-emergency treatment from a health care professional – not necessarily a doctor – within three days, while the necessary treatment must be provided within 3 to 6 months. However, emergency treatment must be provided immediately.

The new legislation also applies to dental care where treatment must at least be initiated within 6 months of the treatment assessment. The Ministry has also published definitions for the necessary treatments in various sectors of dental care – ie those included in the guaranteed access system. However, it is suggested that the new system will cause a lot of problems in dental care, in particular, the reason being that over half of adult patients have turned to private dentists who are not covered by the new legislation

Private Care

In 2008 the Finnish Dental Association estimated that about half of adults were treated within private insurance schemes (about 1% of children under 18 years).

The Quality of Care

Although the state authorities provide recommendations for dentists, for example for filling materials and practice hygiene, the standards of dental care are not actively monitored in private practice in Finland. The only routine system is random checks on billing by the KELA. They assess the average cost per patient and ensure that the calculated bill reflects the amount of work done. Care provided in health centres is subject to quality assurance.

Patient complaints are generally managed by the National Authority of Medicolegal Affairs or the Consumer Complaints Board, supplemented by a patient ombudsman system. Also, since the Patient Injury Act in 1987 there has been a Patient Insurance Centre which may indemnify injuries which occur during treatment. Liability insurance is, however, included in the membership fee of the Finnish Dental Association X-rays are actively monitored by the authorities.

Health Data

		Year	Source
DMFT at age 12	1.20	2003	OECD
DMFT zero at age 12	42%	2003	FDA
Edentulous at age 65	40%	2000	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no fluoridation schemes in Finland.

Education, Training and Registration

Undergraduate Training

To enter dental school a student has to have completed secondary school (usually at the age of 18). There is an entrance examination, which is similar to that of medical students. The undergraduate course lasts for 5 years.

Two of the four original dental schools (known as *Hammaslääketieteen laitos*) were closed 1998, leaving two (Helsinki and Oulu) open. However, the dental school in Turku University reopened as an undergraduate facility in 2004, because of a shortage of dentists (it had remained as a postgraduate school only before then). Dental schools are part of the Colleges of Medicine.

Year of data:	2008
Number of schools	3
Student intake	145
Number of graduates (2007)	81
Percentage female	74%

There has been a large increase in the student intake 2007-08.
Quality assurance for the dental schools is provided by the Ministry of Education.

Qualification and Vocational Training

Primary dental qualification

The primary degree which may be included in the register is: *Licentiate in Odontology (hammaslääketieteen lisensiaatti) (HLL).*

Vocational Training (VT)

Graduates can only register in Finland when they have completed 9 months' salaried, supervised training, working as a dentist under the supervision of an experienced dentist. At least 6 months of this training must be undertaken in health centres, and up to 3 months can be done in a private surgery. In principle there are educational targets, but it is only up to the employer how to fulfil these. There is no theoretical training. They are salaried as "junior" health centre dentists, with salaries of approximately €40,000 a year.

Diplomas from other EU countries are recognised without the need for vocational training.

Registration

To register in Finland, a dentist must have a recognised degree or diploma awarded by the universities, and have completed 9 months supervised training. The register is administered by National Authority for Medicolegal Affairs (the competent authority).

Cost of registration (2008)	€ 300

Finnish university graduates pay a lower fee (€68 in 2008).

Language Requirements

There are no formal linguistic tests in order to register for EU graduates, although dentists are expected to speak and understand Finnish (or Swedish in certain areas).

However, under the EU Directive implemented in 2007 an employer can require that the dentist speaks Finnish.

Dentists from outside the EU have to prove (by examination) that they are proficient in either the Finnish or Swedish languages.

Further Postgraduate and Specialist Training

Continuing education

Continuing education is not mandatory but under Finnish legislation there is a general requirement to keep skills updated. Postgraduate education is delivered through the Finnish Dental Society Apollonia.

Specialist Training

Specialists train in Universities; also, in health centres and hospitals which have contracts with the universities.

There is a minimum of 2 years pre-training (working as a dentist after basic education), before entering specialist training. Training lasts for 3 years (Oral and Maxillofacial Surgery, 6 years) and includes a University examination. Specialist education leads also to a degree, like specialist in orthodontics. To become a Doctor in Odontology a thesis (like a PhD) must be completed.

Oral Surgery was combined in 1999 with maxillo-facial surgery, as a medical specialty. There are about 60 post-graduate positions in the country, so there is a limit to how many can train. Trainees are paid approximately €36,000 a year.

There is training in 4 main specialties:

- Orthodontics
- Dental Public Health
- Oral Maxillo-Facial Surgery
- Clinical Dentistry

Clinical Dentistry is a specialty with 6 subgroups. These are:

- cariology
- periodontology
- prosthetics
- oral radiology
- oral pathology
- microbiology

The titles obtained by specialists in orthodontics and oral surgery, the two specialties recognised by the EU, are:

- 'todistus erikoishammaslaakarin oikeudesta oikomishoidon alalla/bevis om specialisttandlakarrattigheten inom omradet tandreglering' (certificate of orthodontist) issued by the competent authorities.

- 'todistus erikoishammaslaakarin oikeudesta suukirurgian (hammas- ja suukirurgian) alalla/bevis om specialisttandlakarrattigheten inom omradet oralkirurgi (tand- och munkirurgi)' (certificate of oral or dental and oral surgery) issued by the competent authorities.

Workforce

Dentists

Year of data:	2007
Total Registered	5,866
In active practice	4,500
Dentist to population ratio*	1,178
Percentage female	69%
Qualified overseas	200

* active dentists only

Many dentists practice in more than one sphere of practice.

There is a decrease in the workforce as more dentists retire than are being trained. So, a dental school in Turku which had been closed was reopened in 2003. It was calculated that by year 2020 there would be approximately 3,700 dentists in active practice, but with the reopening of the school the number is now estimated at approximately 4,000 (against the 4,600 estimated in 2005).

There is some small reported unemployment amongst dentists in Finland (between 10 to 20 dentists, around 0.33%) - the unemployment benefits are described by the FDA as "good".

Movement of dentists across borders

About 75% of the foreign dentists working in Finland qualified in the EU/EEA and 25% outside the EU/EEA

About 160 Finnish qualified dentists were working abroad.

Specialists

In Finland 4 dental specialities are recognised under the National Authority for Medico-legal Affairs:

- Orthodontics
- Oral Surgery
- Dental Public Health
- Clinical Dentists

Patients can go directly to specialists, without referral

In the following table, the specialty of "Clinical Dentistry" has been broken down into the known sub-specialties

Year of data:	2007
Orthodontists	149
Endodontists	3
Paedodontists	86
Periodontists	2
Prosthodontists	144
Oral Surgeons	85
Dental Public Health	105
Others	86

Auxiliaries

The system of use of dental auxiliaries is well developed in Finland and much oral health care is carried out by them. In Finland, apart from chairside dental surgery assistants, there are three types of clinical dental auxiliary:

- Dental hygienists
- Dental technicians
- Denturists

Year of data:	2006
Hygienists	1,575
Technicians	507
Denturists	331
Assistants	6,168
Therapists	0
Other	0

Dental Hygienists

The title is legally protected and there is a registerable qualification which dental hygienists must obtain before they can practice. There is an entrance examination into a polytechnic, where they undertake 3.5 years education and training, which includes basic professional studies and studies to boost occupational skills. The register is held by the National Authority for Medico-legal Affairs.

Dental hygienists work in all services only under the prescribed instructions of a dentist. They work usually as part of the team although they can work independently. They may undertake infiltration local anaesthesia. They take legal responsibility for their work and they may accept payment from patients, if they have a practice of their own. This is very rare – only some 20 hygienists in the country operate like that.

They are normally salaried.

Dental Technicians

The title is legally protected and there is a registerable qualification which dental technicians must obtain before they can practice. Like hygienists, there is an entrance examination into a polytechnic, where they undertake 3.5 years education and training. A register is held by the National Authority for Medicolegal Affairs. Their duties are to prepare dental prosthetic and orthodontic appliances to the prescription of a dentist and they may not work independently.

Individual technicians are normally salaried and work in commercial laboratories which bill the dentist for work done.

Denturists

In Finland, denturists are operating auxiliaries who can provide complete dentures to the public. There is a qualification and the register is held by the National Authority for Medicolegal Affairs.

They train in the same school as hygienists/technicians, and there is an entrance examination. Their training lasts an additional half-year (the person must be a dental technician first).

They work mostly in their own private practices. Whilst they do receive referrals from dentists, generally their patients come directly from street. Whilst they cannot provide partial dentures it is reported that they do so, illegally. There is control of their ethics and practices by the authorities, as with dentists, but their fees are not regulated. Their average earnings are thought to be less than dentists.

Dental Chairside Assistants

Assistants follow 2.5 years training under the authority of the dentist and with institutional support. They receive a diploma, which they need to register. Registration is by the National Agency of Medico-legal Affairs and they are paid by salary by their employers.

Practice in Finland

Oral health services are provided in both the public and private sectors with about half of dentists in each sector.

Year of data:	2007
General (private) practice	2,280
Public dental service	2,135
University	136
Hospital	72
Armed Forces	10
Student Health Service	72
General Practice as a proportion is	51%

Working in General Practice

In Finland, dentists who practice on their own or as small groups, outside hospitals or health centres, and who provide a broad range of general treatments are said to be in *private practice*. In 2007 dentists who worked in this way, provided approximately 50% of the care for the adult population. About 40% of private practitioners worked in single dentist practices and approximately 600 were employees of private dental care firms, either *PlusTerveys* or small companies of two or three (see below). During the years just prior to 2008, new companies, such as MedOne, which hires dentists for communities, have emerged.

Most dentists in private practice are self-employed and earn their living through charging fees for treatments. The patient pays the dentist in full and some then reclaim partial reimbursement from the local office of the *KELA*.

Fee scales

As already described, Public health insurance (KELA) used to reimburse a certain part of the dental treatment costs of patients born in 1956 or later who sought treatment in private dental surgeries. From December 2002 these age limits were abolished. This compensation amounts to 35 to 40% of the fees charged by private dentists. A private practitioner is free to decide the price for treatment (fee-for-service) but the compensation is calculated from KELA's price list.

Treatments which do not attract a government subsidy include fixed and removable prosthetics and most orthodontics or dental laboratory costs. Orthognatic surgery cases are normally covered – a prerequisite is a statement from orthodontist and oral surgeon. War-veterans have some better benefits, like their prosthodontic care being included in the scheme (at partial reimbursement).

The Finnish Dental Association is not allowed - due to competition law - to make any recommendations for fees and prices are set by the market. However, the majority of dentists stay within a 15-30% range. Prior approval for treatment is not required for any treatment under any of the schemes for receiving free care or a subsidy.

Joining or establishing a practice

There are no rules which limit the size of a dental practice or the number of associate dentists or other staff working there. However, private group practices are supervised by the provincial government. Apart from this there are no standard contractual arrangements prescribed for dental practitioners working in the same practice. Premises may be rented or owned and are normally in houses, flats or business premises - not usually in shops or purpose-built clinics. The state offers no assistance for establishing a new practice, and generally dentists must take out commercial loans from a bank. When starting a new practice private dentists have to inform the local health authorities.

The premises for the surgery are usually rented, but the equipment is usually owned by a single practitioner or by the (small) company owned by the working dentists. The auxiliaries are usually employees for this company but the dentists can be either employees or (more frequently) working as independent dentists.

Working in the Public Dental Service

Public services are provided mainly in health centres organised by municipalities singly or collectively. Dental services are part of other local health services. A local chief dental officer is responsible for arrangements, together with other local authorities.

Before 2002 it was possible to limit dental services to special age groups only. Municipalities in Finland are very independent and some limitations were in use in many of them.

Since 2002 limitation by age is no longer possible, but the municipalities can still organise the services in their own way to some degree. The main principle is that municipalities are - in general - responsible for the health services for people in need, but also the Ministry of Social Affairs ensures that municipalities act within the new law.

Municipalities get funding for these services from the central government, but most of the financing must come from their own internal funds, through taxes. Patients also pay quite a large co-payment. Despite these fees the charges are about half of what patients pay in private sector.

Despite the 2002 law, it has not been possible to arrange all dental services in health centres, because of the limited municipal resources. However the intention was not the organisation of all dental services into the public sector, but was to give patients choice. There has been some change in the content of dental care in health centres, which means more patients are seen, with more adults and older patients.

Health centres have proved popular to dentists as working places. Surveys have shown that patients have attached great value to the dental service they have received both in health centres and in the private sector. There is no major difference in the treatment between the sectors and also the sectors work together well. However, health centres cannot offer continuing care as often as is offered as the private sector - especially in the big cities. The main emphasis has so far been on children and a range of (so called) "special groups".

The procedure for handling of complaints is the same as in the private sector - however, the Consumer Complaints Board is only for the private sector.

In single municipalities, there are different types of procedures for monitoring quality, but there is no national quality system in public health sector.

A dentist working in a health centre can get a higher position usually through specialist training or by being chosen for the position of a local chief dental officer.

The provision of domiciliary (home) care is not very common in Finland, and is usually provided by public health dentists.

Salaries of dentists employed in public health clinics are comparable to that of private practitioners.

Working in Hospitals

Dentists work in hospitals as salaried employees of the local municipality (or a federation of municipalities), or one of the small number of private hospitals. They undertake mostly surgical treatments, but also other demanding treatments and "normal" treatment to hospital patients.

There are generally no restrictions on these dentists seeing other patients outside the hospital. The quality of dental care is assured through dentists working in teams under the direction of experienced specialists. The complaints procedures are the same as those for dentists working in other settings

Working in Universities and Dental Faculties

Dentists working in dental schools are salaried employees of the university. They are allowed to combine their work in the faculty with part-time employment or private practice elsewhere.

The main academic title within a Finnish dental faculty is that of university professor. Other titles include teachers and assistants. There are no formal requirements for postgraduate training but senior teachers and professors will have completed a PhD, and most will also have received a specialist clinical training. Apart from these there are no other regulations or restrictions on promotion.

The quality of clinical care, teaching and research in dental faculties is assured through dentists working in teams under the direction of experienced teaching and academic staff. The complaints procedures are the same as those for dentists working in other settings.

Working in the Armed Forces

The dentists working full time for the Armed Forces are all male.

Professional Matters

Professional associations

There is a single main national association, the Finnish Dental Association. The Association represents private and public health dentists and combines this role by trying to emphasise to common, professional matters.

	Number	Year	Source
Finnish Dental Association	4,218	2008	FDI

The Finnish Dental Association monitors the professional, economic and social interests of its members. The Association operates as a link between dentists working in various professional fields and aims to encourage professional cohesion.

The Dental Association promotes treatment of oral and dental diseases in Finland and sponsors oral health care. The Association pursues sound oral health care and availability of high-quality services across the country.

The association´s highest policy body is a 40-member representative body. The Board consists of 11 members and is led by the President of the Association. In the office in 2008 there were 17 people working, led by the Executive Director. About 98% of active dentists were members.

Ethics

Ethical Code

Dentists are subject to the same ethical code as their medical colleagues. For example, they must only use proven techniques and must constantly update their clinical skills. There is also a special law to protect patients' rights, consent and confidentiality. The Finnish Dental Association has its own ethical code.

There are no specific contractual requirements for dentists working in the same practice. A dentist's employees however are protected by the national and European laws on equal employment opportunities, maternity benefits, occupational health, minimum vacations and health and safety.

Fitness to Practise/Disciplinary Matters

Supervision of the practice of the medical and dental professions is by the National Authority for Medicolegal Affairs, with about 15 complaints being made against dentists each year. Another avenue for complaint can be the provincial government. There is also a Consumer Board, which is only for private practitioners. This receives about 30 complaints against dentists a year.

The consequences of a complaint which is upheld can be a written warning, a reminder of duty to exercise proper care, an admonition or even a restriction on the right to practice dentistry.

There are also local consumer Ombudsmen. When a problem arises, a consumer can get in touch with the consumer advisor in his or her own municipality. The advisor will provide the consumer with information on his or her position, consumer goods, their quality and marketing. Municipal consumer advice is provided free of charge.

Data Protection

In 1993, a law on patients' rights came into force. The law concerns patients' right to information, the right to see any medical documents concerning them and the right to autonomy. A medical ombudsman was also introduced by the law. However, the ombudsman's role to the patient is advisory only.

Advertising

Advertising is permitted, subject to national legislation and a professional code of ethics. Dentists are permitted to use the post, press or telephone directories, without obtaining prior approval.

Dentists are allowed to promote their practices through websites but they are required to respect the legislation on Data Protection and Electronic Commerce.

Insurance and professional indemnity

Under the Patient Injuries Act 1987 (amended in May 1999), the aim was to withdraw from fault liability as a prerequisite for compensation, ie "no-fault insurance". Patient insurance is therefore compulsory for doctors and dentists, and the Finnish Dental Association provides an optional scheme for those members who work in private practice. The scheme provides cover for all patient injuries caused during dental care. Within this cover negligence is not a prerequisite for compensation - no proof of malpractice is needed and compensation is provided for financial losses over €200 (thus excluding insignificant injuries).

The insurance only covers bodily injuries which are likely to have resulted from treatment, so 100% certainty is not necessary. However, the law does not mean that all injuries that occurred in connection with medical and dental treatment are compensated for. In other words, certain consequences that patients might suffer were left outside of the scope of this insurance.

When considering whether a consequence could have been avoided, the evaluation is based on the standard of an experienced medical professional and top specialist skills are not presumed.

Compensation is paid for bodily injuries which are likely to result from treatment injury, a defect in the equipment, an infection which originated from treatment (in certain cases), an accident which is connected with an examination or treatment, wrongful delivery of pharmaceuticals or other unreasonable injury.

The compensation covers medical and dental treatment expenses, other necessary expenses caused by the injury, loss of income, pain and suffering, permanent functional defect and permanent cosmetic injuries. Claims for compensation have to be presented to the Patient Insurance Centre within three years of the date at which patient has learned or should have known about the injury. Notwithstanding this, compensation has to be claimed not later than ten years from the event that led to injury.

In 2007 the Patient Insurance Centre received 701 claims from dental patients, 60% from private sector and 40% from public sector. 36% of these patients obtained compensation. Most common dental injuries were root canal perforations, during root canal treatment, or nerve injuries connected to teeth extractions. Mean compensation in the private sector was approximately € 3,000.

Fees for the insurance do not vary according to the type of treatments undertaken by dentists. In 2008 a general dental practitioner would pay €738 annually for this. Failure to insure by a dentist leads to an eventual increased insurance premium – a penalty premium may be as high as ten times the normal rate; in practice it is three times higher.

The premium covers a dentist's work in Finland only, and not for work undertaken overseas.

Corporate Dentistry

PlusTerveys is built only for dentists and physicians, but other companies can vary and non-dentists may own or part own these companies and share in any profits, this is not being regulated.

Tooth Whitening

Tooth whitening products are partly classified as medicinal and partly cosmetics. In 2008, the authorities have not been active in this matter and so at that time any person can provide tooth whitening to customers as a "cosmetic procedure".

Health and Safety at Work

There is legislation in the field of employee protection. HepB vaccination is not mandatory, however most dentists and dental nurses have had it administered.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Government owned company
Electrical installations	Government owned company
Infection control	National Agency for Medicines www.nam.fi
Medical devices	National Agency for Medicines www.nam.fi
Waste disposal	Local municipality government

Ionising Radiation

Training in radiation protection is part of initial dental training and further training is mandatory – 40 hours every 5 years. A dentist may take radiographs or can delegate this task to a trained dental nurse.

Hazardous Waste

The EU Hazardous Waste Directive 91/689 was incorporated into Finnish laws in 1993. Amalgam separators have been legally required since 1997.

Financial Matters

Retirement pensions and Healthcare

The national insurance premiums (4.1% of earnings) include a contribution to the national pension scheme. Retirement pensions in Finland are typically 60% of a person's salary on retirement. The official retirement age in Finland is 63 to 68, although the average age of retirement is 59. Dentists practice, on average, to a little over 60 years, although they can practice past this age.

Most of general health care is paid directly through income tax.

Taxes

There is a national income tax (dependent on salary), a municipal tax (which varies according to municipality: in Helsinki 17.5%) and a church tax (which church non-attenders do not have to pay).

National income tax:

The highest rate of income tax is 60% of all earnings over about €100,000 (earnings under this attract a lower rate).

In addition to income tax, national insurance premiums are paid at 4.6% of salary, and sickness insurance fees are paid at 1.5% of salary.

VAT/sales tax

There is a value added tax, payable at a rate of 22% on purchases. Medical and dental services are not included.

Various Financial Comparators

Zurich = 100	Helsinki 2003	Helsinki 2008
Prices (excluding rent)	86.1	96.9
Prices (including rent)	84.5	95.0
Wage levels (net)	56.6	77.5
Domestic Purchasing Power	61.5	81.6

Source: UBS August 2003 & January 2008

Other Useful Information

Main national associations and Information Centre:

Suomen Hammaslääkäriliitto
(Finnish Dental Association)
Fabianinkatu 9 B
00130 Helsinki, FINLAND
Tel: +358 9 622 0250
Fax: +358 9 622 3050
Email: hammaslaakariliitto@fimnet.fi
Website: www.hammaslaakariliitto.fi

Specialist associations and societies:
Dentists' scientific organisation:
Finnish Dental Society Apollonia
Bulevardi 30 B
00120 Helsinki, FINLAND
Tel: +358 9 680 3120
Fax: +358 9 646 263
E-mail: toimisto@apollonia.fi
Website: www.apollonia.fi

National Research and Development Centre
for Welfare and Health (STAKES)
PO Box 220
00531 Helsinki, FINLAND
Tel: +358 9 36 671
Fax: +358 9 761 307
Website: www.stakes.fi

Competent Authority:

National Authority for Medicolegal Affairs
PO Box 265
00531 Helsinki
Finland
Tel: +358 9 7729 20
Fax: +358 9 7729 2138
Email: kirjaamo@teo.fi
Website: www.teo.fi

Publications:

The Finnish Dental Journal
(*Suomen Hammaslääkärilehti-Finlands Tandläkartidning*- Finnish Dental Journal)
Fabianinkatu 9 B,
00130 Helsinki, FINLAND
Email: hammaslaakariliitto@fimnet.fi
Homepage: www.hammaslaakariliitto.fi

Dental Schools:

Helsinki

University of Helsinki
Department of Dentistry
Mannerheimintie 172
POB 41
00014 Helsingin yliopisto, Finland
Tel: +358 9 1911
Fax: +358 9 1912 7519
E-mail: jukka.meurman@helsinki.fi
Website: www.Helsinki.fi
Dentists graduating each year: 35
Number of students: 200

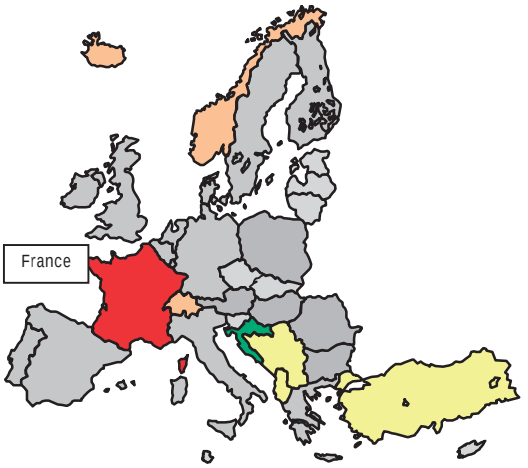
Turku (new school)

University of Turku
Department of Dentistry
Lemminkäisenkatu, 2
20520 Turku, Finland
Tel: +358 2 333 81
Fax: +358 2 333 8413
E-mail: pekka.vallittu@utu.fi
Website: www.utu.fi/med/dent/
Dentists graduating each year: 25 (starting in 2009)
Number of students: 100

Oulu

University of Oulu
Department of Dentistry
Aapistie 3
90220 Oulu, Finland
Tel: +358 8 537 5011
Fax: +358 8 537 5560
E-mail: sinikka.vuoti@oulu.fi
Website: www.oulu.fi/hamm
Dentists graduating each year: 35
Number of students: 220
[DN: figure to be updated]

France



Date of last revision: 1st October 2008

In the EU/EEA since	1957
Population (2008)	63,753,140
GDP PPP per capita (2007)	€27,312
Currency	Euro
Main language	French

The social insurance system is established by law and is divided into 3 major branches, the Sickness Funds (Assurance Maladie), Pension (Retraite) and Family (Allocations Familiales). Each of these is managed by Councils which are independent of the state. Most oral healthcare is provided by 'liberal practitioners' according to an agreement called the Convention. Almost all chirurgien-dentistes (dental surgeons) - 98% - practise within the Convention.

Number of dentists:	40,968
Population to (active) dentist ratio:	1,556
Members of CNSD:	50%

The use of recognised specialists is limited to orthodontics and there are no clinical dental auxiliaries.
Continuing education has been mandatory since 2004.

Government and healthcare in France

France is a democratic republic with a President, elected by universal suffrage. There is a bicameral Parliament or Parlement, which consists of the Senate or Sénat (331 seats - members are indirectly elected by an electoral college to serve nine-year terms; elected by thirds every three years) and the National Assembly or Assemblée Nationale (577 seats - members are elected by popular vote under a single-member majoritarian system to serve five-year terms). There is a third chamber, le *Conseil Economique et Social*, the Economic and Social Council, with an advisory function, composed of representatives of the associations and the professional world. The liberal professions are represented and two dental surgeons have a seat within this Council.

Although the organisation of government is centralised, two political and administrative structures exist below the national level where there are 22 regions and 100 departments (including 4 overseas). Most French institutions exhibit strong liberal traditions and this is mainly reflected in the medical and dental professions.

The Overseas Territories (Nouvelle Calédonie, Polynésie Française, Wallis-et-Futuna) are fully part of the French Republic. However, territorial governments are totally independent in the field of health.

The social insurance system was established by law in 1945 and is divided into three major branches, the Sickness Funds (*Assurance Maladie*), Pension (*Retraite*) and Family (*Allocations Familiales*). Each of these is managed by Councils which are independent of the state. The councils are made up of representatives of the employers and employees who finance the systems. The *Caisse d'Assurance Maladie* of the sickness branch, is administered by a board with an elected president and a government-appointed director. Social security is a "private law association", under the control of the state.

The social insurance system was changed in 2004 due to the last health reform, and now functions in the following way. The government prepares every year - in Autumn - a bill (projet de loi de financement de la sécurité sociale) and submits it to the Parliament. The Parliament discusses and votes on the text, including the new annual budgets of the sickness funds. Then the Caisse controls the application of the bill and negotiates conventions with each representative of health discipline, including the dental profession.

Within the *Assurance Maladie* there are three major *Caisses*: the CNAMTS (*Caisse Nationale d'Assurance Maladie des Travailleurs Salariés*), which covers salaried workers and their dependants (82% of the total population); the CANAM (*Caisse Nationale d'Assurance Maladie des Professions Indépendantes*) for independent professionals; and the UCCMA (*Union des Caisses Centrales de la Mutualité Agricole*) for agricultural workers. The *Assurance Maladie* itself is funded by personal contributions and income tax.

All citizens have an equal and constitutional right to receive healthcare, and the system is organised in the same way throughout the country. Every individual is automatically affiliated to one of the three *caisses* according to their economic status. This obligatory insurance gives them the right to be totally or partially reimbursed for their health expenses including dental treatment for themselves and their dependants.

		Year	Source
% GDP spent on health	11.1%	2006	DREES
% of this spent by governm't	79.8%	2005	OECD

DREES: Direction de la recherche, des études, de l'évaluation et des statistiques, Ministère de la Santé

Generally, hospital expenses are paid by an individual's insurers, and primary care costs directly by the patient who is then reimbursed by the sickness fund, in part or in full.

In 2006, approximately 93.1% of hospital expenses were covered, compared with 67.3% of expenses for ambulatory care and medicines.

Oral healthcare

Public compulsory health insurance

Most oral healthcare is provided by 'liberal practitioners' according to an agreement called the *Convention* (after negotiation between the representative professional unions of dentists and the Caisse). Almost all dental surgeons (99%) in France practice within the *Convention*. If a dental surgeon is not in the *Convention* then the patient cannot reclaim all or part of the cost.

All those legally resident in France are entitled to treatment under the *Convention*. Children and teenagers aged 6, 9, 12, 15 and 18 can benefit from a prevention examination covered 100% by health insurance (mandatory at 6 and 12). This examination is directly paid to the dentists by the Caisse. The necessary care (conservative treatment and sealants) are free as well.

For conservative and surgical treatments the practitioner must charge fees within the agreement and the patient can reclaim up to 70% (limit set by the Caisse). For other treatments eg orthodontics and prosthodontics, dental surgeons may set their own fees, having informed the patient of the estimated cost. The Caisse, subject to prior approval, usually covers a part of these fees on the basis of a scale which has not much changed in the last 40 years. The patient pays the whole fee to the dental surgeon and is then issued with a form with which to reclaim the relevant amount from the *Caisse*. There is no restriction on how often treatment can be received.

A Universal Sickness Insurance (*Couverture Maladie Universelle, CMU*) was created on 1st January 2000 to promote the access to care for the "weaker" part of the population. Practitioners are directly paid by Social Security *Caisses* and complementary insurances. The fees for conservative and surgical care are set by the Convention. For prosthetics there is a different scale of fees. These fees have not been reviewed since their creation on 1st January 2000.

About two-thirds of the population visits a dental surgeon at least once a year.

		Year	Source
% GDP spent on oral health	0.60%	2004	CECDO
% of OH expenditure private	15.4%	2006	DREES

Private insurance for dental care

Approximately 90% of people use complementary insurance schemes, either by voluntary membership or through the CMU to cover all or part of their treatment. There are many such schemes. The financial risk is taken by the insurance company. With regard to conservative and surgical care, these complementary insurances cover all or part of the fees not covered by mandatory insurance. For prosthetic and orthodontics, these complementary insurances cover *at least* the 30% of the fees not covered by mandatory insurance (it means that complementary insurance may pay for more than 30%, depending on the scheme). It is to be noted that some of these schemes may cover more than the responsibility costs of the social security caisses.

There are two types of complementary insurance: the "mutuelles", covered by the "code de la mutualité" and for which the member, in most of the cases, has no need to provide a health questionnaire; and private insurances, covered by the insurance code and for which the members have, in most instances, to provide a health questionnaire. The dental surgeon has no role in selling those products.

The Quality of Care

The statutes for social insured citizens allow patients to ask for the expertise of the treatment received to be examined, if he/she is not satisfied. Complaints can be sent either to the Social Security Caisses, or to the departmental Council of the *Ordre National*, or follow a normal legal procedure (see later). In case of litigation, the practitioner may be assisted by a colleague.

Domiciliary care can be provided on request, by a limited number of patients, such as those ill or disabled. Once requested, a dental surgeon must provide this care.

Health Data

		Year	Source
DMFT at age 12	1.20	2006	WHO
DMFT zero at age 12	56%	2006	OECD
Edentulous at age 65	38%	2006	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

Fluoridated salt has been sold in France for more than 20 years. Fluoride toothpastes are sometimes freely given to children in the framework of education campaign.

Education, Training and Registration

Undergraduate Training

Access to dental studies is open after Baccalaureat (12 years of primary studies). Access to dental faculties is by examination at the end of the first year (in common with medicine). The number of students admitted to 2nd year is set annually by the Ministry in charge of Health together with the Ministry in charge of Education. The duration of dental studies is 6 years, ending with an examination. A thesis in necessary to obtain the title of doctor in dental surgery and required to practise.

Year of data:	2008
Number of schools	16
Student intake	1,047
Number of graduates (2004 data)	900
Percentage female (2004 data)	55%

The dental schools are all state funded.

The responsibility for quality assurance in the faculties is by the Ministry of Education, the Chancellor of the University and the Dean of the Faculty.

Qualification and Vocational Training

Primary dental qualification

The degrees which may be included in the register are:

Diplome d'état de chirurgien dentiste (Dental Surgeon) – before 1972
or
Diplome d'état de docteur en chirurgie dentaire (Doctor in Dental Surgery)

Vocational Training (VT)

There is no post-qualification vocational training.

Registration

One of the functions of the *Ordre National* is to administer the registration of dental surgeons. It ensures that the dental surgeon has the legally required diploma. It also controls processes of de-registration for disciplinary or health reasons.

The list of dental surgeons is held primarily by Departmental Dental Councils, but a national list is also available. The Council has a consultative role in the monitoring of educational standards in the universities.

Cost of registration (2008)	€ 354

Practitioners have to pay an annual charge in order to remain on the register.

A further role of the Ordre National is to check the conditions of registration of foreign dentists (automatic recognition) including appropriate diploma and French language ability.

Language requirements

The president of the departmental section of the "Ordre" judges the language skills of the candidate.

Stomatologists

Stomatologists are doctors specialised in stomatological sciences (medical specialty). They provide the same care as qualified dental surgeons, plus cervical and facial surgery. The duration of their training is 6 years (medical studies) plus 4 years of specialist internship. They then obtain a diploma of doctor in medicine plus a diploma of qualification (DES Diploma of Specialised Studies).

In 2008 they were still being trained. There is no minimum time before they gain "Acquired Rights" to work in other EU countries – it depends on the recognition of this medical specialty in the host country.

The professional title is: "*Médecin spécialiste qualifié en stomatologie*"

Further Postgraduate and Specialist Training

Continuing education

The ethical code gives the moral duty to every practitioner to undertake continuing education during his professional life.

Since 2004 and the law reforming health system, continuing education is mandatory for the dentists. A body, composed of colleges (Ordre, Unions, University) controls the respect of the law and sets the subjects of the training as well as the content of the proposed training sessions. It sets as well the credits - points to be acquired: 800 in 5 years with at least 150 per year.

Specialist Training

France has only one recognised dental specialty - Orthodontics. Training for orthodontics lasts for four years, part-time and takes place in university clinics. A national specialist diploma is then awarded by the authority recognised competent for this purpose: "Certificat d'études cliniques spéciales, mention orthodontie".

The professional title is: " *chirurgien-dentiste spécialiste qualifié en orthopédie dento-faciale*".

The Ordre, University & other professional organisations (including CNSD) agreed to introduce the specialty of Oral Surgery as soon as legislation permits. Legislative arrangements were under discussion in 2008.

Oral Maxillo-facial surgery is a specialty under the Medical Directives. They receive the title: "*Médecin spécialiste qualifié en stomatologie*" (as noted above).

Workforce

Dentists

In 2008 an increase to the student intake was decided by the public authorities, because of a predicted shortage of dental surgeons by 2015.

Year of data:	2008
Total Registered	44,537
In active practice	40,968
Dentist to population ratio*	1,556
Percentage female	37%
Qualified overseas	660

It was reported by the CNSD that there were no unemployed dental surgeons in 2008.

Movement of dentists

In 2008, 1056 "foreign" dentists were practising in France.

Year of data:	2008
Total	1,056
EU graduates	541
EEA graduates	2
Convention d'établissement*	348
Others (Minister's discretion)	165

* the Convention d'établissement is an agreement between foreign countries and France The dentists authorised to practice are foreigners with French qualification.

It is not possible to identify the number of French dentists practising abroad.

Specialists

Only one dental specialty is recognised in France – orthodontics. About one dentist in every 20 specialises in orthodontics. Most orthodontists work in private practice. There is no referral system in France for access to specialists – patients may go directly to them.

Year of data:	2008
Orthodontics	1,937

There are specialists in Maxillo-Facial Surgery, but, as stated earlier, this is a medical specialty. Oral surgery in due course will become a dental specialty.

Auxiliaries

In France no auxiliaries are allowed to work in the mouth. The only recognised auxiliary personnel are dental assistants, receptionists and dental technicians.

Year of data:	2005
Hygienists	0
Technicians	19,500
Denturists	0
Assistants	15,000
Therapists	0

Dental Technicians

Dental technicians (prothésistes dentaires de laboratoire) do not need to be registered. They undertake a minimum 3 years training in laboratories and schools. They have no direct contact with patients, working under the prescription of the dental surgeon.

Most dental surgeons use independent laboratories and there were 4,950 craft or industrial laboratories employing salaried workers in 2008. Some practitioners employ technicians directly in their own private laboratories.

There is a reported problem in the France with illegal denturists/clinical dental technicians – a few prosecutions are mounted each year by the CNSD and on each occasion the technician has been found guilty of illegal practice.

Dental Assistants

Dental assistants qualify after 2 years alternative training in dental practice and one of 7 schools. This training is mainly governed by a "parity" body: the Commission Nationale de Qualification (CNQAOS). They do not have to register.

Practice in France

Year of data:	2008
General (private) practice	35,180
Salaried private practice	544
Public dental service	2,389
University	276
Hospital	250
Armed Forces (2004 data)	42
Stomatologists (2007 data)	1331
General Practice	87%

Working in Liberal (General) Practice

Most dentists work in "liberal practice"; that is on their own or in association with one or more other dental surgeons. Liberal practitioners earn their living entirely through fees from their patients.

It is compulsory for dental surgeons working in the same practice to be in a contract with each other. The *Ordre National* produces different types of collaboration and association agreements and has a register of agreed contracts. For a practice's employees the dental surgeon must respect an employment code which regulates all types of worker and covers equal employment opportunities, maternity benefits, occupational health, legal duration of work (35 h/week), minimum vacations and health and safety. Furthermore, they must respect the collective agreement, which regulates the employment of all staff covering for example continuing education, and salary. Collective agreements are negotiated jointly by dental organisations and employees unions.

A dental surgeon would normally look after about 1,500 patients on his "list". An adult patient would normally attend an average of about 1.5 times every year.

Dental surgeons working under the convention benefit from social advantages in the fields of retirement pensions and social protection.

Fee scales

Oral Healthcare in France is said by the CNSD to be penalised by a fee scale that is "out of date" and has not adapted to new techniques and new materials. It is estimated by CNSD that remuneration at the level of endodontic care in France is one and a half to two times less than in many other countries. Above all, remuneration takes little account of the real cost which they say should be calculated depending on the technical difficulty and time required for each treatment.

On the other hand, prosthetic fees are higher in France than in other countries but the coverage by statutory insurance is very small. In general, the percentage of available funding distributed to sectors of dentistry in France is 60% for general care and surgery, 35% for prosthetics and 5% for orthodontics.

Within the *Convention*, each item of treatment is allocated to a price category or 'quotation'. This is established by a special commission attached to the Health Minister (*Commission de la Nomenclature Générale des Actes Professionels*). There are four types of 'quotation' each with a different monetary value set by the *Convention*, for surgery, orthodontics, conservation and prosthodontics, respectively.

Joining or establishing a practice

There are no rules which limit the size of a dental practice in terms of the number of associate dental surgeons or other staff. Dental surgeons can work on their own, in association or with an assistant-dental surgeon, but a dental surgeon may only have one assistant.

Premises may be rented or owned. Generally new practitioners buy the practice of a retiring dental surgeon. When negotiating the price three elements are included, the building, the equipment (which can be set against tax), and the right of access to the existing patient list. The value of the last factor is based upon the previous three or four years of accounts. There is no state assistance for establishing a new practice, so dental surgeons must take out commercial loans with a bank. However, in some suburbs or special geographical areas, the practitioners can get tax deductions.

Standards

The Social Security Caisses ensure that the "conventioned" practitioner has coded the services provided according to the Nomenclature Générale des Actes Professionnels, and the actual fees. The practitioner is directly paid by the patient. A signature proves that the dental surgeon has been paid by the patient and is required for reimbursement to the patient. The dental surgeons *Conseil* of the Caisses may check the conformity of the treatments with the current state of the art.

Working in the Public Dental Service

There is no real public dental service in France. However, a small number of practices are owned by the *Caisses*, municipalities, or mutual insurance companies (*Mutuelles*). About 5% of dental surgeons work in these practices, are salaried, and can treat any kind of patient. The organisations that own these practices receive fees according to the *Convention*. The *Mutuelles* are regulated by a code (the *Code de la Mutualité*) which allows them, among other things, to advertise.

Working in Hospitals

Every University Hospital Centre (CHU) has a dental service for every type of patient (in- or outpatients). Treatments can be provided by hospital practitioners, university-hospital practitioners and dental students. There also can be dental services in a CHU with no dental faculty.

The conditions which may be treated include maxillo-dental pathologies, oral pathologies and dental trauma. In some regional hospitals, these facilities will include a "general odontology" department. The dental surgeons in charge of these departments are recruited through a national

competitive examination. Dental surgeons employed in hospitals may be part- or full-time, and will usually have the title *Odontologiste des Hôpitaux* (Hospital Odontologist) and are also recruited through a national competitive examination. Hospitals also employ *Attachés*, who work only a few hours a week and may run their own private practice outside the hospital. Part-time odontologists may also work as liberal practitioners outside the hospital.

Working in Universities and Dental Faculties

The education and training of dental surgeons is carried out in *Centres de Soins, d'Enseignement et de Recherche Dentaires* (*CSERD*: Dental Care, Education, and Research Centres). There are 16 such centres employing dental surgeons in University Hospitals. Their operation is financed jointly by the ministries responsible for education and health. The Hospitals provide clinical experience and the universities theoretical and practical education. However, staff typically have a function in both hospital and university and receive a salary for each, as well as having some research responsibilities. Staff may be employed as:

Assistants Hospitaliers Universitaires are recruited through local competitive examinations and are appointed for a limited period of 4 years, without permanent tenure. They are employed part-time (20 hours per week) and usually have a Masters degree in biological and medical sciences.

Maitres de Conférence des Universités - Praticiens Hospitaliers who are recruited through national competitive examinations, less than 45 years old, and have tenure after one year as a trainee. The posts are either part-time or full-time and staff will normally have worked for at least two years as an assistant and have obtained a *Diplôme d'Etudes Approfondies* which is an additional Postgraduate Diploma. *Professeurs des Universités - Praticiens Hospitaliers* who are recruited through national competitive examinations, and are usually less than 55 years old. They work part-time and have spent at least three years as a *Maitre de Conférence* and obtained a certificate of ability to conduct research (*Habilitation à diriger des recherches*) or a doctorate (*Doctorat d'Etat*).

Other practitioners may also take part in the training of dental surgeons. They are recruited directly by the hospital centre or university and work as *Chargés d'Enseignement* (junior lecturer) for theoretical or clinical courses, or as Attachés *Hospitaliers* for limited periods. These practitioners, as well as part-time *Hospitalo-Universitaires*, may also continue work as dental surgeons within their own practice.

Working in the Armed Forces

There are several full-time dental surgeons serving in the Armed Forces – but the number of females is not recorded.

Professional Matters

Professional associations

The main professional union for dental surgeons is the *Confédération Nationale des Syndicats Dentaires* (CNSD) founded in 1935, encapsulating 100 departmental unions, representing about 50% of the practising dental surgeons in France.

It is the privileged partner with the government in planning oral healthcare. The CNSD is also conventional partner with the Caisses and is recognised as the representative union by the public authorities; as such, the CNSD is able to deal with every aspect of dental health politics.

The CNSD through its structures and commissions supports and defends the dental practitioners, by analysing all issues influencing dental practice. On this basis, it defines strategies and politics in the fields of:

- Initial dental education
- Professional capacity
- Professional demography
- Professional practice and definition of the relationship with public authorities and social structures
- Continuing education
- Oral health prevention
- Taxes
- Pension
- Training of the dental staff
- International affairs

The French Dental Association (ADF), founded in 1970, embraces the whole dental profession in France (liberal dental surgeons, specialists, academics, hospital, individual members of professional unions, scientific societies etc).

The ADF is managed by a *conseil d'administration*, composed of all the member organisations and a board of 12 directors elected for 3 years.(OK) A general assembly defines the action programme every year, upon a proposal of the board of directors. Statutory commissions work on permanent issues (institutional, legal, technical) of the profession: annual congress organisation, continuing education, international affairs, information, professional legislation, hospital-university life. Advisory commissions work on specific issues such as health economics, medical devices, quality etc.

	Number	Year	Source
Ordre	44,537	2008	CNO
ADF	20,800	2008	ADF
CNSD	15,000	2007	CNSD

Ethics and Regulation

Ethical Code

The organisation of the profession concerns the *Ordre National des Chirurgiens-Dentistes*, entrusted by law with a mission of public service.

The Order compulsorily covers all dental practitioners in France (departments and overseas territories included), whatever the form of practice, and its central finality is patients' and public health protection.

The law defines the competencies and the roles of the Order. It watches the respect of the principles of morality, probity, competence and devotion, essential to the practice of the profession and of the professional duties and rules observation enacted by the Code of Public Health and Ethical Code. It ensures the defence of the profession's honour and its independence. It studies questions and projects submitted by the Ministry for Health, or the Ministry for Education, and represents the profession with national and European authorities.

To achieve this, the Order has three main prerogatives:

- It controls access to the profession by registration process: administrative competence
- Its steps in the regulation of the profession according to legal methods: lawful competence
- It controls the profession and more specifically at a disciplinary level: jurisdictional competence.

The Order achieves its missions through departmental councils, regional or interregional councils and the National council. There are two levels of jurisdiction: the regional council (first level) and the disciplinary chamber of the national council (appeal level). Over all, the Conseil d'Etat can broker an appeal decision on its formal and proceeding aspects. Sanctions may be a simple warning, up to the banning from practice.

The Ethical Code covers the contract with the patient, consent and confidentiality, continuing education, relationships and behaviour between dental surgeons and advertising.

Under normal judicial procedures, a court makes a judgement based on evidence from an expert witness

All dental practitioners elect the members of their departmental councils. The members of the departmental council elect the regional councillors. The departmental councillors in a region or inter-region elect the National councillors.

Fitness to Practise/Disciplinary Matters

When it is a *conventional conflict*, the case of the dental surgeon is studied by a committee composed of *chirurgiens-dentistes conseils* and of representatives of professional organisations, which have contracted to the convention. There is no lay (non-dental) representation on the committee. Sanctions may be financial penalties up to temporary suspension or erasure.

Data Protection

By law, since August 2004 (*loi relative à la protection des personnes physiques à l'égard des traitements de données à caractère personnel*), France has implemented the Data Protection Directive.

Moreover, for health data protection, Articles 5, 5.1 and 5.2 of the Ethical Code give guidance for professional secret and personal health data protection as well as for the dental

surgeon and his employees. Consultation is not allowed online. The law and the Code of Ethics regulate health personal data protection and are the corner stones of a Charter edicted by the Ordre, whose aim is the regulation of publicity on professional websites, which is permitted.

A practitioner has to declare his computerised files to the CNIL (*Commission nationale informatique et liberté*); he also has to inform his patients that their files are computerised and that they have the right to know their contents.

Advertising

General guidance is given in Article 12 of the Code of Ethics which states that dental surgeons are "notably forbidden any form of direct or indirect advertising".

Article 13: defines information that a dental surgeon is allowed to put in the telephone book as: "surname, first names, address, telephone and fax numbers, opening hours, speciality". Any entry that is charged for is considered as advertising and is thus forbidden.

Article 14: defines information that a dental surgeon is allowed to mention on a professional plaque at the entrance of a building, or practice, with the professional title of "chirurgien-dentiste", and: "surname, first names and speciality". The dental surgeon must add the name and location of the establishment or examining board which awarded his/her diploma, and may add the opening hours and the floor and telephone number of the practice.

Dentists are allowed to have websites for their practices in a very controlled and regulated framework by the Order.

Indemnity Insurance

Liability insurance has been compulsory for all health professions since March 2002. For CNSD members, it is included as a part of association membership as a group insurance. Different insurance companies provide professional civil liability cover for a dental surgeon's patients during their working life. There are different prices for different types of practice.

For example, a liberal practitioner who is a *CNSD* member will pay €160 annually, plus a €215 implant supplement, (plus €80 for private legal assistance and €60 for professional legal assistance), while non members will be charged €400 for civil and professional liability *with* legal assistance (private and professional), or €795 with implantology and €235 and €630 respectively, without legal assistance (2008 fees).

This insurance does not cover dentists for working abroad, except for a maximum duration of 2 months in EU countries + Andorra + Switzerland (for temporary practice or for dentists migrating and acquiring new insurance).

Corporate Dentistry

Dental surgeons may run practices as corporates, on their own or in association with others. However, a non-dentist cannot be a part or full owner of a practice, *except* in the case of a Société d'Exercice Libéral (SEL, which is an incorporated practice), where an *ayant-droit* (legal successor) of a dead dentist can inherit the practice for five years. After that time, and if the *ayant droit* is not successful in the practice, he or she must sell his or her participation. This is a relatively new rule.

Other than this, when a dental surgeon dies, non-dentist successors do not have the right to own a practice. However, they can be allowed by the Ordre National to contract with a dental surgeon manager during a variable time, allowing them to sell the practice in the best possible way, or if one of the successors had started a course in dental education, to wait the end of the course.

Tooth whitening

Tooth whitening is considered as cosmetic and some products are available over the counter. The CNSD however, strongly advises dentists against selling these products (on regulatory, ethical and fiscal level).

Health and Safety at Work

An individual who, in a public or private care or prevention establishment, practises a professional activity exposing him/her to contamination risks, has to be immunised against Hepatitis B, diphtheria, tetanus, and poliomyelitis (it means anybody working in the practice, staff or dental surgeon). This is supervised by the *Health General Direction*.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Institut de radioprotection et de sureté nucléaire (IRSN)
Electrical installations	Local town planning authority
Waste disposal	Direction Regionales des Affaires Sanitaires et Sociales (DRASS)
Medical devices	Health General Direction
Infection control	Health General Direction

Ionising Radiation

Training in radiation protection is now part of the undergraduate curriculum. Since 2004, this training is complemented with a mandatory training in patient radioprotection (continuing education) in which every dentist will have to be qualified by 19 June 2009 (this qualification will be renewed every 10 years).

The equipment has to be declared with IRSN (see above) and this declaration is valid for 5 years. France is still waiting for new rules to be applied to dentists as Radiation Protection Supervisors, planned in 2009 but not yet known.

Hazardous Waste

The EU Hazardous Waste Directive (requiring amalgam waste to be collected as hazardous waste) has been incorporated into French law. Amalgam separators have been legally required since 1998 in all units, requiring the collection of 95% of the weight of the amalgam in waste water.

There are regulations restricting who collects the waste to registered or licensed carriers.

Financial Matters

Retirement pensions and Healthcare

As non-salaried workers liberal dental surgeons contribute to a special retirement scheme, the CARCD (*Caisse Autonome de Retraite des Chirurgiens-Dentistes*) which is a *caisse* attached to the Ministry of Social Affairs. A basic dentists' retirement pension scheme has been established by law since 1948. It has been amended by the 'Complementary Retirement Scheme since 1955. The CARCD is administered by a board whose members are elected jointly by the contributors and the beneficiaries.

The normal retirement age for salaried workers in France is 65, but liberal dentists can practice beyond that age and there is no legal age limitation.

Taxes

There is a national income tax, and also a general social tax (*Contribution Sociale Généralisée - CSG*) and an additional tax on salaries called the *Contribution destinée au Remboursement de la Dette Sociale* (RDS) which is planned to be implemented until 31st January 2014 (regularly postponed by government). CSG and CRDS are based on gross salaries, indemnities, allocations and bonus.

They are calculated before social security salaried contributions and other contributions.

The highest rate of income tax is 40% on earnings over €67,546.

VAT

Normal rate: 19.6% (alcohol, tobacco etc, and the rate charged to dental surgeons for equipment, materials and instruments)
Reduced rate: 5.5% (food)
Super-reduced rate: 2.2% (refundable drugs)

Various Financial Comparators

Zurich = 100	Paris 2003	Paris 2008
Prices (excluding rent)	79.2	94.5
Prices (including rent)	75.7	95.0
Wage levels (net)	56.0	58.0
Domestic Purchasing Power	64.5	61.0

Source: UBS August 2003 and January 2008

Other Useful Information

Main national associations:	
Confédération Nationale des Syndicats Dentaires (CNSD) 54 rue Ampère 75017 Paris FRANCE Tel: +33 1 56 79 20 20 Fax: +33 1 56 79 20 21 Email: cnsd@cnsd.fr Website: http://cnsd.fr	Association Dentaire Française (ADF) 7 rue Mariotte 75017 Paris FRANCE Tel: +33 1 58 22 17 10 Fax: +33 1 58 22 17 40 Email: adf@adf.asso.fr Website: http://www.adf.asso.fr
Competent Authority and information centre:	*Monaco:*
Conseil National de l'Ordre des Chirurgien-Dentistes 22 rue Emile Menier 75116 Paris FRANCE Tel: +33 1 44 34 78 80 Fax: +33 1 47 04 36 55 Email: europe@oncd.org Website: www.ordre-chirurgiens-dentistes.fr	Collège des chirurgiens-dentistes de la principauté de Monaco 3 avenue Saint Michel Monte Carlo - MC 98000
Publications with information on vacancies for dentists:	*Details of indemnity organisations:*
Le Chirurgien-Dentiste de France 54 rue Ampère 75017 PARIS Tel: +33 1 56 79 20 48 Fax: +33 1 56 79 80 25 Email: cdf@cnsd.fr Website: www.cnsd.fr	MACSF, Service Assurance Dentaire Tel: +33 1 71 23 80 92 Fax: +33 1 71 23 88 92 E-mail: Website: www.macsf.fr

Dental Schools:

Number of students: this is the number in the 2nd year of the curricula, since the 1st year is common to medicine and pharmacy. The number of graduates refers to the calendar year 2007, the number of students to the academic year 2007-08.

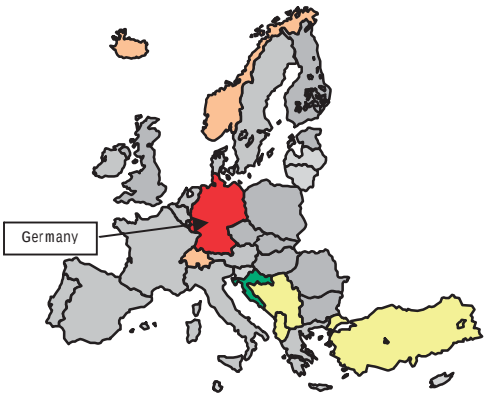
Please note that the gap between the number of students and the number of graduates is due to the recent increase in the number of students (it takes 6 years to train a professional), and not to a high percentage of students' failure! Moreover, dental studies include a thesis to be presented within 18 months after the 6th year of dental curricula.

Paris 5 Université Paris V (René Descartes) Faculté de Chirurgie-Dentaire de Paris V 1 rue Maurice Arnoux 92120 Montrouge, Paris Tel: +33 1 58 07 67 02 Fax: +33 1 58 07 68 99 Email: gerard.levy@univ-paris5.fr Website: http://www.odontologie.univ-paris5.fr Dentists graduate: 89 Number of students: 103	Paris 7 Université Paris 7 (Denis Diderot) UFR d'Odontologie 5, rue Garancière 75006 Paris Tel: +33 1 57 27 79 78 Email: jean-jacques.hourcade@univ-paris-diderot.fr Website: http://www.univ-paris-diderot.fr/formation/ListeMED.php Dentists graduate: 62 Number of students: 85
Bordeaux Université Victor Segalen Bordeaux II UFR d'Odontologie 16, cours de la Marne 33082 Bordeaux Cedex Tel: +33 5 57 57 1800 Fax: +33 5 57 57 3010 Email: admin.odonto@u-bordeaux2.fr Website: http://www.u-bordeaux2.fr Dentists graduate: 66 Number of students: 93 (this university welcomes overseas French territory students)	Brest Université de Bretagne Occidentale Faculté d'Odontologie de Brest 22 avenue Camille Desmoulins 29271 Brest Cedex Tel: +33 2 98 01 6489 Fax: +33 2 98 01 6932 http://www.univ-brest.fr/ODONTOLOGIE/Welcome.html Dentists graduate: 12 Number of students: 19
Clermont Ferrand UFR d'Odontologie 11 boulevard Charles de Gaulle 63000 Clermont Ferrand Tel: +33 4 73 43 64 00 Fax: +33 4 73 17 73 09 Email: ufr-odontologie@u-clermont1.fr Website: http://webodonto.u-clermont1.fr Dentists graduate: 40 Number of students: 53	Lille Université de Lille 2 – Droit et Santé Faculté d'Odontologie Place de Verdun, 59000 Lille Tel: +33 3 20 16 79 00 Fax : +33 (0)3 20 16 79 99 Website: http://chirdent.univ-lille2.fr Dentists graduate: 68 Number of students: 80
Lyon Université Claude Bernard Lyon 1 Faculté d'Odontologie Rue Guillaume Paradin 69372 Lyon Cedex 08 Tel: +33 4 78 77 86 00 Website : http://www.univ-lyon1.fr Dentists graduate: 57 Number of students: 77	Marseille Faculté d'Odontologie 27 Boulevard Jean Moulin 13355 Marseille Cedex 5 Tel: +33 4 91 78 46 70 Fax: +33 4 91 78 23 43 Contact: http://www.univmed.fr/public/contact/mail.asp Website: http://www.univmed.fr/odontologie/ Dentists graduate: 52 Number of students: 70
Montpellier Faculté d'Odontologie Université Montpellier 1 545 avenue du Professeur J.L. Viala 34193 Montpellier Cedex 5 Tel: +33 4 67 10 44 70 Fax: + 33 4 67 10 45 82 Website: http://www.odonto.univ-montp1.fr/ Dentists graduate: 41 Number of students: 58	Nancy Faculté de Chirurgie Dentaire UFR d'Odontologie 96 av de Lattre de Tassigny, BP 50208 54004 Nancy Cedex Tel: +33 3 83 68 29 50 Fax: +33 3 83 68 29 81 Contact: webmaster@uhp-nancy.fr Website: http://www.odonto.uhp-nancy.fr/ Dentists graduate: 43 Number of students: 57

Nantes Faculté de Chirurgie Dentaire–UFR d'Odontologie 1 Place Alexis Ricordeau, BP84215,44042 Nantes Cedex 2 Tel: +33 2 40 41 29 21 Fax: +33 2 40 20 18 67 Contact: accueil.odontologie@univ-nantes.fr Website: http://www.odontologie.univ-nantes.fr/ Dentists graduate: 54 Number of students: 70	Nice Faculté de Chirurgie Dentaire UFR d'Odontologie Pôle Universitaire Saint Jean d'Angély 24, avenue des diables bleus 06357 Nice cedex 4 Tel: +33 4 92 00 11 11 /62 Contact : scolarite-odonto@unice.fr Website : http://portail.unice.fr/jahia/page19.html Dentists graduate: 21 Number of students: 34
Reims Université de Reims Champagne-Ardenne Unité de formation et de recherche d'odontologie 2 rue du Général Koenig 51100 Reims Tel: +33 3.26 91 34 55 Contact: scol.odontologie@univ-reims.fr Website: http://www.univ-reims.fr/index.php?p=143&art_id=265 Dentists graduate: 32 Number of students: 76	Rennes Faculté de Chirurgie Dentaire de Rennes UFR d'Odontologie 2 avenue du Professeur Léon Bernard (Bat 15) 35043 Rennes Cedex Tel: +33 2 23 23 43 41 Fax: +33 2 23 23 43 93 Contact : secretariat.doyen-odonto@univ-rennes1.fr Website: http://www.odonto.univ-rennes1.fr Dentists graduate: 33 Number of students: 56
Strasbourg Faculté de Chirurgie Dentaire Université Louis Pasteur – Strasbourg 1 1 place de l'Hôpital, 67000 Strasbourg Tel: +33 3 90 24 39 01 Fax: +33 3 90 24 39 00 Contact : dentaire@adm-ulp.u-strasbg.fr Website : http://facdentaire.u-strasbg.fr/faculte/ Dentists graduate: 47 Number of students: 60	Toulouse Faculté de Chirurgie Dentaire UFR d'Odontologie Toulouse III – Université Paul Sabatier 3 chemin des Maraichers 31062 Toulouse Cedex 4 Tel: +33 5 62 17 29 29 Fax: +33 5 61 25 47 19 Email: resdental@adm.ups.tlse.fr Website: http://www.dentaire.ups-tlse.fr/ Dentists graduate: 53 Number of students: 70

	No of 2nd year Undergrads		Annual Graduates
	2008		2007
Paris 5	103		89
Paris 7	85		62
Bordeaux	93		66
Brest	19		12
Clermont Ferrand	53		40
Lille	80		68
Lyon	77		57
Marseille	70		52
Montpellier	58		41
Nancy	57		43
Nantes	70		54
Nice	34		21
Reims	76		32
Rennes	56		33
Strasbourg	60		47
Toulouse	70		53
Total	1,061		770

Germany



Date of last revision: 1st October 2008

In the EU/EEA since	1957
Population (2008)	82,221,808
GDP PPP per capita (2007)	€28,314
Currency	Euro
Main language	German

There is a long established insurance based healthcare system of "sick funds", which are not for profit organisations. Almost 90% of the population belong to one of the 355 funds. There is also wide use of private insurance. Dental fees, both inside and outside sick funds and insurance based care are regulated.

Number of dentists:	83,339
Population to (active) dentist ratio:	1,247
Members of Dental Association:	100%

The use of dental specialists and the development of dental auxiliaries are both well advanced. The national federation of Chambers is known as the Bundeszahnärztekammer (BZÄK) and all dentists must be a member of the local Chamber.
Continuing education for dentists has been mandatory since 2004.

Government and healthcare in Germany

Germany is one of the founder members of the EU. Its Federal system of government delegates most of the responsibility for expenditure and many policy decisions to the regional level which also has additional powers to raise local taxes.

The capital is Berlin.

There is a bicameral Parliament, which consists of the Federal Assembly or *Bundestag* (603 seats; elected by popular vote under a system combining direct and proportional representation; a party must win 5% of the national vote or three direct mandates to gain representation; members serve four-year terms) and the Federal Council or *Bundesrat* (69 votes; state governments are directly represented by votes; each has 3 to 6 votes depending on population and are required to vote as a block).

Elections for the Federal Assembly are held every 4 years (or less). There are no elections for the Bundesrat; the composition is determined by the composition of the state-level governments so the Bundesrat has the potential to change any time one of the 16 states (*Länder*) holds an election.

The President of Germany is elected for a five-year term by a Federal Convention including all members of the Federal Assembly; the Chancellor (equivalent to Prime Minister) is elected by an absolute majority of the Federal Assembly for a four-year term.

There is a long-established statutory health insurance system where health care depends on membership of a "sick fund". Sick funds are state-approved health insurance organisations, and there are currently 253 in the country. As well as the state-approved sick funds there are also private insurance organisations.

The majority 87.5% of the population are members of a sick fund, which provides a legally prescribed standard package of healthcare.

The sick funds are not 'for profit' organisations, which employees with incomes less than €4,012.50 gross/month must join. On average the premiums paid are 14.8% of total income up to a maximum of €4,012.50 (in 2007), of which the employer and employee each contributes 50%. If an individual is already a member of a sick fund, when their income exceeds the minimum, they may retain their membership or change to a private insurance scheme. However, the self-employed, and those whose income exceeds the minimum when they take up their appointment, are excluded from membership.

Most of those who are not members of legal sick funds are members of private insurance schemes, which are regulated by insurance law only and may thus offer more flexible packages of care. For example, the schemes carry all the financial risks of treatment or reimburse only a defined percentage of the costs and the premiums vary according to the level of cover required and the age or past health of the member. Membership of a private sick fund is also a personal contract, so dependants must be separately insured.

The actual provision of health care in the statutory system is managed jointly by the sick funds, and the doctors' and dentists' organisations. As with many other aspects of German government, this takes place at both the Federal level and at the regional level of the *Länder*.

		Year	Source
% GDP spent on health	10.9%	2007	BZÄK
% of this spent by governm't	76.9%	2006	OECD

Oral healthcare

Public health care

The key organisations in oral healthcare delivery are:

Sick funds	There are over 350 sick funds in Germany, organised broadly into five main groups. They are self-governing state-approved not-for-profit insurance bodies, jointly managed by employers' and employees' representatives. They generally insure employees and their dependants whose incomes are less than a specified amount.
Private Insurances	These are 'for-profit organisations' which may insure those who are not compulsory members of a sick fund. The activities of the private insurance companies are only regulated by general insurance law.
KZVs	KZVs are the 22 self-governing regional authorities, which every dentist has to be a member of in order to treat patients in the social security system. The KZVs are the key partners with the sick funds, holding budgets and paying dentists.
KZBV	This is the national legal entity, which together with the sick funds defines the standard package of care benefits within the legal framework. It also provides support services for the regional KZVs.
Dental Chambers	The 17 Dental Chambers (*Zahnärztekammern)* at the Lander level are the traditional professional associations (legal entities) with the overall responsibility for defending the interests of the profession, but also with a duty to protect the public's health. Every dentist has to be a member of a Dental Chamber.
BZÄK	The *Bundeszahnärztekammer* is the voluntary union of the Dental Chambers at a national level. It represents the common interests of all dentists on a national and international level

The delivery of oral health care in the legally based system is organised by the Federal dental authority (the *Kassenzahnärztliche Bundesvereinigung* or *KZBV*) nationally, and locally by the regional dental authorities (the *Kassenzahnärztliche Vereinigungen*, or *KZV*) in partnership with the sick funds. There are 17 KZVs within the 16 German *Länder*, KZVs (one for each *Länder*, with two for Nordrhein-Westfalen, the largest state). They represent all the dentists who can treat patients covered by a 'sick fund', and are therefore members.

The main functions of the KZVs are:

- to ensure the provision of dental care to all members of sick funds and their dependants
- to supervise and control the duties of its member dentists
- to negotiate contracts with regional associations of sick funds
- to protect the rights of member dentists
- to establish and manage committees for the examination and admission of dentists, and the resolution of disputes
- to collect the total fees from the sick funds and distribute them to member dentists
- to keep the dental register
- to appoint dental representatives on admission, appeal and contract committees and for regional arbitration courts

Benefits in the legal system

In principle, membership of a statutory sick fund entitles all adults and children to receive care from the statutory health insurance system. For radiographic investigation, examinations, diagnoses, fillings, inlays, oral surgery, preventive treatments, periodontology and endodontics, the sick funds pay 100% of the cost of the care. Advanced treatment such as crowns and bridges, attract a contribution of 50% and orthodontics for children, 80%. Implantology is not included in the benefits. In a typical year approximately 75% of adults and 70% of children use the system.

Before seeking general care from the state oral health system the patient must have a voucher from the sick fund. This voucher is both a certificate to demonstrate entitlement to care, and if care is given is also the dentist's claim form. The patient hands the voucher to the dentist at the first visit. The dentist then treats the patient without charging them and forwards the completed vouchers quarterly to the KZV, which checks the invoices, sends them to the 'sick funds', collects the money from the 'funds' and pays the total amount to the practitioner.

Since January 2004, for each dental visit per quarter, adult patients must pay a €10 "practice fee", which the dentist has to transfer to the legal sick funds.

For prosthetic treatment all legally insured persons may choose between a private health insurance or the statutory scheme – but it is mandatory to be insured in one or the other.

Oral re-examinations would normally be carried out for most adult patients on an annual basis.

		Year	Source
% GDP spent on oral health	0.80%	2004	BZÄK
% OH expenditure private			

Private insurance for dental care

Persons not required or not entitled to participate in the statutory scheme can apply for insurance cover from a private health insurance company – for example, freelance workers and members of the liberal professions, civil servants and employees with incomes above the limit for

compulsory insurance. The content of cover is contractually agreed and flexible - that is to say part cover can be taken out if required.

As at the end of 2006, 8.5 million people had comprehensive private health insurance policies. In 2008, there were about 48 private health insurers, with the legal form either of public limited companies or of mutual insurance funds, organised on a cooperative basis. The private health insurance companies differ appreciably in economic significance and size - the three largest companies, with some 3.3 million comprehensively insured persons, account for more than 40% of the total.

Less than 2% of all dentists in private practice treat only patients with private insurance schemes, that is to say they have no contract with the statutory sickness funds.

The Quality of Care

The standards of dental care are monitored by a federal committee on guidelines for dental care (the *Gemainsame Bundesausschuss*). Both the sick funds and the federal authority for dental care (the *Kassenzahnärztliche Bundesvereinigung*) are represented on this committee. Its main role is to establish within the legal framework the range of treatments which are necessary and can be legally provided as a part of the sick fund system. This includes approving new treatments or the use of new materials. Another responsibility of the committee is to determine the value of any treatment relative to other items of care.

Routine monitoring is carried out by the *KZV* and consists of checking invoices and the amount of work provided by each dentist. Those carrying out substantially more or less than the average of particular treatments are required to explain the anomaly. Other measures of quality are patient complaints and expert opinion procedures.

For dentists in free practice the controls for monitoring the standard of care are those described above. The same monitoring framework also applies for patients who pay the whole cost of care themselves; their bills do not need to be submitted to any external body for approval, but influence is exercised by the insurance companies who reimburse the invoices. The threat of patient complaints has a direct effect on the quality of care for most dentists.

Domiciliary (home) care is undertaken by dentists in free practice for their patients at home, or they may have a contract with a residential home for the elderly or another institution.

Health data

		Year	Source
DMFT at age 12	0.70	2005	WHO
DMFT zero at age 12	70.1%	2005	DMS IV
Edentulous at age 65	22.6%	2005	DMS IV

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

DMS IV refers to Micheelis, W., Schiffner, M.: Vierte Deutsche
Mundgesundheitsstudie (DMS IV). Institut der Deutschen Zahnärzte, Deutscher, Zahnärzteverlag, Köln 2006

Fluoridation

There is no water or milk fluoridation, however there is extensive salt fluoridation. 69.2 % of all consumed table salt contains fluoride as an additive.

Education, Training and Registration

Undergraduate Training

To enter dental school a student has to have passed the general qualification for university entrance (*Abitur/ Allgemeine Hochschulreife*) and a successful result in a Medical Courses Qualifying Test.

All but one of the dental schools are publicly funded and are part of the Colleges of Medicine of Universities. There is only one private dental school, in Witten-Herdecke. The undergraduate course lasts 5 years.

Year of data:	2006
Number of schools	31
Student intake	2,547
Number of graduates	1,539
Percentage female	60%

In 2006, there were about 2,030 places at the publicly funded dental schools, for entry each year (thus, excluding any figures for the private university at Witten-Herdecke). However, more students actually enter dental schools, because there are more applicants and dental schools are forced to accept the excess students (*Numerus Clausus*) who pass the entrance examinations. So, the real number of students entering dental schools is over 2,500, and the estimated number of all dental undergraduates is approximately 13,600.

Quality assurance for the dental schools is provided by control mechanisms and regulations of the universities, and the Ministry of Science and Education in each state.

Qualification and Vocational Training

Primary dental qualification

The main degree which may be included in the register is: *Zeugnis über die zahnärztliche Staatsprüfung* (the State examination certificate in dentistry).

Vocational Training (VT)

In order to register as a dentist and provide care within the legal sick fund system, a German dentist with a German diploma must have two years of approved supervised experience. This is in addition to the five years of a university dental training. A dentist can then apply to the admission committee of the *Kassenzahnärztliche Vereinigungen* (*KZV*).

The conduct of an independent dental practice providing treatment under the statutory health insurance scheme demands extensive professional and management knowledge and skills: knowledge of law applicable to health insurance practitioners and to the profession, as well as of management, of educational skills for the training of dental auxiliaries, organisational talent in the conduct of a practice and familiarity with the institutions involved in dental self-government and their functions. Hence work as an assistant is intended principally to prepare young dentists to cope with the many different kinds of problems associated with the running of a practice of their own.

There is no obligatory formal training for the assistants – however, courses on a voluntary basis are offered to assistants where a broad and systematic knowledge in all aspects of running a practice are offered by most of the dental chambers. There is no leaving examination - it is sufficient to prove the participation as an assistant for two years, to the admission committee. Assistants working only part time have to do more than 2 years.

Dentists from EU member countries with an EU diploma are not required to have the additional two years experience.

Registration

Applications are made to the KZV for registration and have to be supported by degree certificates and a letter of good standing from the dentist's current registering body. In 2006 there were 1,754 admissions, 1,725 leavers.

The cost of registration is included within the subscription to the KZV.

Language requirements

There are no legal requirements to be able to understand German in order to communicate with patients. However, where there is justifiable doubt about the language competence of an applicant, he/she may be tested by the responsible health authorities.

Further Postgraduate and Specialist Training

Continuing education

In Germany there is an ethical obligation to participate in continuing education. The costs for participation in continuing education courses are deductible from income tax as a practice expense.

New legislation on health care (Gesundheitssystem-Modernisierungsgesetz, GMG 2003) introduced, from January 2004, compulsory CE and regular monitoring in the form of recertification, after a 5 years period. The content and amount of the compulsory CE was defined by the KZBV, in agreement with BZÄK, in June 2004. [The KZBV is the association of KZVs on a national level].

Postgraduate Master programmes

In recent years, postgraduate Masters studies have been established by the universities, mostly part-time alongside work, for example in implantology, functional therapy, periodontics, endodontics, orthodontics, surgery, aesthetics, lasers in dentistry. The courses cover about 60 – 120 ECTS (European Credit Transfer System in which 1 ECT = 25 to 30 hours workload) and the final examination is for a Master degree (MSc).

Specialist Training

Four dental specialties are recognised, although not in all seventeen Lander:

- Oral Surgery
- Orthodontics
- Periodontology
- Dental Public Health

Periodontology is only recognised in Westfalen.

Training for all specialties lasts four years and takes place in University clinics or recognised training practices, except dental public health, which trains in its own environment.

- An orthodontist would receive the 'Fachzahnärztliche Anerkennung für Kieferorthopädie' (certificate of orthodontist), issued by the 'Landeszahnärztekammern' (Chamber of Dental Practitioners of the 'Länder'), as the outcome to training.
- An oral surgeon would receive the 'Fachzahnärztliche Anerkennung für Oralchirurgie/Mundchirurgie' (certificate of oral surgery), issued by the 'Landeszahnärztekammern'.
- For periodontists the same as for orthodontists and oral surgeons (certificate of periodontology issued by the Zahnärztekammer Westfalen-Lippe) is awarded.
- For Dental Public Health the dentist will receive the title "Zahnarzt für Öffentliches Gesundheitswesen", if he has passed an examination at a academy for public health (Akademie für Öffentliches Gesundheitswesen).

In principle, there is no limitation in the number of trainees, because there are sufficient dentists in free practice with the permission to train a dentist in orthodontics or oral surgery. However, since all dentists who want to specialise have to attend one year at the university, there is in fact a limitation in the number of trainees. The trainee has the status of an employee and gets a salary from his or her employer (the dentist in free practice with the special permission to train specialising dentists, the university or a hospital).

After completion of the specialised training the trainee has to pass an examination organized and in the responsibility of the dental chamber. He or she then gets the approval as specialist. He or she is registered by the dental chamber as a specialist.

Workforce

Dentists

Between 1,500 and 1,600 new dentists graduate each year and the numbers of dentists are increasing. However, this growth has slowed in the early years of the century. The BZÄK believes that there are too many dentists (in 2008).

Year of data:	2008
Total Registered	83,339
In active practice	65,929
Dentist to population ratio*	1,247
Percentage female	39%
Qualified outside Germany	2,838

There is some small reported unemployment amongst dentists in Germany.

Movement of dentists across borders

In 2008 there were over 3,300 dentists from outside Germany registered although less than 90% were actually active. There are no figures for how many German qualified dentists are practising outside Germany.

Specialists

Specialists work mainly in private practice, hospitals and universities but those specialists in dental public health are largely located in the public dental service or are employed directly by the sick funds. There are many regional associations and societies for specialists.

Year of data:	2007
Orthodontics	3,309
Endodontics	
Paedodontics	
Periodontics	40
Prosthodontics	
Oral Surgery	2,048
Dental Public Health	480

There are no limitations on the ratio of specialists to other dentists in Germany and there is no compulsory referral system for access to them. In general, patients are referred from the general dentist to a specialist, however the patient may also visit the specialist without referral.

Auxiliaries

In Germany, auxiliary personnel can only work under the supervision of a dentist, who is always responsible for the treatment of the patient. They cannot practice independently.

The range of auxiliaries is fairly complex, leading progressively (with training) from chairside assistant (Zahnmedizinische Fachangestellte) to Dental Hygienist. Registered *Zahnmedizinische Fachangestellte* may qualify as *Zahnmedizinische Fachassistentin (ZMF)*, *Zahnmedizinische Verwaltungsassistentin (ZMV)*, *Zahnmedizinische Prophylaxeassistentin (ZMP)* or Dental Hygienist. These registerable qualifications do exist in almost all *Länder* and are co-ordinated by the Bundeszahnärztekammer.

Year of data:	2007
Hygienists	350
Technicians	58,000
Denturists	0
Assistants	170,000
Therapists	0
Other	0

All figures estimated

Dental Chairside Assistants (Zahnmedizinische Fachangestellte)

The main type of dental auxiliary is *Zahnmedizinische Fachangestellte*. After 3 years in dental practice, attendance at a vocational school and a successful examination by the Dental Chamber they are awarded a registerable qualification.

Zahnmedizinische Fachassistenten

There are 3 grades of *Zahnmedizinische Fachassistenten*: ZMF, ZMP and ZMV, all specialisations of Dental Chairside Assistants (*Zahnmedizinische Fachangestellte*):

- *Zahnmedizinische Fachassistentin (ZMF)*: requires 700 hours training at a Dental Chamber, and their duties include support in prevention and therapy, organisation and administration, and training of *Zahnmedizinische Fachangestellte*.
- *Zahnmedizinische Prophylaxeassistentin (ZMP)*: requires a minimum 350 hours training at a Dental Chamber, and their duties include support in prevention/prophylaxis, motivation of patients and oral health information.
- *Zahnmedizinische Verwaltungsassistentin (ZMV)*: requires a minimum 350 hours training at a Dental Chamber, and their duties include support in organisation, filing and training of Zahnmedizinische Fachangestellte.

There is no available data about numbers of each group.

Dental Hygienists

To become a hygienist a student needs to undertake 3 years training and examination as a dental chairside assistant and 300 - 700 hours training and examination as ZMP or ZMF first. There is a further 800 hours training, followed by examination by the dental chamber.

Their duties include advice and motivation of patients, in prevention, therapeutic measures for prophylaxis and scaling of teeth.

They are normally salaried.

Dental Technicians (Zahntechniker)

Dental technicians are also not permitted to treat patients. They train for 3 years, 40% in vocational school and 60% in the dental laboratory. After a successful examination by the Chamber of Handicraft they are awarded a registerable qualification. However, only those who run a technical laboratory register (with the dental technicians' guild).

A dentist may employ a Zahntechniker but most use independent laboratories. They produce prosthodontic appliances according to a written prescription from a dentist. They do not deal directly with the public.

Practice in the Germany

Year of data:	2008
General (private) practice	63,000
Public dental service	450
University	2000
Hospital	200
Armed Forces	450
General Practice as a proportion is	96%

All figures estimated

Working in Free (Liberal or General) Practice

In Germany, dentists who practice on their own or as small groups, outside hospitals or schools, and who provide a broad range of general and specialist treatments are said to be in *Free Practice*. More than 60,000 dentists work in this way, which represents 95% of all dentists registered and practising. Most of those in free practice are self-employed and earn their living through charging fees for treatments. Very few dentists (less than 2%) accept only private fee-paying patients.

Once registered with a KZV a dentist in free practice may treat legally insured persons and claim payments from the sick fund via the regional KZV.

Fee scales

Fees are not nationally standard. Negotiations between the national association for dental care (the KZBV) and the major sick funds establish the standard care package for people insured with legal sick funds. Using a points system, relative values are allotted to each type of treatment. It is then up to the regional associations and sick funds to decide the monetary value of each point for payments in each region.

For private patients, whether insured or not insured, the levels of private fees payable are governed by federal law (*Gebührenordnung für Zahnärzte - GOZ*). Under this law the different types of treatment are described and a value in Euros is set. Depending on the difficulty of the treatment required the dentist may increase the basic value of his invoice by up to 3.5 times the recommended value. 2.3 times is the average fee for an average difficult treatment with the extra time needed. Over 2.3 times, the invoice must include evidence to justify the increase. An invoice higher than 3.5 times needs written agreement from the patient. Although there is no direct link between the GOZ and the private insurances, the private insurances co-ordinate their fees with the GOZ system and reimburse for treatment up to 3.5 times the standard fee.

Joining or establishing a practice

There are no rules which limit the size of a dental practice in terms of the number of associate dentists or other staff. Premises may be rented or owned, but any obligations to the owner of the practice must not influence the clinical autonomy of the dentist. There is no state assistance for establishing a new practice and dentists must take out commercial loans or other contracts with a bank.

There are no special contractual requirements for practitioners working in the same practice but a dentist's employees are protected by National and European laws for equal employment opportunities, maternity benefits, occupational health, minimum vacations and health and safety.

Dentists can set up completely new practices, they can buy existing practices or they can buy into existing joint practices. In 2006 (old German states), 19% of all new establishments were new solo practices, 52% were acquisitions of an existing solo practice and 29% were practice partnerships, either establishing a new practice partnership or joining an existing one. By buying an existing practice they usually buy a list of patients as well.

Establishing a new practice means to acquire totally new patients. Since 2007 limitations on establishing a practice in a special location were abolished for dentists practising under the statutory health insurance scheme. That means that a dentist may establish his or her practice whereever he or she chooses, with only financial considerations being a limiting factor. There are still planning provisions necessary but no limitations of provision with one exception – a licence to practice as a statutory health insurance dentist expires at the age of 68 years.

Practices are usually sited in offices or private houses or apartments, not in shops or malls.

Number of patients on a "list" of a full-time dentist has been estimated at about 1,000.

Working in the Public Dental Service

There is a public dental service to oversee and monitor the healthcare of the total population. The care provided is restricted to examination, diagnosis and prevention. The service employs dentists as *Zahnarzt für öffentliches Gesundheitwesen* and its size is stable. Working in the public dental service requires postgraduate training and examination by an academy of public health. Currently the specialty of dental public health is represented in all but one of the 16 *Länder*.

The quality of dentistry in the public dental service is assured through dentists working within teams which are led by experienced senior dentists, and the complaints procedures are the same as those for dentists working in other services.

In general there is more part-time work available in the public dental service than in other types of dental practice, and working hours are more flexible, or are shortened to reflect the length of the school day and the percentage of female dentists working in the public dental service is much higher. They are permitted to work in liberal practice as well as in public health.

Working in Hospitals

About 200 dentists work in hospitals, all Oral Maxillo-Facial Surgeons. Because Oral Maxillo-Facial Surgeons may register with either a dental or a medical chamber – and probably most register with a medical chamber, there is no accurate data relating to actual numbers.

Surgeons who need in-patient care for their patients with severe diseases may use beds in public or private clinics/hospitals, but they are working in free practice and are not employed by the hospitals. Very few dental ambulatories with employed dentists exist, for example some owned by the sick funds (AOK). So, there are normally no restrictions on seeing other patients in private practice.

Working in Universities and Dental Faculties

Over 2,000 dentists work in universities and dental faculties as employees of a university. With the permission of the university, they may carry out some private practice outside the faculty. As all dental schools are combined with dental clinics for outpatient and inpatient care, almost all employees at universities and dental faculties treat patients in the associated polyclinics and clinics.

The main academic title in a German dental faculty is that of university professor. Other titles include university assistants, *Oberarzt*, and academic dentists. There are no formal requirements for postgraduate training but professors usually qualify for the title through a process called *habilitation*. This involves a further degree, a record of original research and earning the "right to teach" by delivering a special lecture to the faculty. Professorships are mostly filled by external candidates through competition. Apart from these there are no other regulations or restrictions on the promotion of dentists. The complaints procedures are the same as those for dentists working in other areas, as described earlier.

Their salaries differ considerably from assistant to professor. Since professors have the right to treat patients privately their private incomes will augment the normal salary paid by the university.

Working in the Armed Forces

There are over 450 dentists working full time for the Armed Forces, an unreported (but small) number female.

Professional Matters

Professional associations

	Number	Year	Source
Bundeszahnärztekammer	65,929	2008	BZÄK

Zahnärztekammern (*Dental Chambers*)

Zahnärztekammern (or Dental Chambers) are the traditional bodies which represent the interests of dentists working in all of the oral health systems. Every dentist has to be a member of a Dental Chamber. The Chambers are also responsible for other defined legal tasks. There are 17 Dental Chambers in 16 *Länder* and also, in some parts of the country, some subdivisions of the chamber, which work at a more local level. They are democratically elected organisations with strong traditions of self-regulation. Their main duties are:

- to create and maintain uniform professional ethics
- to advise and support members
- to organise and promote dental undergraduate and continuing education, including the training of auxiliaries
- to represent professional interests to authorities, legislative bodies, associations and in public
- to monitor the professional duties of its members
- to assure a dental emergency service
- to support quality assurance and continuing education
- to arbitrate disputes between dentists, and between dentists and patients

The Bundeszahnärztekammer (BZÄK)

The *Bundeszahnärztekammer* - BZÄK, *Arbeitsgemeinschaft der deutschen Zahnärztekammern e.V.* (German Dental Association), is the professional representative organisation for all German dentists, at federal level. Members of BZÄK are the dental chambers of the federal states ("Länder"), which send delegates to the Federal Assembly, the supreme decision-taking body of the *Bundeszahnärztekammer*. The Presidents of the dental chambers of the federal German states form the BZÄK-Board, together with the federal President and the Vice-presidents.

The *Bundeszahnärztekammer* represents the health-political and professional interests of the dentists. In 2003, its supreme mission was to strive for a liberal future-orientated health care system, with the patient as centre of its efforts and objectives in the dental field, and with the objective of establishing and developing a relationship between dentist and patient without any outside influence.

Since 1993 the Bundeszahnärztekammer has also had its own representation in Brussels, with a full-time office based near the European Commission. This office also handles the administrative functions of the Council of European Dentists.

Related bodies

Zahnärztliche Mitteilungen (zm) is published twice a month. It is a communication means of both the German Dental Association and Federal Dental Authority (KZBV). It informs about the topics of national and international professional politics, health and social politics, of topical scientific findings and innovations as well as of dental events and meetings. It offers services covering the whole range of dental subjects: dental exercise, dental management, and dental economy.

Institut der Deutschen Zahnärzte (IDZ) the Institute of German Dentists is an institution of both the German Dental Association and Federal Dental Authority. The task of the IDZ is to initiate and implement research and practice-oriented work in the interest of the professional politics, and to act as a scientific advisory body for BZÄK and KZBV in their fields of activities.

Zahnärztliche Zentralstelle Qualitätssicherung (ZZQ)
Agency for Quality in Dentistry in the IDZ gives advice and support to BTÄK and KZBV in all matters of dental quality.

The Freier Verband Deutscher Zahnärzte e.V. (FVDZ)

The FVDZ (Liberal Association of German Dentists) is the largest liberal professional association of dentists in Germany. Since it was established in the 1950s, the FVDZ has advocated a liberal health policy in Germany, vis-à-vis politicians and the German Parliament - a health policy which is centred around the patient. In addition to its activities at national level, FVDZ plays an active role in European and international professional dental policy. The FVDZ is active in the Council of European Dentists, as well as being an associate Member of the European Regional Organisation of the Fédération Dentaire Internationale (FDI).

The objective of the FVDZ is to promote and represent the professional interests of German dentists in accordance with the principles set out in the following preamble:

- The purpose of the Liberal Association of German Dentists is to safeguard the free exercise of the dental profession in the best interest of the patients.
- Dentists can only discharge their professional and ethical duties to their full extent if they can practise freely, without patronisation and with financial security.
- It is the objective of the Liberal Association of German Dentists to further the confidential relationship between patients and dentists that is necessary for dentists to discharge their professional duties.
- The Liberal Association of German Dentists wishes to enforce these basic demands in the statutory dental corporations too.

The entire profession is called upon to help in realising these basic demands.

Ethics and Regulation

Ethical Code

Dentists in Germany must work within an ethical code which includes the relationships and behaviour between dentists, contracts with patients, consent and confidentiality, continuing education and advertising, although the latter is very strongly regulated. This code is administered by the regional dental chambers and varies slightly from region to region. The BZÄK provides a sample ethical code on which variations may be based.

The contract with the patient is usually verbal, but for complex treatments or those requiring prior approval from the sick funds, for example crowns and prosthodontic appliances, written consent and payment terms must be recorded. All treatment carried out must be recorded by the dentist and must demonstrate informed consent.

Fitness to Practise/Disciplinary Matters

If a patient complains about treatment, both the Dental Chamber and the KZV have grievance committees. Following a complaint a second opinion is sought from an experienced, impartial dentist, appointed by the local dental chamber. If this dentist judges that the original care was unsatisfactory then the work must be repeated at no extra charge to the patient. Under both grievance procedures the dentist has a right of appeal to the *grievance committee*.

For serious complaints about malpractice the dental chambers have installed *boards of arbitration* and *courts of professional law*. The sanctions from the court of professional law may be: an oral or written rebuke or admonition, administrative fine (up to €50,000), or temporary or permanent withdrawal of licence. Heavier sanctions are very seldom.

Advertising

A dentist may inform the public about his professional qualifications and priorities, key aspects of his activity and of the equipment in his practice. The information must be factual, adequate, verifiable and not misleading. The regulations on advertising in dentistry were very much softened and liberalised in 2001/02 through judgements of the Federal Constitutional Court, (*Bundesverfassungsgericht*).

The Electronic Commerce Directive has not been implemented, because existing regulations in Germany are even stronger.

Data Protection

A dentist is obliged to maintain professional secrecy. The duty of preserving medical confidentiality is an element both of the dentists' professional codes and of the criminal law. The duty of secrecy applies to all facts that have been entrusted or become known to the dentist in his or her capacity as a medical or dental practitioner. Professional secrecy must be observed not only by the dentist himself or herself, but also by his or her employees and agents and by persons working in the practice.

Patient data protection in accordance with the Federal Data Protection Law is very important owing to these implications for medical professional secrecy.

Insurance and professional indemnity

Liability insurance is compulsory for dentists. Insurance is provided by private insurance companies and covers costs up to a predetermined maximum, usually €2 million. An average practitioner pays approximately €250 annually for the insurance. This insurance does not cover a dentist's practise in another EEU country, except in individual cases, or short-term treatments - but not for permanent activity.

Corporate Dentistry

Companies or non-dentists are not allowed to be the owner of a dental practice – the majority of owners have to be dentists. For several years there have been moves to ease and liberalise the types of professional practice, in order to allow more competition. Since 2007 the employment of dentists has been facilitated and for the first time the establishment of branch dental practices and practices where members with a variety of qualifications of the medical or dental profession work together in different locations have been allowed. This means, that mega-dental surgeries and practice chains with international investors have been facilitated.

Tooth whitening

Tooth whitening is covered by medical regulations in Germany, as whitening is considered as a medical device. This means that only a dentist (or a qualified auxiliary under supervision of the dentist) may apply the whitening products.

Health and Safety at Work

Infection control is regulated by law and has to be followed by the dentist and his or her team. The responsible health authorities monitor the compliance. Non-compliance causes sanctions.

Ionising Radiation

There are specific regulations about the radiation protection - the "Röntgenverordnung" (2003). Training in radio protection is mandatory for undergraduate dentists who then become the competent person in the practice. The dentist must undergo regularly (every 5 years) mandatory continuing training in radio protection. He/She has to participate in an eight hours course. The dental assistant is only allowed to do the technical execution under the direction of the dentist.

Radiation equipment must be registered. It is technically authorised by an expert and is controlled in 5 yearly intervals as well as where there are considerable changes of the radiation equipment.

Hazardous waste

There are regulations to cover the disposal of clinical waste (Richtlinie für Abfallversorgung in Einrichtungen des Gesundheitswesens).

There is a special Directive concerning amalgam separators (Richtlinie zur Indirekteinleiter-Versorgung), permission to load used water into public systems. Amalgam separators have been obligatory since 1990.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Dental Chambers
Electrical installations	Factory Inspectorate
Infection control	The responsible health authorities
Medical devices	*Bundesinstitut für Arzneimittel und Medizinprodukte (BfARM)* – the Federal Institute for drugs and medical devices
Waste disposal	Dental Chambers and local authority

Financial Matters

Retirement pensions and Healthcare

The normal retirement age is now 62 to 68, depending upon individual circumstances and preferences. At the age of 68 dentists treating patients insured in the legal sick funds have to retire.

Retirement pensions in Germany average 60% of the salary on retirement. Any additional (insurance) pension depends on the individual contract and the amount insured. Dentists in free practice are members of a so called *Altersversorgungswerk*, a special pension fund/pool for the liberal professions, especially physicians and dentists, which is organised and supported by the chambers. Some of these old age pension funds are organised in cooperation with the physicians' chambers, some are for dentists only.

Taxes

National income tax:

The highest rate of income tax is 45% on earnings over about €205,000 for single persons & €500,000 for married persons.

VAT/sales tax

There is a value added tax, payable at a rate of 19% on purchases.

Various Financial Comparators

Zurich = 100	Berlin 2003	Berlin 2008
Prices (excluding rent)	75.4	81.2
Prices (including rent)	71.9	78.2
Wage levels (net)	54.5	70.1
Domestic Purchasing Power	65.0	89.5

Source: UBS August 2003 & January 2008

Other Useful Information

Main national associations and Information Centre:	*BZÄK Brussels office*
Bundeszahnärztekammer (BZÄK) Chausseestr. 13 10115 Berlin Tel: +49 30 40005 0 Fax: +49 30 40005 200 Email: info@bzaek.de Website: www.bzaek.de Kassenzahnärztliche Bundesvereinigung (KZBV) Universitätsstr. 73 50931 Köln Telefon: +49 221 4001 0 Telefax: +49 221 40 40 35 Email: post@kzbv.de Website: www.kzbv.de Freier Verband Deutscher Zahnärzte e.V. Bundesgeschäftsstelle Mallwitzstraße 16, 53177 Bonn Tel: +49 228 8557 0 Fax: +49 228 3406 71 Email: info@fvdz.de Website: www.fvdz.de	Bundeszahnärztekammer (BZÄK) Büro Brüssel 1, Avenue de la Renaissance 1000 Brüssel Belgien Phone: +32 2 7 32 84 15 Fax: +32 2 7 35 56 79 E-mail: info@bzak.be
Competent Authority:	
(For articles 2 & 3) Bundesministerium für Gesundheit Am Probsthof 78a 53121 Bonn Tel: +49 228 308 3515 Fax: +49 228 930 2221 Email: info@bmgs.bund.de Website: www.bmgs.bund.de/	(For specialist diplomas contact the *Zahnärztekammern* of the relevant "Länder") Lists available from the Bundeszahnärztekammer
Publications:	*Employment bureaux, and other bodies or publications with information on vacancies for dentists:*
Zahnärztliche Mitteilungen, and regional dental journals (each *Zahnärztekammer* and *Kassenzahnärztliche Vereinigungen* publishes its own dental journal)	*Employment bureaux:* Bundesanstalt für Arbeit Zentralstelle für Arbeitsvermittlung Villemombler Str. 76, 53123 Bonn GERMANY Email: Website: www.arbeitsamt.de/zav/

Dental Schools:

The figures refer to places at the dental school for entry each year, due to Numerus Clausus. The actual number of students may exceed these figures, because there are more applicants. However dental schools are forced to accept some more students.

Aachen

Medizinische Fakultät an der
Rhein – Westf. Techn. Hochschule
Aachen, Universitätsklinikum
Paulwelsstrasse 30, 52074 Aachen
Tel: +49 241 800
Fax: +49 241 80 – 82 460
Email: info@ukaachen.de
Website: www.rwth-aachen.de

Number of students*: 58

Berlin

Charité-Universitätsmedizin
Campus Virchow-Klinikum
Charité Centrum für Zahn-, Mund- und Kieferheilkunde
Augustenburger Platz 1
13353, Berlin
Tel: +49 30 450-562602
Fax: +49 30 450-562900
Email: ilona.wilken@charite.de
Website: www.charite.de

Campus Benjamin Franklin
Klinik und Poliklinik für Zahn-,
Mund- und Kieferheilkunde
Assmannshauser Strasse 4-6, 14197 Berlin
Tel: +49 30 8445-6266
Fax: +49 30 8445-6392
Email: ralf.radlanski@charite.de

Number of students: 90

Bonn

Zentrum für Zahn-, Mund- und Kieferheilkunde
Welschnonnenstr. 17,
53111 Bonn
Tel: +49 228 287-0
Fax: +49 228 287 22588
Email: mkg@uni-bonn.de
Website: www.zmk.uni-bonn.de/

Number of students: 70

Dresden

Universitätsklinikum Carl Gustav
Carus der Technischen
Universität Dresden, Zentrum für
Zahn-, Mund-, und Kieferheilkunde
Fetscherstrasse 74, 01307 Dresden
Tel: +49 351 458 2812
Fax: +49 351 458 5381
Email:
Website: www.uniklinikum-dresden.de

Number of students: 50

Düsseldorf

Zentrum für Zahn-, Mund- und Kieferheilkunde
der Heinrich-Heine-Universität,
Westdeutsche Kiefer-klinik Moorenstr. 5,
40 225 Düsseldorf
Postfach 101007, 40001 Düsseldorf
Tel: +49 211 811 6382
Fax: +49 211 811 9510
Email: D.Drescher@uni-duesseldorf.de
Website: www.kfo.uni-duesseldorf.de

Number of students: 54

Erlangen

Klinik und Polikliniken für Zahn-, Mund, und Kieferkrankheiten
der Universität Erlangen-Nürnberg
Glückstr. 11, 91054 Erlangen
Tel: +49 9131 853 4201
Fax: +49 9131 853 3603
Email: info@dent.uni-erlangen.de
Website: www.dent.uni-erlangen.de

Number of students: 97

Frankfurt

Zentrum der Zahn-, Mund- und Kieferheilkunde
des Klinikums der Johann Wolfgang Goethe-Universität
Frankfurt Theodor-Stern-Kai 7, 60590 Frankfurt am Main
Tel: +49 69/6301 1
Fax: +49 69/ 6301 6741
Email: d.heidemann@en.uni-frankfurt.de
Website: www.klinik.uni-frankfurt.de/zzmk/

Number of students: 96

Freiburg

Universitätsklinik für Zahn-, Mund- und
Kieferheilkunde
Hugstetter Str. 55, 79106 Frieburg i.Br.
Tel: +49 761/270 4701
Fax: +49 761/270 4788
Email: info@uniklinik-freiburg.de
Website: www.uniklinik-freiburg.de

Number of students: 84

Giessen

Med. Zentrum für Zahn-, Mund- und Kieferheilkunde
an der Justus-Liebig-Universität Gießen
Schlangenzahl 14, 35392 Gießen
oder
Tel: +49 641 99 46 200 or 201
Fax: +49 99 46 209
Email: geschaeftsfuehrung@dentist.med.uni-giessen.de
Website: www.uni-giessen.de

Number of students: 64

Göttingen

Zentrum Zahn-, Mund- und Kieferheilkunde
der Universität Göttingen
Robert-Koch-Str. 40, 37075 Göttingen
Tel: +49 551 39 83 43
Fax: +49 551 39 12 653
Email: schliephake.@med.uni-goettingen.de
Website: www.med.uni-goettingen.de

Number of students: 77

Greifswald

Ernst-Moritz-Arndt-Universität Greifswald
Zentrum für Zahn-, Mund- und Kieferheilkunde
der Medizinischen Fakultät Rotgerberstrasse 8
17487 Greifswald
Tel: +49 3834 86 71 30
Fax: +49 3834 86 71 71
Email: gmeyer@uni-greifswald.de
Website: www.dental.uni-greifswald.de

Number of students: 49

Halle/Saale

Martin-Luther-Universität Halle-Wittenberg
Medizinische Fakultat, Zentrum für Zahn-,
Mund-und Kieferheilkunde
Grosse Steinstrasse 19, 6097 Halle/Saale
Tel: +49 345 557 37 63
Fax: +49 345 557 37 73
Email: hans-guenter.schaller@medizin.uni-halle.de
Website: www.medizin.uni-halle.de

Number of students: 40

Hamburg

Universitäts-Krankenhaus Eppendorf, Klinik und Poliklinik für
Zahn-, Mund- und Poliklinik fur Zahn Mund-und
Kieferkrankheiten Martinistr. 52,
20246 Hamburg
Tel: +49 40/4717 1
Fax: keine Angabe
Email: kahl-nieke@uke.uni-hamburg.de
Website: www.uke.uni-hamburg.de/zentren.de.html

Number of students: 80

Hannover

Medizinische Hochschule Hannover
Zentrum Zahn-, Mund- und Kieferheilkunde
Klinik und Poliklinik für Mund-, Kiefer- und Gesichtschirurgie
Carl-Neuberg-Straße 1
30625 Hannover
Tel: +49 511 532 4748
Fax: +49 511 532 4740
Email: MKG-Chirurgie@mh-hannover.de
Website: www.mh-hannover.de

Number of students: 78

Heidelberg

Universitätsklinik für Mund-, Zahn- und
Kieferkrankheiten
Im Neuenheimer-Feld 400
69120 Heidelberg
Tel: +49 6221 56 6002
Fax: +49 6221 56 5074
Email: renate_sammet@med.uni-heidelberg.de
Website: www.klinikum.uni-heidelberg.de

Number of students: 81

Homburg (Saar)

Universitätsklinikum des Saarlandes
Universitätsklinik und Poliklinik für Zahn-, Mund- und
Kieferkrankheiten
Klinik für Mund-, Kiefer- und Gesichtschirurgie
Gebäude 71.1
66421 Homburg/Saar
Tel: +49 6841 162 - 49 22
Fax: +49 6841 162 - 49 55
Email: zmkwspi@uks.eu
Website: www.mkg-homburg.de
Number of students: 24

Jena

Zentrum für Zahn-, Mund- und Kieferheilkunde an der
Medizinischen Fakultät der
Friedrich-Schiller-Universität Jena
An der alten Post 4, 07743 Jena
Tel: +49 3641 93 44 10
Fax: +49 3641 93 44 11
Email: jana.mierl@med.uni-jena.de
Website: www2.uni-jena.de/med/kichi/

Number of students: 57

Kiel

Klinik für Zahnerhaltungskunde und Parodontologie im
Universitätsklinikum Schleswig-Holstein
Arnold-Heller Str. 16, 24105 Kiel
Tel: +49 431 597 2781
Fax: +49 431 597 4108
Email: albers@konspar.uni-kiel.de
Website: www.uni-kiel.de/konspar/

Number of students: 65

Köln

Zentrum für Zahn-, Mund- und Kieferheilkunde
der Universität zu Köln,
Kerpener Str. 32
50931 Köln
Tel: + 49 221 478 4748
Fax: + 49 221 478 3892
Email: Gabriele.Haenisch@uk-koeln.de
Website:
http://cms.uk-koeln.de/zahnzentrum/content/index_ger.html

Number of students: 66

Leipzig

Zentrum für Zahn-, Mund- und Kieferheilkunde
der Universität Leipzig
Nürnberger Str. 57, 04103 Leipzig
Tel: +49 341 9721 000
Fax: +49 341 9721 009
Email: zzmk@medizin.uni-leipzig.de
Website: www.uni-leipzig.de

Number of students: 51

Mainz

Johannes Gutenberg-Universität,
Klinik und Polikliniken für Zahn-
Mund- und Kieferkrankheiten
Augustusplatz 2, 55131 Mainz
Tel: +49 6131 17 30 20
Fax: +49 6131 17 55 17
Email:
Website: www.klinik.uni-mainz.de/ZMK

Number of students: 98

Marburg a. d. Lahn

Med. Zentrum für Zahn-, Mund- und Kieferheilkunde
der Philipps-Universität
Georg-Voigt-Str. 3, 35039 Marburg
Tel: +49 6421 28 3203
Fax: +49 6421 28 3204
Email: mzzmk@med.uni-marburg.de
Website: www.uni-marburg.de/zahnmedizin/

Number of students: 30

München

Klinik für Zahn-, Mund- und Kieferkrankheiten,
Ludwig-Maximilians-Universität
Goethestr. 70, 80336 München
Tel.: +49 89 5160 9301
Fax: +49 89 5160 9302
Email: michael.ehrenfeld@mkg-i.med.uni-muenchen.de
Website: www.dent.med.uni-muenchen.de

Number of students: 124

Münster

Zentrum für Zahn-, Mund- und Kieferheilkunde,
Waldeyerstr. 30, 48149 Münster
Tel: +49 251 83 470 04
Fax: +49 251 83 471 84
Email: ehmer@uni-muenster.de
Website: www.uni-muenster.de/institute/zmk/

Number of students: 105

Regensburg

Klinikum der Universität Regensburg
Klinik und Poliklinik für Mund-, Kiefer- und Gesichtschirurgie
Franz-Josef-Strauss-Allee 11, 93053, Regensburg
Tel: +49 941 9440 63 00
Fax: +49 941 9440 63 02
Email: torsten.reichert@klinik.uni-regensburg.de
Website: www.uni-regensburg.de

Number of students: 84

Rostock

Universität Rostock, Medizinische Fakultät, Klinik und Polikliniken
für Zahn-, Mund- und Kieferheilkunde, „Hans Moral"
Postfach 100888, 18055 Rostock,
Tel: +49 381/ 494-6500
Fax: +49 381/ 494-6503
Email: zmk@med.uni-rostock.de
Website: www.uni-rostock.de/fakult/medfak/zahn/zmk.htm

Number of students: 25

Tübingen

Zentrum für Zahn-, Mund- und Kieferheilkunde
Klinik und Poliklinik für Mund-, Kiefer- und Gesichtschirurgie
Osianderstr. 2 – 8, 72076 Tübingen
Tel: +49 7071 29 86 174
Fax: +49 7071 29 34 81
Email: siegmar.reinert@med.uni-tuebingen.de
Website: www.uni-tuebingen.de/mkg

Number of students: 61

Ulm

Universitätsklinik für Zahn-, Mund- und Kieferheilkunde
Department für Zahnheilkunde
Schwerpunkt Zahnerhaltungskunde und Parodontologie
Albert-Einstein-Allee 11, 89081 Ulm
Tel: +49 731 500 64101
Fax: +49 731 500 64102
Email: zmk.zahnerhaltung@uniklinik-ulm.de
Website: www.uni-ulm.de/zahnmedizin
Number of students: 54

Witten-Herdecke

Universität Witten/Herdecke,
Fakultät für Zahn-, Mund- und Kieferheilkunde
Alfred-Herrhausen-Str. 50, 58448 Witten
Tel: +49 2302 926 660
Fax: +49 2302 926 661
Email: dagmark@uni-wh.de
Website: www.uni-wh.de

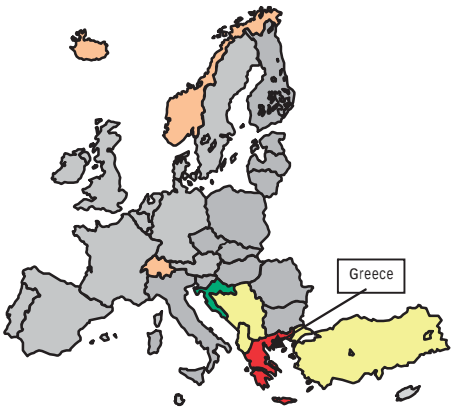
Number of students: approx. 20

Würzburg

Klinik und Polikliniken für Zahn-, Mund- und Kieferkrankheiten
Pleicherwall 2, 97070 Würzburg
Tel: +49 931 201 73 320 or 360
Fax: +49 931 201 73 300
Email: mkg@mail.uni-wuerzburg.de
Website: www.uni-wuerzburg.de

Number of students: 118

Greece



Date of last revision: 1st October 2008

In the EU/EEA since	1982
Population (2008)	11,214,992
GDP PPP per capita (2007)	€24,596
Currency	Euro
Main language	Greek

General healthcare is provided by a complex mixture of private practitioners, social security organisations and, since 1983, of a basic state-funded national health service. Oral healthcare, besides preventive services offered free by NHS clinics to all children, is almost entirely provided by private practitioners, with patients paying the total cost of care. Indeed, one third of total private healthcare expenditure is on oral health, and about 80% of dentists are in private practice.

Number of dentists:	14,126
Population to (active) dentist ratio:	794
Members of Dental Association:	100%

There are only two recognised specialties (Orthodontics and Oral and Maxillofacial Surgery) but there are many other specialists in private practice. The only auxiliaries are dental technicians and a limited number of chairside assistants. There is a single national association, the Hellenic Dental Association (HDA), to which all dentists must belong through their registration with the Regional Dental Society. Continuing education is not mandatory in practical terms & is organised by the HDA and the dental societies in various fields and specialisations

Government and healthcare in Greece

Geographically, Greece is a very rural and mountainous country, but the population is urbanising rapidly, with over 4 million people (nearly half the population) living in the capital, Athens.

The Constitution of 1975, which was twice revised (in 1986 and 2001), introduced a Presidential Parliamentary Republic form of Government:

- Legislature is exercised by the Parliament and the President of the Republic.
- The Executive is exercised by the President of the Republic and the Government.
- Judicial function is exercised by Courts. Decisions are executed in the name of Greek people.

The President of the Republic is elected by the Parliament. Members of the Parliament, who are elected directly by the citizens, cannot be less than 200 or more than 300.

Through the revision of 2001, the responsibilities of the President of the Republic were curtailed to a significant extent, whereas decentralisation was reinforced. Regional organs of the State have general decisive competency for the affairs of their region - whereas central organs of the State lead, coordinate and control the legitimacy of the actions of the Regional organs.

It is important to add that the Constitution provides for the participation of Greece in International organisations and the European Union, as well as the superior effect of such organisations' legislation.

So, Greece possesses a Constitution which enjoys political and historical legitimacy, is modern, is adapted to international developments, and despite possible reservations on particular issues, provides a satisfactory institutional framework for Greece in the 21st century.

There are many small islands in Greece, which makes the planning of many services more difficult. There are 13 regions but no regional governments and many services are provided locally by 54 prefectures, each headed by an elected prefect and with a public health department. There are also several layers of regional administration, each with different legal responsibilities. Access to health services has been a constitutional right since 1975.

Healthcare in Greece is provided by a complex mixture of social security organisations and since 1983, a basic framework of state-funded national health services has been established. The laws which established and modernized the National Health System (*NHS* or *ΕΣΥ)* afterwards, were intended to cover all the Healthcare requirements and demands of the whole population of Greece. The Hellenic NHS is therefore a partially unified system of public hospitals in large cities, supported by a system of rural health centres and regional medical centres staffed by full-time and exclusive salaried doctors.

Therefore, Primary Health Care services are provided apart from Health Centres, within the NHS as mentioned above, by private practitioners as well as by medical centres of Social Security Organizations. The IKA (Institute of Social Security), covers approximately 60% of the population, its insured people as well as OGA's (see below) insured, providing healthcare services through its own outpatients' health departments. The IKA (see below) is the only Social Security Organization which owns hospitals (secondary healthcare services) which will be, most probably, absorbed in the near future by NHS. *(please see change in the content of this paragraph)*.

The Social Security System in Greece was reformed a few years ago to abolish the 300 social security schemes (mostly occupational schemes) which formerly existed and to replace them by or unify them in 3-4 major ones.

The OGA, the insurance organisation for agricultural workers, remains just the same, as before.

Specifically by the Law 3029/02 , all Social Security Schemes covering salaried people (employees of Banks, Electricity Organisation, Telecommunications, Means of Transportation) are unified within IKA pension scheme, and renamed IKA-ETAM (Institute of Social Security-Unified Security Scheme for salaried people). IKA-ETAM continues to provide healthcare services to its insured people, as well as to OGA's insured people of all ages, directly through its own health departments.

In the meantime, another major security scheme has been set up under the name OAEE (Social Security Scheme of Liberal Professionals: covering tradesmen, craftsmen, and employees in the sector of Tourism).

In April 2008, a new Law was enacted providing for the administrative and organisational reform of the System of Social Security. Among other provisions by this law three occupational schemes which used to cover liberal professionals - Scientists (ie Doctors, Dentists, Pharmacists, Lawyers, Notaries, Engineers, Architects.) are incorporated to one new one - the ETAA (Unified Scheme for Independent Professionals). The Hellenic Dental Association along with the other Independent professionals reacted unfavourably to the implication of the new law, because they perceived that it will affect their rights.

		Year	Source
% GDP spent on health	9.1%	2006	OECD
% of this spent by governm't	61.6%	2006	OECD

Oral healthcare

Public health care

		Year	Source
% GDP spent on oral health	1.10%	2004	HDA
% of OH expenditure private	96%	2004	HDA

Later figures are not available.

NHS provides free healthcare to all. NHS health centres emphasise more on preventive and other simple treatments to children under the age of 18, without excluding the rest of the population. The Social Security pays 75% of the dental care for children up to 16 years of age – the parents have to pay the balance.

This apart, oral healthcare in Greece is almost entirely provided by private practitioners, with patients paying the entire cost of the care themselves. This is reflected in that one third of the total expenditure on private healthcare in Greece is on oral health, and about 80% of dentists are in private practice. Those who are not self-employed private practitioners work in hospitals (as NHS employees), in NHS rural health centres, or are employed part-time by the IKA. The IKA has its own outpatient departments in many urban areas, providing dental care to insured people of all ages.

Within NHS hospitals dentists provide preventive care and emergency or full treatment as needed to all hospitalised patients, free of charge. Adults over the age of 67 also get social security subsidies if they are on low incomes, as well as those handicapped due to accidents or birth defects.

IKA, the main social security organisation via its Dental Clinics, or its dentists working for the System provides Primary Oral Health Care to directly insured or retired adult people, plus full and/or partial dentures. Crowns, bridges and inlays are not available. Since 2003, via the Paediatric Dental Clinic located in Athens, a full coverage in Paediatric Dentistry (plus General Anaesthesia cases), as well as Orthodontic Services, has been provided.

Although NHS dental services are free at point of delivery, under the social security schemes, there is no uniform system of contributions and benefits for the other existing insurance schemes. Broadly speaking, however, a member's "professional status" will determine their contribution levels, and therefore the benefits to which they are entitled. Generally, if a patient is treated in an outpatient health department, which is run by their insurance scheme, they will pay no fees. If however, a member receives treatment from a private practitioner, regardless if he/she is contracted or not with the insurance scheme, usually they have to pay the whole of the fee by themselves, and the insurance company then partially reimburses the patient.

The level of reimbursement to the patient depends on the insurance scheme and the treatment provided and varies from 50 to 70% (of the contracted price which differs greatly for the free-market price) if the dentist providing the treatment is contracted, and from 20-30% if not. This is due to the fact that there are insurance schemes which give the benefit of the free choice of dentist, while some others do not. Dentists may have contracts with any number of social security organisations, each with its own fee scale, coverage and subsidy levels of treatments.

A dentist working full time at the NHS would look after about 1,500 – 1,800 children and young people under 18 years, as an average estimate, depending on the area). Patients typically return to their dentist for routine oral re-examinations annually.

Private insurance for dental care

In Greece, very few people (approximately 1%) use private insurance schemes to cover their dental care costs. It only exists as a supplementary cover to medical insurance. Individuals insure themselves by paying premiums directly to the insurance company. Any dental costs are still paid in full by the patient, and are then reclaimed from the company concerned.

Private insurance companies are self-regulating and bear all the financial risks of treatment. Generally the level of the premiums is not linked to the level of risk or current health status of the person as it is the case with other medical insurance. Also dentists play no role in promoting or selling this insurance. In Greece there are a limited number of private dental care plans - schemes where the dentist or a group of dentists bear most of the risk.

The Quality of Care

The National Government has the ultimate responsibility for the payment of fees, the quantity and quality of work and, together with the Hellenic Dental Association - the HDA – ethical behaviour.

For work carried out on behalf of the Social Security Schemes, standards of dental care are monitored by dentists employed part-time by the Schemes. They examine the mouths of patients after treatments which required prior approval, but do not perform random checks. For ethical reasons they are restricted to judgement about whether treatment has been completed - the "quantity" of treatment, and may not comment on the quality of the work carried out.

Health data

		Year	Source
DMFT at age 12	2.07	2007	HDA
DMFT zero at age 12	37.1%	2007	HDA
Edentulous at age 65	25%	2000	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There is no fluoridation of any kind in Greece.

Education, Training and Registration

Undergraduate Training

There are two dental schools, both publicly funded and part of universities. To enter university students have to participate in national exams, where the written part plays the most crucial role.

Year of data:	2008
Number of schools	2
Student intake	280
Number of graduates	270
Percentage female	62%

The dental course lasts 10 semesters (5 years). There are approximately 1.400 dental undergraduates.

Qualification and Vocational Training

Primary dental qualification

The main qualifications which may be included in the dental register are:

- Diploma in Dentistry (*'Ptychio odontiatrikis tou Panepistimiou'*) and
- Licence to Practise Dentistry from the Competent Authorities (Prefecture)
- Registration to a Regional Dental Society.

Vocational Training (VT)

There is no structured, regulated post-qualification vocational training in Greece. However, for those graduates who are applying for enrolment in a postgraduate programme, in a clinical dental specialty, a 2 year period of clinical experience after graduation is required, on the basis of an "unwritten law" and as an extra requirement for acceptance into the programme.

Registration

In order to practice in Greece, a dentist must have a recognised diploma, obtain a licence to practice from the Competent Authority, the Prefecture, have no criminal record, and be registered with one of the 52 competent Regional Dental Societies. All regional Societies are automatically members of the Hellenic Dental Association (HDA). Dentists pay an annual fee, in order to be registered with the competent Regional Societies.

Each Regional Dental Society sets a fixed amount of subscription required of the dentist each year which may vary, for example Regional Society of Attica was €180 in 2008. Out of this fee, a fixed amount (€50 in 2008) is contributed to the HDA.

Language requirements

Dentists from other member-states of the EU, who wish to practice within the National Health Service, or under a contract with a social security scheme, need to show competency in using and communicating in Greek language.

Private practitioners from outside Greece have to make a "declaration of responsibility". This is an oath including a statement that the dentist can speak and understand the Greek language.

Further Postgraduate and Specialist Training

Continuing Education

For dentists practicing within the NHS, continuing education is required by law. However, since there is no structured continuing education programme available, there are no sanctions connected with non-compliance.

Although a large number and variety of scientific activities take place annually all over the country for all dentists, no continuing education system exists, in a mode of mandatory and points-earning attendance of lectures, seminars, symposia and conventions. The Board of the Hellenic Dental Association has already asked the members of its Scientific Committee to submit their proposals on the above referred subject, and the Oral Health Committee of the Ministry of Health and Welfare has discussed some early proposals. The proposals had been submitted to the Ministry of Health and Social Solidarity in 2008 and legislation is expected to be effected at a later date.

Specialist Training

Two dental specialties are recognised by the Ministry of Health and Social Solidarity, namely Orthodontics and Oral and Maxillofacial Surgery.

Orthodontic training takes three years, again in a dental school.

By a Law of 2003 the training period for the acquisition of the specialty has been increased to 5 years altogether, including General Surgery and 48 months of specialty training. It is both a Dental and a Medical specialty.

Apart from the above two specialisations, Ministerial Decisions have recently caused the Ministry of Education to approve and recognise the existence of postgraduate programmes in clinical Dental Specialisations, leading to a Master's Degree at Athens University. The duration of these programmes is 2- 3 years, at the end of which a certificate along with the Master's Degree is awarded in one of the following specialisations:

- Prosthodontics,
- Orthodontics,
- Oral Biopathology oriented to Oral Surgery,
- Endodontics,
- Paediatric Dentistry,
- Oral Biopathology oriented to Oral Diagnosis and Radiology,
- Oral Pathology,
- Operative Dentistry,
- Dental Biomaterials,
- Periodontics,
- Implants Biology
- Oral Biology
- Community Dentistry

Following other Ministerial Decisions, the Ministry of Education approved and recognised for the Dental School of the Aristotle University of Thessaloniki the existence of postgraduate programmes leading to the following specialisations:

- Orthodontics
- Fixed Prosthodontics-Implantology
- Removable Prosthodontics
- Endodontology
- Oral Surgery –Implantology and Dental Radiology
- Operative Dentistry
- Periodontology-Implantology
- Oral Pathology
- Preventive and Community Dentistry

There are various purely scientific societies for specialists. These are best contacted via the Hellenic Dental Association.

Workforce

Dentists

Year of data:	2008
Total Registered	14,126
In active practice	14,126
Dentist to population ratio*	794
Percentage female	46%
Qualified overseas	2,051

Approximately 230 dentists who are not Greek citizens were practising in 2008

The workforce is growing, with increasing competition for work and so in 2003 there was about 6% unemployment amongst dentists in Greece. The average age for dentists was 45 years old, with nearly 4,000 (about one third) over the age of 50. Later figures are not available.

Movement of dentists across borders

Taking into account the graduates of the two dental schools, the HDA estimates that they are training the correct number of dentists. However, taking into account graduates from other countries (EU and Third countries' diplomas) who are entering Greece to practise, it is reported that there is an annual increase in the number of dentists in Greece.

There is no information about dentists from Greece practising abroad.

Specialists

There are two categories of recognised specialists in Greece:

- Orthodontists
- Oral Maxillo-facial surgeons

Most Orthodontists work in private practice, while most surgeons work in Hospitals and private practice.

Year of data:	2007
Orthodontics	396
Endodontics	
Paedodontics	
Periodontics	
Prosthodontics	
OMFS	174
Dental Public Health	

40% of orthodontists and 80% of OMF surgeons are female.

Besides the two categories of recognised specialists there are a considerable number of specialists who are working in private practice or at a university, and they are covering all the common specialisations in dentistry.

Patients usually consult specialists on referral from a primary care dentist but they are permitted to go directly to specialists.

Auxiliaries

The only recognised dental auxiliaries in Greece are dental technicians, although there are some dental chairside assistants. There are no hygienists or therapists in Greece.

Dental Technicians

To be a dental technician in Greece it is necessary to train for 3 years in a Technical Professional Institute or Lyceum and work in a dental laboratory. Registration, following exams, is with the Ministry of Health and Welfare.

Dental technicians are allowed to work independently by establishing a private office or a laboratory - working under the strict prescription of the dentist - but they are not allowed to work in the mouth of a patient.

However, and in spite of the strict restrictions on this, there are some cases of Dental Technicians who have violated this rule and they have been caught working in the mouth of patients. Greek justice has intervened, imposing penalties.

In 2008 it was estimated (by the HAD) that there were 5,000 dental technicians.

Dental chairside assistants

Dental Chairside Assistants may not work without the supervision of a dentist. They must hold a diploma, certificate or other evidence of formal qualification, after a two year course at a Private Technical College (including 6 months in a dental office) then at least 6 months post-qualification in a practice. They must be registered with the Ministry of Health and Welfare.

Their duties include the preparation of the dental office, infection control, secretarial duties and assisting the dentist at the chairside.

The majority of dentists work without assistants.

Practice in Greece

Year of data:	2008
General (private) practice	10,923
Public dental service	934
University	226
Hospital	578
Armed Forces	73
Others	1,392
General Practice as a proportion is	77%

About 10% of those who work in general practice also work in salaried employment at the same time.

Working in General (Private) Practice

Dentists who practice on their own, and who provide a broad range of general treatments are said to be in *Private Practice*. About 80% of dentists work in private practice.

Fees

Dentists in private practice are self-employed, and earn their living through charging fees for treatments (item of service).

Approximately 10% of dentists in private practice are also part-time salaried employees of the IKA, of other social security funds or are part-time academics or military dentists. The terms of any contracts with social security organisations state that insured members must be accepted as patients, and a prescribed scale of fees, decided by the State, must be used. There are also some other social security organizations which have a fixed amount of fee per work, which the patient is entitled to have (reimbursed), regardless if the dentist is "Contracted to the Organisation" or not (free choice of dentist). The contract also describes other conditions which must be met for working on insured patients, eg when prior approval for treatment must be sought, or how the treatment provided may be checked.

For treatments where the patient is paying the total amount of the cost, there is no externally regulated scale of fees per work at the most (upper limits), while there is a regulated price at the least (lower limits) – although this lower scale is basically now obsolete, having been issued in 1993.

Joining or establishing a practice

A Presidential Decree of 2001 provides for the function of Private Agents of Provision of Primary Health Services (ie Dental Clinics). This decree provides that dentists can share a clinic or dental chair, as well as establish Dental Companies ("Multi-dental clinics": Orthodontic care, oral maxillofacial care, etc). In 2008, the Ministry of Health and Social Solidarity was about to issue new provisions for the establishment and function of Private Health Care Practices.

There is no state assistance for establishing a new practice, but there is a central fund which may lend up to €3,000. Since at least €40,000 is typically required, to open a practice dentists usually take out a commercial loan from a bank. New dental practices may be located anywhere, except from regions characterised as "purely residential area" and there is no limitation on the number of practices.

For dentists in private practice, the controls for monitoring the standards of care are the same as described previously.

Working in Public Clinics

Just over half the dentists employed in the NHS work in health centres, providing services to children under the age of 18. They are full-time salaried employees in 'exclusive occupation' - without other part-time work commitments. These centres also provide emergency services to adults and the elderly.

Working in Hospitals

The creation of the NHS in 1983 successfully brought the majority of hospitals in Greece into public ownership. Hospital dentists work as salaried employees of the government, the army or a university - treating patients who are confined to hospital, have other special needs or need emergency care. Hospital dentists are always employed in "full and exclusive occupation", a secure form of job tenure which does not allow other private or part-time work.

Dentists in hospitals may be employed as a *director*, or one of three grades of *supervisor*. For each grade there is a minimum age (lowest grade, 45; highest grade, 55) and a minimum number of years of required experience. The whole process of appointing a hospital dentist is governed by law and the final decision lies with an appointments committee.

A law ensures that statutory Social Security Organisations must act jointly with the Consortium or Union of Social Security to:

- co-operate and enter into policy contracts with the Ministry of Health and Welfare. These contracts will specify charges for the care provided as well as the diagnostic tests (clinical and laboratory).
- Negotiate with private clinics and foreign hospitals with the permission of the Minister of Labour and Social Affairs and the Minister of Health and Welfare.

Working in Universities and Dental Faculties

Dentists who work in dental faculties are employees of universities. There are both full-time and part-time staff in the University and they are free to work in private practice. Those who do work as such, they must contribute 15% of their earnings to the University.

The main academic titles within a Greek dental faculty are full-time clinical instructor, lecturer, assistant professor, associate professor and professor. "Faculty members" (ie. those at lecturer grade and above, with secure job tenure) must hold a PhD. or equivalent. When faculty posts become vacant they are filled by open competition, with the final decision made by the Assembly of the Electorate.

Working in the Armed Forces

Over 70 dentists work in the Armed Forces. Two of them are women (2008).

Professional Matters

Professional associations

	Number	Year	Source
Hellenic Dental Association	9,100	2008	FDI

There is a single national association, the Hellenic Dental Association which is a federation of 52 regional societies. All Greek dentists must belong to the HDA.

HDA is administered by a Council consisting of 15 members. This Council is elected every three years by the General Assembly of the HDA. The GA consists of the Presidents of the Regional Dental Societies (52), the 15 members of the previous Council and the electors who, in their turn, are elected by the General Assemblies of their Societies. The number of the electors is proportionate to the number of the dentists of the Societies. The 10 out of the 15 members of the Council of HDA are elected in any case from the wider geographical area of Athens (Athens, Piraeus, suburbs). The other 5 can be from the provinces of the Country.

The HDA has its headquarters in Athens and there are no regional offices.

Ethics and Regulation

Ethical Code

Dentists in Greece have to work within an ethical code which covers relationships and behaviour between dentists, and advertising. The ethical code is administered by the Regional Dental Associations and the Hellenic Dental Association.

If a dentist has employees, they are protected by the national policies and European laws on equal employment opportunities, maternity benefits, occupational health, minimum vacations and health and safety.

Fitness to Practise/Disciplinary Matters

Serious complaints by patients are referred to the Central Disciplinary Council of the Ministry of Health and Welfare and within the NHS there are also disciplinary councils in hospitals and in local health centres. Furthermore the disciplinary boards of each local dental association will deal with complaints. Where complaints are not due to misunderstandings, a patient may be examined by an expert dentist from a university.

The theoretical ultimate sanction for either a private practitioner or a NHS-employed dentist is the forfeiture of the right to practice. However the sanctions which are typically applied are usually restricted to warnings and financial penalties. Dentists have a right of appeal within this process, to the disciplinary board of the Hellenic Dental Association.

Ultimately patients also have the right to appeal to Greek civil and criminal law.

Data Protection

The EU Directive on Data Protection has been enacted in Law. This law has introduced an independent body for data protection.

Advertising

Legally, advertising in the health sector is not allowed and dentists are only allowed to publish a notice three times in the newspapers, when they open a practice.

Dentists may provide information by way of a website, but they must conform to the CED Code of Ethics relating to the Electronic Commerce Directive.

Indemnity Insurance

Liability insurance is not compulsory for dentists. However, professional indemnity insurance is available from private general insurance companies. A dental practitioner will pay approximately €8 minimum fees annually for this, providing €25,000 in case of certified liability (malpractice on behalf of the dentist), if he/she is insured through a group-insurance plan – with his/her Regional Dental Society - and not individually. Practitioners may increase their cover beyond the minimum and even include overseas cover.

Corporate Dentistry

Companies may provide oral healthcare under the Presidential Decree of 2001. The legal status of companies may vary. Only in Limited Companies can people other than health professionals (fund holders such as businessmen etc) participate.

Tooth whitening

Tooth whitening is regulated under medicinal rules in Greece, and as with all items of procedure in the oral cavity, may only be provided by dentists.

Health and Safety at Work

Inoculations - such as for Hepatitis B - are not compulsory for dental workers. However, since 1995, all faculty members and all undergraduate level students at the University of Athens, School of Dentistry are inoculated for Hepatitis B. Students refusing to be vaccinated have to sign a special form explaining the reasons.

Ionising Radiation

Both the EU and the National Radiological Protection Board Guideline Notes for Dental Practitioners have been adopted and presented on the site of the Dental School of the University of Athens.

Apart from requiring the usual "CE" tag, radiological equipment does not require any specific notification. Specifc continuing education is also not mandatory for those conducting ionising radiation.

Hazardous waste

Amalgam separators are required by Common Ministerial Decision in 2003: "Handling and Management of Hazardous Waste Materials". Regulations cover the disposal of clinical waste.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Greek Atomic Energy Commission
Electrical installations	Ministry of Health and Social Solidarity
Waste disposal	Common Ministerial Decision 37591/ 2031/2003, Ministry of Health and Welfare, Ministry of the Interior, Ministry of the Environment, Central Union Of Municipalities and Communities, Ministry of the Finance, Public Administration, Ministry of Labour
Medical devices	Hellenic Drug Organization
Infection control	Centre for Disease Control, Athens University-School of Dentistry, Regional Dental Society of Attica

Financial Matters

Retirement Pensions and Healthcare

All dentists who practise, whatever their working status (self-employed, employees, NHS) are obligatorily registered with the ΤΣΑΥ (Insurance and Retirement Fund of Health Professionals) and consequently, are entitled to get a pension from ΤΣΑΥ. Dentists who are exclusively self-employed, get a full pension from ΤΣΑΥ. Dentists entitled to other pension schemes, get a reduced pension from ΤΣΑΥ, and a supplementary one from where they provide their services. For example, a dentist employed by IKA will also take a pension from IKA, or a dentist in the NHS will take a pension from ΤΣΑΥ and also a pension from the public sector.

The full pension of ETAA for an exclusively self-employed dentist who has been practising for at least 39 years is approximately €1,540 (before taxes) a month.

Normal retirement age is 65 years, but this is not compulsory and dentists may work beyond this, in private practice.

Taxes

The highest rate of income tax is 40% on earnings over about €75,000

VAT

There are two rates of VAT/sales tax. They are 8% and 19% depending on the category of goods sold. VAT (at 19%) is payable on most dental materials and equipment. No VAT applies on the payment of dental fees.

Various Financial Comparators

Zurich = 100	Athens 2003	Athens 2008
Prices (excluding rent)	73.8	74.1
Prices (including rent)	72.0	71.6
Wage levels (net)	37.3	42.3
Domestic Purchasing Power	46.7	59.0

Source: UBS August 2003 & January 2008

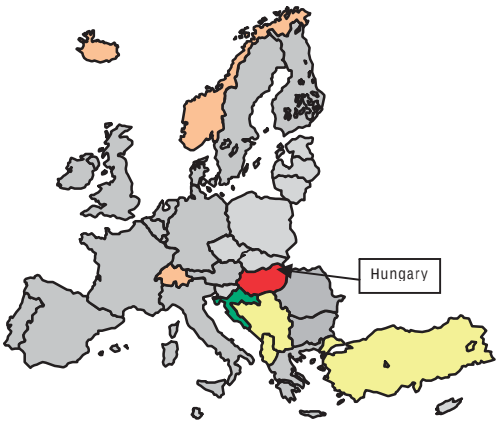
Other Useful Information

Main national association and information centre	Competent Authority and Information centre for NHS posts:
Hellenic Dental Association 38, Themistokleous Street GR- 106 78 ATHENS GREECE Tel: +30.210 38 13 380 +30.210 33 02 343 Fax: +30.210 38 34 385 E-mail: eoo@otenet.gr, or heldenas@otenet.gr medicallaw02@yahoo.gr	Ministry of Health and Social Solidarity 17-19 Aristotelous Street GR- 101 87 ATHENS GREECE Tel: +30.210 52 32 821-9 Fax: Email: Website: www.mohaw.gr
Publications:	
Journal of the Hellenic Dental Association *Hellenic Stomatological Review*	

Dental Schools:

Athens	Thessaloniki
National & Kapodestrian University of Athens Faculty of Dentistry 2 Thivon str., Goudi GR - 115 27 ATHENS Tel: +32 10 7461120, 12 11 19117 Fax: +32 10 7461187 Email: psakel@dent.uoa.gr Website: www.dent.uoa.gr Dentists graduating each year: 130 Number of students: 700	Aristotle University of Thessaloniki Faculty of Dentistry University Campus GR-541 24 THESSALONIKI Tel: +32 31 0995 022, 99 94 71-73 Fax: +32 31 0999 474 Email: info@dent.auth.gr Website: www.dent.auth.gr Dentists graduating each year 140-150 Number of students: 700-750

Hungary



In the EU/EEA since	2004
Population (2008)	10,045,000
GDP PPP per capita (2007)	€15,840
Currency	Forint (HUF)
	238 HUF = €1.00 (2008)
Main language	Hungarian

A National Health Insurance (NHI) Fund was introduced in 1993 with the goal of being self-supporting, based on compulsory payroll contributions from both employers and employees (and a very limited investment portfolio). Dental services are provided through the NHI, or by private dentists.

Number of dentists:	5,500
Population to (active) dentist ratio:	2,020
Members of (Dental) Chamber:	88%

There is a well developed system of specialists and dental hygienists dental hygienists. Continuing education for dentists is mandatory, and is administered by the Dental section of the Medical Chamber, to which most dentists belong. Hungary has an extensive dental undergraduate training programme for overseas students.

Date of last revision: 1st October 2008

Government and healthcare in Hungary

Hungary is a landlocked, strategically located country astride the main land routes between Western Europe and the Balkan Peninsula, as well as between the Ukraine and the Mediterranean basin. The country is adjacent to 7 other countries. The north-south flowing Duna (Danube) and Tisza Rivers divide the country into three large regions.

The Republic of Hungary is an independent, democratic constitutional state with an elected parliament. The current constitution dates from 1972. The country is administered as 19 counties + Budapest (capital). The President of the Republic, elected by the National Assembly every 5 years, has a largely ceremonial role but powers also include appointing the Prime Minister. The Prime Minister selects cabinet ministers and has the exclusive right to dismiss them. The unicameral National Assembly is the highest organ of state authority and initiates and approves legislation sponsored by the Prime Minister.

A Constitutional Court has power to challenge legislation on grounds of unconstitutionality.

The Local Government Act of 1990 shifted the responsibility for the ownership and management of health and social services to local and municipal governments.

A Health Insurance Fund was introduced in 1993 with the goal of being self-supporting, based on compulsory payroll contributions from both employers and employees (and a very limited investment portfolio). The contributions are funded from the employer who pays 5% and the employee 6%. The self-employed contribute 9% and unemployed people do not contribute.

There is a global amount decided each year by Parliament for public health expenditure.

		Year	Source
% GDP spent on health	4.9%	2007	Chamber
% of this spent by governmen	70.0%	2007	Chamber

Oral healthcare

Public compulsory health insurance

Dental services are delivered either through dentists contracted with the National Health Insurance System, or by private practitioners.

The basic principles of establishing dental care facilities, subsidised by the National Health Insurance, are defined with respect to the number of inhabitants of a given geographic area. The facilities are assessed partly on the basis of a stipulated monthly allowance and partly on the basis of the output. The assessment is carried out on the basis of a care delivery score system, which is defined by the Ministry of Health, having considered the suggestions of the National Board of Dentistry. This board has 23 members, all dentists. The president is appointed by the Minister of Health. They hold a meeting 4 times a year. Representatives of other bodies (like the National Public Health and Medical Officers Service, Ministry) can be invited to the sittings.

There are about 8 million registered (NHI) patient visits in a year for 10 million NHI registered people. As some people visit the dentist more than once a year and others do not visit at all it is estimated that 50% of the population will visit a dentist in any one year. There are no data from the private sector.

Oral examinations would normally be carried out annually for regular adult patients, twice a year for children.

Emergency care, examination and diagnosis, conservative dentistry, including fillings and endodontics, periodontal therapy and extractions, are free in each of the three defined age groups (0-18, 19-60, above 60). Crowns and bridges, implants, fixed orthodontic appliances and other complex or cosmetic treatments have to be paid for by the patients. Among those aged 18 to 60 years, in active employment, the patient pays 100% of the dental and technical costs. Only active workers have to pay, and the amount is not set – it is dependent upon the type of treatment. The Medical Chamber has a minimum-price recommendation for each item, but it is not compulsory for dentists to keep to this.

Those who belong to the age group 0-18, and those who are over 60, do not have to pay for the dental treatment, but there is a co-payment for the technical costs – for example: for orthodontic devices between 0-18 years 15% of the technical costs will be paid by the patient and 85% by the NHI. For those aged above 60 for partial dentures 50% of the technical costs will be paid by the patient and 50% by the NHI.

There is prior approval for treatment in special cases: for example, in patients who have allergies. The National Health Insurance Company will decide about the level of patient contribution for the treatment.

The allocation of funding to dentists is managed by the National Health Insurance Company and also local government.

Re-examinations normally are carried out for most adult patients annually.

The quantity of work done by a dentist is monitored by routine reports to the National Health Insurance Company about treatments done in the practice, every month.

A dentist would typically have up to 3,000 regular patients on his "list". For basic general dental treatment there are no difficulties in accessing public health care, but there are geographic areas where specialist treatment (for example orthodontics) is difficult to obtain.

In the NHI, dental procedures are allocated a certain number of points. The monetary value of each point is determined every three months in the following way. The total number of points earned in the period is divided into the amount of money in the budget. Thus the value of a point varies monthly.

		Year	Source
% GDP spent on oral health	0.08%	2007	Chamber
% OH expenditure private	60%	2007	Chamber

Private Care

There are only 160,000 people, who have a private health insurance in Hungary (2008), at one of the 42 private insurance companies (just 9 private insurance companies have more than 5,000 members) – so they have little significance in the dental health care system.

About 30% of dentists work wholly privately, outside the State system (2008). Patients pay their dentist directly, under an item of treatment system. There is no regulation of private fees.

Of the 70% who work in the State system, some will also work privately, part-time. For dentists who are contracted to work with the NHI the only private items that can be provided are those which are not covered by the insurance scheme. For those dentists who are in private practice, their patients pay for all of their care.

The Quality of Care

There is a compulsory internal quality insurance system for those dental care providers who are contracted with the National Health Insurance Company.

Health data

		Year	Source
DMFT at age 12	3.30	2001	OECD
DMFT zero at age 12	16%	2001	OECD
Edentulous at age 65	30%	2006	Chamber

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

Since 2001 drinking water has to contain 1.5 mg/l fluoride and not more than 1.7 mg/l. By 2008 there was only one village (population 151) over the limit.

Education, Training and Registration

Undergraduate Training

To enter dental school students must obtain the General Certificate of Education and then successfully pass an entrance examination. No other vocational entry is possible.

Dental schools are known as *Fogorvostudományi Kar Dental Faculty* (Semmelweis University, Budapest, University of Szeged and the University of Debrecen); *Fogorvostudományi Szak Dental "section"* (University of Pécs, where there is no extra faculty for dentistry, but it is part of the Medical Faculty).

Year of data:	2007
Number of schools	4
Student intake	255
Number of graduates	210
Percentage female	53%

All the dental schools are state funded, although some of the students have to pay their own fees. Student intake includes about a large number from overseas. The Hungarian undergraduate dental training is 5 years, with minimum of 5,000 contact hours.

There are courses offered to foreign students in Budapest Semmelweis University, the University of Szeged and the University of Debrecen. At Semmelweis, in 2008, there were over 650 undergraduates, with about a third from EU and non-EU countries - from Greece, Cyprus, Israel and some countries in the Middle East. Most were taught mainly in English but there is also one course in German, with 80 undergraduates.

At Debrecen, about half of the 460 undergraduates were from outside Hungary, all but a handful being from outside the EU. The course for them is in English.

At Szeged, the dental course in English was launched in the academic year 2004/2005. About a third of the 230 students were not Hungarian and the first dentists will graduate in 2009.

Quality Assurance is monitored and checked by the National Accreditation Committee. The course has been revised in the light of advice, and alterations were made in 1996. Since then the course has been compliant with the EU Directives on the training of dentists. The four dental faculties were simultaneously accredited by the National Accreditation Committee in 2005.

Qualification and Vocational Training

Primary dental qualification

The title upon qualification is: *Fogorvos Dentist* (DMD)

Vocational Training (VT)

Until 2004, upon qualification, there was a programme of mandatory vocational postgraduate residency training for 26 months, under the guidance of a skilled dentist and based on a government decree. The programme was organised by the Universities/Dental Schools and was totally financed by the Ministry of Health, which paid the salaries. Residents, known as *Központi gyakornok*, needed to hold Hungarian citizenship. The residents were mainly employed in the public sector. The programme consisted of a theoretical part which covered all fields of dentistry including practice management, legal requirements and first aid and a practical part undertaken either at the University clinics or in other polyclinics accredited by the University. The residents worked under the supervision of a tutor and the whole programme was supervised and coordinated by mentors appointed by the Dental Schools.

Residents had to complete the courses, meet the practical and theoretical requirements, and pass their midterm exams in each dental subject successfully, in order to take the license exam at the end of the 26 month training programme. At completion of the programme they were qualified to open a private general dental practice or be employed by municipal or private practices.

This vocational training was compulsory for all graduates, including those of other EU countries' dental schools. However, changes to the law abolished the mandatory general dentistry residency programmeme, giving full access to liberal private practice, from 2004.

So, all dental graduates since 2004 have full rights to free practice after graduation.

Registration

Dentists must register with the Ministry of Health. Whilst registration was free in 2008, the Chamber suggested that a registration fee will be introduced at some time in the future.

For the recognition of non-EU diplomas it is necessary to pass an exam.

Language testing

Additionally, a Hungaro-logic test (which tests knowledge of the insurance and legal systems) previously had to be passed by all, to work in Hungary. The test is conducted in Hungarian. However, since 2006 language testing has not been regulated.

Further Postgraduate and Specialist Training

Continuing education

Participation in continuing education has been mandatory since 1999. The system is delivered mainly by the Dental Section of the Hungarian Medical Chamber, which is responsible for the supervision.

There is a scoring system, with accredited continuing education courses. A dentist must achieve 250 points in 5 years. This represents 250 hours, and some reading is allowed to be counted. The ultimate sanction for non-compliance is suspension from practice and the first audit of compliance took place in 2004, resulting in two dentists of retirement age needing extra training.

Specialist Training

Specialist Training takes place in universities and is 3 years for all specialties. A special committee is responsible for this training.

There are five recognised specialties for training in Hungary:

- Orthodontics, with the title: Fogszabályozó szakorovs
- Periodontology, with the title: Parodontológus
- Paediatric dentistry, with the title: Gyermekfogorvos
- Dento-alveolar surgery, with the title: Dento alveoláris szájsebész
- Conservative Dentistry and Prosthodontics - with the title: Konzerváló Fogászat és Fogpótlástan szakorvos

Until 2002, Oral Surgery was the only specialisation in oral surgery open for both medical and dental doctors. Those working in hospitals and head and neck surgery departments needed double qualification, both MD and DMD degree. Those working in polyclinics could be licensed only with DMD academic degree. It is no longer a dental specialty.

Since 2002, Oral and maxillofacial surgery has been available for medical doctors, only. However, also since 2002, the new speciality, Dento-alveolar surgery was introduced and accredited by the government, and is only for dental graduates. This has a three year residency programme. Its competency level covers only the dento-alveolar region up to minor sinus operations.

Since 2004 the Hungarian DMD degree has provided full competence and the right to practice individually and abolished the two year mandatory vocational training and the licence exam. After graduation any dentist can receive a working licence and can work independently. Since then the new specialty has been named as "conservative dentistry and prosthodontics" and has replaced the old "general dentistry and oral diseases" vocational training exam. It is theoretically and practically equivalent to this previous general dentistry licence exam.

Those who had passed the previous licence exam – and practically each dentist had done that - are eligible to sign up for the new "conservative dentistry and prosthodontics" exam if they had enough previous working experience. By 2008 many dentists have already passed this exam, especially because of office accreditation for dental resident training.

The combined number of the previous licence exam holders and the current "conservative dentistry and prosthodontics" specialists leads to overlapping figures, so an accurate figure for the new specialty cannot yet be assessed. Consequently about 4,800 dentists (by 2008) have a qualification in either the previous or the new type of specialities or both.

The generation of dentists who have entered into the new postgraduate training system introduced iafter 2004 have gained qualification in only the new speciality of "conservative dentistry and prosthodontics".

Workforce

Dentists

Year of data:	2008
Total Registered	5,500
In active practice	4,973
Dentist to population ratio*	2,020
Percentage female	57%
Qualified overseas	453

**active dentists*

The Dental Section of the Hungarian Medical Chamber reports that the workforce is decreasing as the government is training fewer Hungarian dentists than those retiring or otherwise leaving full-time work as a dentist. Figures show that there a large number of dentists (both male and female) over the age of 50 who will be retiring in the years to 2013, more than the number of Hungarian nationals who will graduate from the four Hungarian dental schools.

There were no reports of unemployed dentists, in 2008.

Specialists

Specialists work in both the public and private sector. Patients may access specialists directly, or by referral.

The National Health Insurance Fund will make contracts only with specialists.

Year of data:	2008
Orthodontics	268
Endodontics	
Paedodontics	285
Periodontics	40
Conservative dentistry &	NK
Prosthodontics	
Oral Radiology	
Dental-alveolar	43
OMFS	208
Dental Public Health	

NK = "Not known" – see previous section

Auxiliaries

There are two kinds of clinical auxiliaries in Hungary – Dental Hygienists and Dental Technicians. Additionally, there are dental nurses.

Year of data:	2008
Hygienists	1,000
Technicians	3,000
Denturists	0
Assistants	4,668
Therapists	0
Other	0

Dental Hygienists

Hygienists are permitted to work in Hungary, provided they have a Certificate. They train in one of seven State financed schools specifically for dental hygienists, for one year, following two years' training as a dental assistant.

They work under the supervision of a dentist, only, and their duties include scaling, cleaning and polishing, the insertion of preventive sealants and Oral Health Education. They do not have to be registered, but registration is planned for the future.

Their work is governed by the Ministry of Health.

They are usually paid a set fee for every patient they treat.

Dental Technicians

Technicians train in one of four state financed training schools and the training period is four years. Theoretical training is undertaken at the school and practical training in special, contracted laboratories. They receive a certificate on the satisfactory completion of their training. Laboratory master technicians are registered by the regional Chambers of Industry. while those who are entrepreneurial technicians running a private firm should also be registered by the Hungarian Court of Registration and should have a VAT number.

Technicians normally work in commercial laboratories. They construct prostheses for insertion by dentists and they invoice the dentist for the work that is done.

It is presumed that there are illegal denturists in Hungary because of the complaints that are received from patients.

Dental Assistants (Nurses)

Dental nurses assist the dentist at the chairside. Until 2008 They were trained for two years, in one of 22 specialised secondary schools, after leaving secondary school with the general certificate of education. However, since 2008 training has been centralised to four centres.

They have to be registered with the Ministry of Health, in the Department of Nursing.

Practice in Hungary

The major investments like construction and maintenance of premises, or equipment purchasing are financed by the owner, or co-financed from the Ministry of Health.

All expenditures for day to day operations, including salaries of health care professionals, are financed by the National Health Insurance Fund. However, rates can be too low to cover the real costs of providing the services. The lack of adequate funding has led to the continuation of informal payments and use of public facilities for private practice businesses, to enable health care staff to supplement their incomes.

Domiciliary care is not formally organised in Hungary, although some private dentists may provide this.

Year of data:	2008
General (private) practice	4,040
Public dental service	40
University	200
Hospital	40
Armed Forces	80
General Practice as a proportion is	92%

Working in General (Private) Practice

Joining or establishing a practice

A dentist can buy or rent a practice, join an existing practice, but can also establish a completely new practice. A general practice may be located in a shop, a house etc. However, when a dentist buys a practice it is just the equipment and facilities which are bought, and there is no amount for "goodwill" – ie, the patient list. Anyone may own a dental practice (see Corporate dentistry).

The state offers no assistance for establishing a new practice. When starting a new practice private dentists have to get permission from the local health authorities – the National Public Health and Medical Officers Service. There are only restrictions on setting up practices which provide dental care in the national health insurance system (contract with the National Health Insurance Company). The restricting factor is the population (4,000 people have to be on the "list" of a practice).

There are no limits for the size of a practice in terms of associate dentists or other staff. There are minimum requirements for establishing a new practice - for example, the size of the treatment room for one piece of equipment (a dental unit) has to be a minimum of 16 sq metres. This is prescribed and strictly checked by the National Public Health and Medical Officers Service.

There are no restrictions for setting up private dental practice.

Fee scales

For those dentists with a contract with the National Health Insurance Fund the prices are regulated - based on the German type points system. The Insurance Fund establishes the point value of each procedure. For those dental procedures that the Health Insurance does not finance at all such as crown and bridge work, the laboratory fees are regulated but the dentists' fees are matter of a limited bargain between patient and dentist. In independent private practice the prices are dependent on the location of the office and the qualification of the health care provider. There is no centralized control on these dentists and laboratory fees.

Working in Public Clinics

In some towns there are dental clinics owned by the local government. Dentists may work in these clinics and participate in the NHI system on the same terms as liberal dentists, although they are salaried employees of the clinic. So, patients may receive fillings, surgery and endodontics within the NHI, but will have to make co-payments for prosthetic appliances.

Quality Assurance would be given by the heads of the clinics.

Working in Hospitals

Salaried dentists work in hospitals or university clinics, as specialists in oral surgery. All the hospitals are State-owned. A part-time hospital dentist may work concurrently in private practice.

Working in the University Dental Faculty

Dentists in the universities are allowed the combination of part-time teaching employment and private practice (with the permission of the university).

However, more usually they are full-time salaried employees of the University.

The titles of university teachers are: Assistant Lecturer, Senior Lecturer, Associate Professor or Professor - this involves a further degree (publication activities and a record of original research) leading to a PhD and habilitation (second round of PhD).

Regular epidemiological studies are not carried out, but research teams at Dental Schools do undertake some surveys. The latest pathfinder survey which included 5,000 adults was carried out in 2005-2006.

Working in the Armed Forces

About 50% of dentists who serve in the Armed Forces are females. These dentists would be normally officers undertaking national service.

Professional Matters

Professional associations

	Number	Year	Source
Hungarian Dental Association	1,600	2008	FDI
Chamber (Dental Section)	5,200	2008	Chamber

The Hungarian Medical Chamber is the national professional association, it has a Dental Section in which the membership has not been mandatory since January 2007. It is the only public body in dentistry. As of 2008, about 90% of all Hungarian dentists voluntarily registered in the new Dental Section of the Medical Chamber.

Since January 2007, the Office of Health Authorisation and Administrative Procedures of the Ministry of Health has awarded the right to practice medicine or dentistry and undertakes registration.

There is equal status for both physicians and dental practitioners.

The New Chamber is also divided into regional sections There are 19 provinces and Budapest, and also the Dental Section, The term of office for officers is four years. Dental practitioners are represented at all organisational levels of the Medical Chamber. The representation of dental practitioners is secured in the Supreme Medical Council, and one of the two Vice-Presidents has to be a dentist.

The Hungarian Dental Association is a scientific organisation and has several professional societies - the Hungarian Society of Periodontology, the Orthodontic and Paedodontic Society, the Society of Implantology, the Prosthodontic Society, the Association for Preventive Dentistry, the Society of Oral and Maxillofacial Surgeons, the Society of Dento-maxillofacial Radiology and the Endodontic Society. Membership of the Hungarian Dental Association is not mandatory.

The tasks of the Hungarian Medical Association (and its Dental Section) are:

- exercising care over conscientious practice, protecting the prestige of physicians and dentists
- preparing, performing, controlling and updating of decisions concerning the quality and conditions of medical practice, expressing its opinion on matters concerning public health and health policy of the state with its national and provincial local bodies, in cooperation with other associations and institutions in Hungary and in foreign countries: Communication of the standpoints of the medical profession on matters of health policy and medicine
- setting the principles of professional ethics. Ethical Code: regulate ethical and professional obligations of doctors among themselves and vis-à-vis patients
- defending individual and collective interests of members, offering mutual aid and other form of assistance to members
- expressing its opinion on matters concerning postgraduate education of physicians and dentists, taking part in its realisation
- Promotion of quality assurance

The Hungarian Medical Association performs the tasks by means of

- keeping the register of physicians and dentists
- cooperation in working out the general conditions of contractions between physicians and the National Health Insurance Fund
- delivery of opinions on draft legislation concerning the protection of health and practising as a physician
- making decisions with respect of inability to practice as a physician or a dentist
- professional and ethical supervision of members
- negotiating conditions of work and remuneration
- defending individual and collective interests of the members

Ethics and Regulation

Ethical Code

There is an ethical code in Hungary. There are both local and national ethical committees that enforce the code. It is a joint system with the medical profession but the ethical committee always has a dental member.

Fitness to Practise/Disciplinary Matters

Patients' complaints about State or Private care can be sent to the dental care providers, to the National Public Health & Medical Officers Service, or to the court. (Ethical complaints are judged by the Ethics Committee of the Medical Chamber).

There are authorised regional legal representatives for patients, who help with obtaining remedy for them.

The most serious penalty is that a dentist may lose their license to practice, but this is very rare. A member may also be admonished. It is possible to appeal to an upper level and finally to the courts. Only the Hungarian Ethical Court may withdraw the licence to practice for a practitioner.

Advertising

Advertising is permitted under the framework of the ethical code, but this is very limited. It is restricted to information on name, title, telephone number/address, specialisation and consultation hours. It does not include the use of advertisements on the TV or radio.

Hungarian dentists may use websites, within the ethical considerations, based on the CED Guidelines and following the EU Directives – although the code does not include a specific section on the issue.

Data Protection

The rules for data protection in Hungary follow the EU Directives. There is a Data Protection Ombudsman.

Indemnity Insurance

This is compulsory for all dentists in Hungary. There are many insurance companies offering this service. Costs are approximately €150 to €250 per year. This does not cover dentists going to work outside Hungary.

Corporate Dentistry

Dentists are allowed to form corporate bodies (companies). Anyone may own or invest in a dental surgery. The person undertaking the dentistry must be a dentist but there is no requirement for the investors to be a dentist.

Tooth whitening

Tooth whitening products of greater than 6% are regulated as Medicinal products and can only be applied by dentists and hygienists working under the supervision of dentists.

Products with less than 6% effective material are classified as Cosmetics and are OTC.

Health and Safety at Work

Dentists, and those who work for them, must be inoculated against Hepatitis B. The employer usually pays for inoculation of the dental staff.

Ionising Radiation

There are specific regulations about radiation protection. Radiation protection training is mandatory for both under-graduate dentists and for practising dentists possessing X-Ray equipment. The licensing course must be retaken in each five year period.

Radiation equipment must be registered by the Department of Public Health Service and is checked regularly by them.

Hazardous waste

The EU Hazardous Waste Directive has been fully transposed into national law, therefore requiring amalgam waste to be collected as a hazardous waste. The law is actively enforced in practice. According governmental guidance on environmental management of waste amalgam should be stored and carried as a biohazard.

Amalgam separators are not required by law for old unit but are where new units are equipped. The use of separators is recommended or advised by environmental managements for all units. By 2008, approximately 50%, of practices were equipped. Centrifugal or tank-type separators are used.

The collection of dental amalgam is made by registered, licensed carriers. It is separated from other hazardous dental waste. The dentists or the owner of the practice, are liable for the procedure. The collected amalgam waste is recycled. The collected amalgam scrap (i.e. the mixed amalgam not used for the filling) is also collected and carried as biohazardous waste, but separately and is also recycled.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	National Public and Medical Officer's Service. Also the Department of Public Health Service
Electrical installations	Compulsory annual checks by MEEI
Waste disposal	National Public and Medical Officer's Service. There is compulsory contracting with special companies who transport and dispose of waste
Medical devices	Institute for Medical and Hospital Engineering (ORKI) (A professional, non-profit organisation structured in the form of an institute, performing tests and conformity assessment of medical and hospital equipment. In the frame of international co-operation ORKI maintains contact with foreign medico-technical institutes and with other organisations involved in this field).
Infection control	National Public and Medical Officer's Service

Financial Matters

Retirement pensions and Healthcare

The normal age for retirement is 62, although dentists and staff can work past then.

There is a state-funded system of pensions, of which dentists and their staff are a normal part. The pension would be €200 per month.

A further compulsory private scheme commenced in 1998, in which contributions are made at the rate of 20% by the dentist and 80% by the government.

Taxes

Hungary has graduated taxation. Under €5,000 per annum tax is 18%. Above €5,000 tax rises to 36%.

VAT

Since 2004 there have been three VAT rates: 5% (for medicaments), 15% (materials) and 25% for equipment, instruments and disposables).

Various Financial Comparators

Zurich = 100	Budapest 2003	Budapest 2008
Prices (excluding rent)	55.9	64.8
Prices (including rent)	57.3	63.5
Wage levels (net)	15.6	18.2
Domestic Purchasing Power	30.3	28.7

Source: UBS August 2003 & January 2008

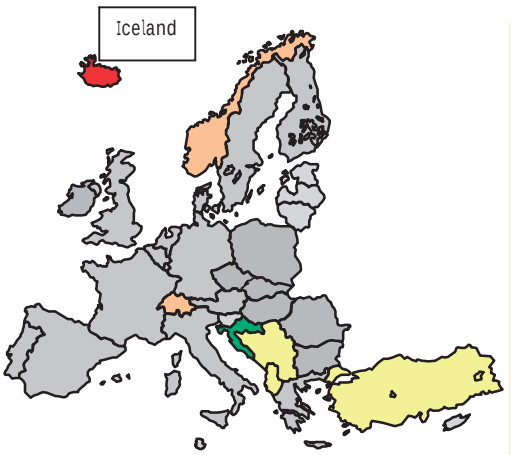
Other Useful Information

Main National association and information centre	*Main specialist association:*
Dental Section of the Hungarian Medical Chamber Szondi u 100 H – 1085 Budapest Hungary Tel: + 36 1 354 0469 Fax: + 36 1 353 2188 E-mail: kamara@fogorvos.hu Website: http://www.kamara.fogorvos.hu/	Hungarian Dental Association (Magyar Fogorvosok Egyesülete, MFE) Budapest Szentkirályi u. 40 H-1088 Budapest Tel: +36 -52 342 224 (Prof Ildiko Márton-president) +36 1 318 5222 (Prof Gera István secretary general) Email: gera@fok.usn.hu marton@jaguar.dote.hu Website: www.mfe-hda.hu
Journals	
Name: Magyar Fogorvos Tel: +36 1 301 3879 Editor in Chief: Dr. Janos Gerle Editor: Dr. Peter Hermann E-mail: reveszi.valeria@mediprint.hu Website: www.magyar.fogorvos.hu	Name: Fogorvosi Szemle Editor in Chief: Prof Pal Fejerdy Editor: Dr. Peter Hermann Tel: +36 1 317 1094 Fax: +36 1 317 1094 E-mail: ilike@fok.usn.hu Website: www.mfe-hda.hu

Dental Schools:

City: Budapest Name of University: Semmelweis University Tel: +361 266 0453 Fax: +361 266 1967 E-mail: gera@fok.usn.hu Website: www.sote.hu Dentists graduating each year: 100 Number of students (Hungarian): 440 Number of students (not Hungarian): 210	City: Debrecen Name of University: University of Debrecen Tel: +36 52 342-208 Fax: +36 52 342-224 E-mail: fokdh@dote.hu Website: www.unideb.hu Dentists graduating each year: 50 Number of students (Hungarian): 226 Number of students (not Hungarian): 234
City: Szeged Name of University: University of Szeged Tel: +36 62 545 283 Fax: +36 62 545 282 E-mail: stoma@stoma.szote.u-szeged.hu Website: www.szote.u-szeged.hu Dentists graduating each year: 29 Number of students (Hungarian): 160 Number of students (not Hungarian): 72	City:Pécs Name of University: University of Pécs Tel: +36 72 535 901 Fax: +3672 535 905 E-mail: fogaszatiroda@freemail.hu Web site: www.pote.hu Dentists graduating each year: 30 Number of students (Hungarian): 150

Iceland



Date of last revision: 1st October 2008
(please note changes arising from the financial problems later in October 2008 are not reflected in this Manual)

In the European Economic Area	
Population (2008)	314,321
GDP PPP per capita (2007)	€31,444
Currency	Kroner ISK)
	118 ISK = €1.00 (2008)
Main languages	Icelandic

There is a comprehensive state healthcare system funded mostly by general taxation. Care provided within hospitals is free at the point of delivery, except some accident and emergency care. But, in contrast to general healthcare, almost all oral healthcare is paid for by private individuals and households, on a fee-per-item basis. Assistance in paying for these dental fees is limited to the reimbursements from the Icelandic social security agency.

Number of dentists:	360
Population to (active) dentist ratio:	1,107
Members of Dental Association:	90%

The use of dental specialists is widespread but the development of clinical dental auxiliaries is limited to dental hygienists. Continuing education for dentists is not mandatory.

Government and healthcare in Iceland

Iceland is a large mountainous island situated in the Atlantic Ocean, just south of the Arctic Circle. It is 798 km from its nearest European neighbour, Scotland. The highland interior is largely uninhabitable and most of the population centres are situated on the coast. 180,000 people, over 62% of the total population, live in the greater Reykjavik area (the capital).

Settled since 874AD, the present republic was founded in 1944 and is governed by the *Althing* (Parliament) whose members are elected every four years. There is also a President, who is a former minister of the parliament. The President has no role in day to day politics. The economy is heavily dependent on fisheries, with marine products constituting 51% of all exports. Aluminium from aluminium smelters provide an increasing part of the export.

The health service in Iceland is primarily financed by central government. Financing is mainly based on taxes (85%) with 15% as patient co-payments by way of fee for service. Care provided within hospitals is free at the point of delivery, except some accident and emergency care.

		Year	Source
% GDP spent on health	10.0%	2007	OECD
% of this spent by governm't	82.4%	2007	OECD

Oral healthcare

In contrast to general healthcare, for which a comprehensive state-funded system exists, most oral healthcare for adults is paid for by individuals and households, on a fee-per-item basis. Assistance in paying for these dental fees is limited to the reimbursements from the Icelandic social security agency.

The national dental health insurance system pays according to a public fee schedule set by the Minister of Health. These fees are generally different from the fees used by private dental practitioners, since private dentists in Iceland are allowed to set their own fees.

The national dental health insurance scheme offers partial reimbursement of the cost of dental treatment for children under 18 and adults aged 67 years or older. For children under 18, 75 per cent (according to the public fee schedule) of the cost of most dental treatment is reimbursed with the exception of crowns, bridges and orthodontic treatment. The cost of orthodontic treatment can be reimbursed up to ISK 150,000 (€1,272) according to special rules.

People with chronic illness, old-age pensioners and disability pensioners also have their costs covered in full or in part. For this group 50, 75 or 100 per cent of the cost (according to the public fee schedule) of dental treatment may be covered. Full dentures and partial dentures are covered. Gold and porcelain crowns or bridges and implants can be reimbursed up to ISK 80,000 (€678) per year. The cost of implants for use with attachments under dentures is partially reimbursed for pensioners who cannot use full dentures due to ridge resorption or other problems. The cost of dental treatment (including orthodontic treatment), for congenital malformations and serious abnormalities such as cleft palate and aplasia, and the cost of dental treatment necessary because of accidents and illness, is reimbursed according to special rules. Part of the cost of dental treatment that is necessary to prevent serious complications due to infection in teeth and periodontium, of the immunocompromised patients, such as patients with leukemia or head- and neck cancer, patients waiting for a transplant, (transplant patients), patients who need bone marrow transplants and other comparable patients is also reimbursed.

Dental treatment is not subsidized for the rest of the population. No private dental insurance is available either.

		Year	Source
% GDP spent on oral health	0.60%	2001	IDA
% OH expenditure private	No data		

The social security agency operates the system independently within the framework of health policy set by the Ministry of Health. It spends an annual budget of central government funds, which is set by the Ministry of Finance. Within the Ministry of Health there is a Chief Dental Officer (*yfirtannlæknir*) who promotes dental policy and also has a public health role monitoring oral health at a national level. The social security agency also has its own Chief Dental Officer (*tryggingayfirtannlæknir*).

No information is available of how often the whole population visit their dentists.

Recall visits are normally carried out for most adult patients at 6-12 monthly intervals.

Private Insurance

There is no private dental insurance. Only accidents are covered by private insurance.

The Quality of Care

Quality of care is monitored by the Chief Medical Officer, mostly through patient complaints. There is also a basic statistical analysis of the patterns of treatment provided by each dentist, and any practitioner whose profile differs substantially from the norm may be questioned by the social security agency.

For most minor issues the agency will issue a warning to the dentist; more serious cases are referred to a liaison committee where both the agency and the dental association have their representatives.

Health data

		Year	Source
DMFT at age 12	2.12	2005	MUNNIS
DMFT zero at age 12	48%	1998	OECD
Edentulous at age 65	25%	2004	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no schemes to increase the fluoride intake in Iceland.

Education, Training and Registration

Undergraduate Training

Iceland has one dental school (http://www.hi.is/pub/tann) - the Faculty of Odontology at the Icelandic University in Reykjavík.

Year of data:	2008
Number of schools	1
Student intake	7
Number of graduates	6
Percentage female	67%

This small faculty offers undergraduate training in dentistry. The course normally lasts six years and the first term is devoted to chemistry, dental morphology and an introduction to anatomy and physiology. At the end of the first term there is a competitive examination from which the seven students with the highest average mark are permitted to continue into the second term.

Although instruction is in Icelandic, the course texts are in English and examinations in the first year may be written in English. Tuition in Icelandic is available in the University and after the first year all instruction and examinations are in Icelandic. Class sizes are small in the clinical courses, which has ensured a very high standard of clinical training.

Qualification and Vocational Training

Primary dental qualification

The title on qualification is the degree *candidatus odontologiae*, which is recognised as a dental qualification throughout the European Economic Area.

Vocational Training (VT)

There is no post-qualification vocational training.

Registration

The Ministry of Health and Social Security is the competent authority responsible for issuing dental qualifications. A dentist seeking recognition in Iceland should therefore approach the Ministry for application. If the applicant is a national of an EU/EEA Member State and holds a dental qualification awarded on completion of training in a Member State he/she is eligible to benefit under the Dental Directive. In addition to an application the following documents must be submitted:

- a certified proof of citizenship in a EEA country.
- a statement from the competent authorities in the home country of the applicant that his/her training for basic qualifications complies with the training standards laid down in the Directive.
- a certified copy of the diploma showing that the applicant is registered as a dentist in the home country.
- a certified copy of the applicant's licence as a specialist (if applying for a specialty).
- a certificate of good standing with the competent authority in the Member State of origin or last residence. This certificate must not be older than three months.
- a translation of any document in English certified as correct by government authority or official translator.
- a curriculum vitae (not compulsory)

When the Ministry has made the formal assessment the applicant will become fully registered and the licence to practice will be issued.

If the applicant is not a national of a EEA Member State the procedure for recognition is more complicated, but the same documents have to be submitted, then the qualifications of the applicant will be assessed by a special board under the medical faculty of the University of Iceland, responsible for evaluating the dental training in Iceland. The board always contacts the applicant's university directly. Full address and telephone/fax numbers of that university are therefore needed. In individual cases more documents may be needed.

The cost of registration (for dentists) in 2008 was not given.

Language requirements

When the confirmation of the applicant's university has been received the applicant has to pass an examination, where his/her knowledge in the Icelandic language is tested, and in most cases the applicant also has to pass other tests, including public health and health legislation. When these requirements are fulfilled the medical faculty will give its recommendations to the Ministry.

Further Postgraduate and Specialist Training

Continuing education

Continuing education for dentists is not mandatory. Nevertheless, the Icelandic Dental Association has an active continuing education system for Icelandic dentists.

The purpose of organised continuing education for dentists is to promote the maintenance of professional knowledge among the greatest number of dentists for the benefit of themselves and their patients (clients). The name of the continuing education project is "Active Continuing Education for Icelandic Dentists" (ACEID), and a Professional Committee is appointed to oversee the continuing education system. Dentists presenting confirmation of having attended courses, congresses and lectures recognised by the ACEID board acquire points for accumulation of units within ACEID.

The reading of articles in recognised professional journals also merits points for up to 5 hours of units per year. The Professional Committee have to approve the articles. Dentists can then send responses into the ACEID Professional Committee and thus earn units. Annually, certificates are issued to dentists fulfilling the ACEID requirements. To be deemed active in ACEID, dentists must have attended recognised continuing education courses for at least 20 hours per year.

The Professional Committee consists of three members:

- One appointed by the Iceland Dental Association (TFÍ) board of directors.
- One from the University of Iceland's Faculty of Dentistry.
- One elected at the TFÍ annual meeting.

The chairman of the professional committee is a member of the TFÍ board. The committee's function is to evaluate the courses, lectures, congresses and article reading worth units in ACEID. The committee keeps a record of dentists' participation in ACEID and sees to it that they receive certificates at the beginning of the year for their participation. Dentists active in ACEID may display their certificates in their waiting rooms and, in addition, may use ACEID after their names in the telephone directory.

Specialist Training

The Faculty of Odontology has no specialist training programmes. Specialist training courses are only available at universities outside Iceland. To be accredited by the Ministry of Health training must last at least 3 years and be at an approved institution, approved by the Icelandic University and the Ministry of Health.

Continuing education arrangements are limited to one lecture series in the spring semester about subjects related to dentistry and weekend courses on irregular schedule. Teaching is in Icelandic.

Workforce

Dentists

Year of data:	2008
Total Registered	360
In active practice	284
Dentist to population ratio*	1,107
Percentage female	35%
Qualified overseas	41

* this refers to *active* dentists only

About 60% of practising dentists live, and work, in the Greater Reykjavik area.

Movement of dentists across borders

Whilst about 10% of the workforce qualified overseas, there is a very little movement of Icelandic trained dentists to other countries.

Specialists

All specialists work in private practice, although some do part-time work at the dental school.

Year of data:	2008
Orthodontics	10
Endodontics	2
Paedodontics	4
Periodontics	10
Prosthodontics	4
Oral Radiology	0
Oral Surgery	3
Dental Public Health	4
Others	5

Patients may go directly to a specialist, without the need for a referral from a primary dentist.

In 2008, there were also a number of registered but retired specialists (5 orthodontists, 1 paedodontist, 1 periodontists and 2 prosthodontists).

Auxiliaries

In Iceland, other than dental chairside assistants, there are two types of dental auxiliary:

- Dental hygienists
- Dental technicians

Year of data:	2004
Hygienists	30
Technicians	125
Denturists	0
Assistants	304
Therapists	0
Other	0

Later figures not available

Dental hygienists

There is no dental hygienist training available in Iceland. The Ministry of Health decides which external diplomas are recognised and awards licences to hygienists to practice.

They work in private practices and at the dental school as salaried employees. Whilst they can diagnose, they can only practice under the supervision of a dentist. They may give local anaesthetics and they take their own legal responsibility for their work.

Most Icelandic hygienists are members of the Union of Dental Hygienists. They are paid by salaries or fees.

Dental technicians

There is a school for Dental Technicians in Reykjavik, near the Dental School, and training lasts for 4 years. Dental technicians are usually self-employed, working in their own laboratories or workshops – although some technicians are employees of an individual dentist or group practice.

Technicians can work without supervision, but not clinically directly with patients, and the dentist is ultimately responsible for the quality of the prostheses. Technicans have to register to the Ministry of Industry.

There are no denturists in Iceland.

Dental Chairside Assistants

Since 1990 there has been a qualification for dental chairside assistants and it is in fact a requirement to have this in order to work for a dentist. Training is for two years in high school and one year in dental school. Registration is under the auspices of the Chief Medical Officer. However due to the shortage of dental chairside assistants, dentists are allowed to hire whomever they choose if no qualified DCA applies.

Dental assistants are normally salaried.

Practice in Iceland

All dentists in Iceland work in general practice. Some teach also part-time in the dental school – hence the numbers below total more than the number of active dentists.

Year of data:	2008
General (private) practice	284
Public dental service	
University	23
Hospital	
Armed Forces	
General Practice as a proportion is	100%

Working in General (Private) Practice

Dentists who practise on their own or as small groups, outside hospitals or schools, and who provide a broad range of general and sometimes specialist treatments are said to be in *private practice*. All dentists in Iceland are in private practice. A dentist would normally look after about 800 regular patients on his/her "list".

All dentists are self-employed and earn their living partly through charging fees for treatments and partly by claiming government subsidies for some types of patient.

All Icelandic dentists must work under the Law of Competition so they are not allowed to have a fixed rate for anything. Some patient groups (0-18 years, older than 67 and the officially disabled) get some refunds of their dental bills from the social security agency and that sum is fixed. This fixed sum is decided upon by the Ministry of Health. The Icelandic Dental Association has no say in deciding how much is refunded.

The main treatments, for which the level of reimbursement is fixed and automatic, are examination and diagnosis, fillings, X-ray investigation, periodontology, endodontics and prevention. Reimbursements for oral surgery, crowns and bridges or orthodontics are only decided after prior approval of the treatment plan by the social security agency.

A dentist only receives a payment directly from the social security agency in particular circumstances which include treating the institutionalised elderly, those with learning difficulties or patients receiving subsidised treatment for birth defects and other handicaps. The effects of some serious accidents are also covered.

Fee scales

The fee scale for social security subsidised treatment is a highly detailed list of over 100 possible treatment items. Specialists may charge up to 32% above the stated fixed fee for social security subsidised work.

Joining or establishing a practice

There are no rules which limit the size of a dental practice in terms of the number of associate dentists or other staff. However, most dentists own their own practice, with a few younger practitioners who work with colleagues, often in dental centres. There are no standard contractual arrangements prescribed for dental practitioners working in the same practice.

The TFI Moralising Rules

Premises may be rented or owned, but cannot be in the same part of a building as another dentist without that practitioner's consent, or for up to two years after the original dentist has left the property. There is no state assistance for establishing a new practice, so normally dentists take out commercial loans from a bank. Occasionally small communities will create incentives to attract or keep a dentist in their area, for example by providing cheap accommodation or buying the dental equipment and leasing it back to the dentist at a low cost.

The clinics are housed in ordinary buildings, in malls, among offices etc., where the need for dental care or convenience for people for a visit is the priority.

There are no specific contractual requirements between practitioners working in the same practice. A dentist's employees however are protected by national laws on equal employment opportunities, maternity benefits, occupational health, minimum vacations and health and safety. Furthermore, a contract between the Icelandic Dental Association (TFÍ) and the Association of Chairside Assistants (the *Félag tanntækna og aðstoðarfólks tannlækna*, or *FTAT*) sets a minimum wage for qualified dental chairside assistants.

There are no private practitioners practising completely outside any state or insurance system. Dentists are able to form companies/corporate bodies.

Working in Hospitals

In Iceland no dentists hold positions in hospitals. Instead hospitals hold lists of dentists who are contracted to be on call for any patients, usually emergency cases, who require dental treatment. Urgent care may be provided in an operating theatre, but since there are no dental clinics within any of the hospitals in Iceland, most treatment is deferred until the patient can attend a private practice.

Working in the University Dental Faculty

Dentists work in the dental faculty, but only as part-time employees of the University. They also work in private practice outside the faculty.

Within the faculty there are three main grades of staff, Professors, Assistant Professors and Lecturers who have typically received at least three years' postgraduate training; and general part-time teachers who only require the basic *Cand. Odont.* qualification.

Working in the Armed Forces

The US Navy base at Keflavik has its own dental service, operated by the Navy. However, the soldiers and their families can visit Icelandic specialists outside the base. In that case it is based on a special agreement between the navy and those specialists who want to be a part of such agreement.

Professional Matters

Professional associations

There is a single professional association, the Icelandic Dental Association (*Tannlæknafélag Íslands* or *TFÍ*) to which over 90% of dentists belong.

	Number	Year	Source
Icelandic Dental Association	303	2008	FDI

It is funded totally by members' subscriptions and has a permanent office in *Reykjavík*. As well as advising members on ethical and disciplinary matters, the association also has a role in negotiating conditions of work and pay, in conjunction with the government social security agency.

All specialties are represented within a single Society of Specialists, the *Félag sérfræðimenntaðra tannlækna*, which is best contacted through the Icelandic Dental Association.

Ethics

Dentists in Iceland work under an ethical code which covers relationships and behaviour between dentists, contact with patients, consent and confidentiality, continuing education and advertising. The code is administered by the Icelandic Dental Association through an ethical committee. Within the laws governing dentistry many of the same ethical issues are also monitored by a government committee chaired by the Chief Medical Officer.

Fitness to Practise/Disciplinary Matters

Patients may complain directly to the social security agency, to the Chief Medical Officer, to a special committee established by Icelandic Dental Association (TFÍ) and The Consumers' Association of Iceland, or to the TFÍ who can set up an arbitration committee.

The liaison committee meets when necessary and has 3 representatives from the Icelandic TFÍ and 3 from the social security agency. The Committee decides which complaints should be upheld and determines the resulting penalties, including warnings or fines but usually paying back the cost of treatment. In extreme cases a dentist may have their right to practise, within the TFÍ/social security agency contract, temporarily limited.

Advertising

People in the health care profession are forbidden to advertise their businesses. However, they are allowed to have their own internet homepage with the following information: name and profession, address, opening hours, telephone number and fax. The home pages may also carry a picture of the staff and/or of the building.

Insurance and professional indemnity

Liability insurance is a compulsory for dentists. It is called "Patients' Insurance". All insurance is provided by private insurance companies. The normal cost would be about IKR 66,000 (€560) per year.

This insurance does not cover a dentist practising abroad.

Data protection

Clinical records must be kept in a safe place and access restricted to those workers who must use them.

The Data Protection Commission is authorised, pursuant to the Act on the Recording and Presentation of Personal Information, to give access to information contained in clinical records, including biological samples, for the purposes of scientific research, provided that the research meets the conditions for scientific research, cf. Article 2 (4) of this Act. Such access may be subject to conditions considered necessary at each time. Every time a clinical record is examined for the purposes of scientific research, this must be entered into the record, in keeping with paragraph 1 and 2.

Corporate Dentistry

Only dentists may be part-owners and/or on the board of the small companies allowed in Iceland.

Tooth whitening

The supply of products with less than 0.1% peroxide is relevant to Cosmetics and is likened to sales of toothpaste – open to anybody. For products with greater than 0.1% supply and use is limited to dentists (and dental hygienists under prescription).

Health and safety at work

Inoculations, such as Hep B, are not a compulsory for the workforce, but highly recommended. The TFÍ every 5 years organise inoculations for dentists and their staff.

Regulations for Health and Safety

for	*administered by*
Ionising radiation	The Ionising Radiation Agency
Electrical installations	The Electrical Society Agency
Waste disposal	Environmental Health and Protection Offices in each commune in the country, eg. Reykjavik
Medical Devices	Icelandic Medicines Control Agency
Infection Control	Environmental Health and Protection Offices in each commune in the country

Ionising Radiation

There are specific regulation about radiation protection, they are issued by Icelandic Radiation Protection Institute (http://www.gr.is/english/). Dentists and Dental Chairside Assistance staff are educated in radio protection. There is no mandatory continuing training for radiation protection.

Hazardous waste

The EU law on the disposal of clinical waste are enforced. Since 2000 amalgam separators have been mandatory and there are regulations for the safe disposal of clinical waste.

Financial Matters

Retirement pensions and Healthcare

In Defined Benefit Schemes the retirement pension is typically 50% of a person's salary on retirement, with a lump sum of one and a half times the final salary. This assumes a minimum number of years service. All other dentists can arrange private pension schemes, contributing up to a maximum of 30% (depending upon age) of *net relevant income* to a *money purchase plan*. The retirement age in Iceland is 67. Dentists may practise beyond 67 years of age.

The government funds approximately 85% of health care costs with remaining costs being paid for privately.

Taxes

The principal direct taxes are individual income tax (the regular rate being 35.72% in 2007 after deduction of personal allowance) and corporate income tax (15%). Individual income tax is divided between a national tax of 22.75% for the income year 2007 and municipal income tax at an average rate of 12.97%. Income up to ISK 79,055 (€670) per month is tax-free. A charge of ISK 6,075 (€51.50) is levied on individuals 16- 69 years old, who have income above ISK 948,660 (€8,040) for a Construction Fund for the Elderly.

Capital gains are taxed according to special rules for financial income for individuals, but treated as ordinary income for companies. Inheritance tax is also levied.

VAT

VAT/sales tax: Payable at 24.5% on some goods; including dental equipment and consumables.

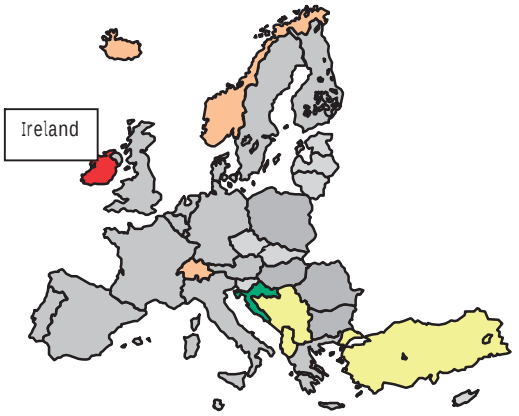
Other Useful Information

Main National association and information centre	*Competent Authority:*
Tannlæknafélag Islands Icelandic Dental Association Síðumúla 35 Box 8596 128 Reykjavik ICELAND Tel: +354 57 50 500 Fax: +354 57 50 501 Email: tannsi@tannsi.is Website: http://www.tannsi.is	Ministry of Health– Vegmula 3 - IS-150 Reykjavik - Iceland Tel: +354 545 8700 Fax: +354 551 9165 E-mail: postur@hbr.stjr.is Website: http://hbr.stjr.is/interpro/htr/htr.nsf/pages/forsid-ensk
Publication:	
The Icelandic Dental Journal – information can be found at: http://um.margmidlun.is/um/tannsi/vefsidur.nsf/index/1.0010?open	

Dental School:

The Dental Faculty The University of Iceland Tel: +354 525 4871 & - 4850 Fax: +354 525 4874 Email: givars@hi.is Website: http://www.hi.is/pub/tann Dentists graduating each year: 7 Number of students: 35

Ireland



Date of last revision: 1st October 2008

In the EU/EEA since	1973
Population (2008)	4,419,859
GDP PPP per capita (2007)	€35,532
Currency	Euro
Main languages	English
	Irish

Oral healthcare is provided through a complicated mix of publicly funded NHS schemes and fully private provision.

Number of dentists:	2,578
	2,221
Members of Dental Association:	82%

There is a well developed system of specialists, and dental hygienists are also widely used.
Continuing education for dentists is not mandatory.

Government and healthcare in Ireland

The Republic of Ireland is one of the smaller countries of the European Union in terms of population. The capital is Dublin. Compared with most other European countries Ireland has a relatively high percentage of civilian employment in agriculture and also has a burgeoning computer software industry.

Ireland is a parliamentary democracy. The National Parliament (*Oireachtas*) consists of the President and two Houses: *Dáil Éireann* (the House of Representatives) and *Seanad Éireann* (the Senate) whose powers and functions derive from the Constitution of Ireland enacted by the People on 1 July 1937. The method of election to each House is different. The 166 Members of Dáil Éireann are directly elected by the people, by proportional representation. Of the 60 Members of Seanad Éireann some are nominated and some elected.

The sole and exclusive power of making laws is vested in the Oireachtas subject to the obligations of Community membership as provided for in the Constitution. The primacy of Dáil Éireann in regard to the life of the Parliament is recognised in that a general election to Seanad Éireann must take place not later than 90 days after the dissolution of the Dáil. In matters of legislation the Constitution provides that Seanad Éireann cannot delay indefinitely the passage of legislation. Bills to amend the Constitution and Money Bills i.e. financial legislation, can only be initiated in Dáil Éireann. Seanad Éireann can make recommendations (but not amendments) to Money Bills and these must be made within 21 days as against 90 days for non-Money Bills.

In addition to its legislative role, each House may examine and criticise Government policy and administration. However, Dáil Éireann is the House from which the Government (the Executive) is formed and to which it is responsible. Should the Government fail to retain the support of the majority of the Members of Dáil Éireann, the result can either be the dissolution of the Dáil and a General Election or the formation of a successor Government.
The Houses have separate constitutional identities. However, in recent years the setting up of a well organised system of Joint Committees (i.e Committees of both Houses sitting and voting together) has resulted in Members of both Houses having additional opportunities to participate to an even greater extent in specialised parliamentary work in several areas. The proceedings of the Houses and parliamentary committees are televised.

General healthcare is administered largely by the Department of Health and Children. State healthcare expenditure in 2008 was €2281 per head per year and €644 per head per year was spent on private healthcare. However, a significant proportion of healthcare is privately funded, and the private sector is subsidised through tax allowances for health insurance premiums. State-financed healthcare is available in two ways; these are:

The Health Service Executive (HSE) is responsible for providing Health and Personal Social Services for everyone living in the Republic of Ireland. The HSE was set up as part of the provisions of the Health Act, 2004, which states the objective of the HSE is to provide services that improve, promote and protect the health and welfare of the public.

The HSE provides thousands of different services in hospitals and communities across the country. These services range from public health nurses treating older people in the community to caring for children with challenging behaviour; from educating people how to live healthier lives to performing highly-complex brain surgery; from planning for major emergencies to controlling the spread of infectious diseases. At some stage every year, everybody in Ireland will use one or more of the services provided. They are of vital importance to the entire population.

The establishment of the HSE represented the beginning of the largest programme of change ever undertaken in the Irish public service. Prior to its establishment, services were delivered through a complex structure of ten regional Health Boards, the Eastern Regional Health Authority and a number of other different agencies and organisations. The HSE replaced all of these organisations. It is now the single body responsible for ensuring that everybody can access cost effective and consistently high quality health and personal social services. The services are delivered making best use of resources allocated by Government. The largest employer in the State, the HSE employed (in 2008) more than 65,000 staff in direct employment and a further 35,000 staff are funded by the HSE. The budget of almost €15 billion was the largest of any public sector organisation.

Voluntary private health insurance

There are three providers of voluntary health insurance. One is a non-profit mutual organisation established by statute in 1957 called the Voluntary Health Insurance Board, the second and third leading independent health care organisations, the Quinn Health Group Vivas Healthcare. Under their schemes insured persons and their spouses can receive care in private and public hospitals, and outpatient specialist clinics, together with limited dental oral surgery and emergency dental trauma, optical and audiology services. Most members of the scheme (over 90%) also choose to pay enough contributions to cover the cost of private medical care. Primary care through GPs and the cost of drugs are not included.

General Medical Service from Health Service Executive (HSE)

The General Medical Service (or GMS) provides standard public, primary care services to low-income families, all persons of 70+ and dependants of those working in another EU member state. The services are provided free.

There is an annual predetermined budget by the Department of Finance and the Department of Health and Children, published in the Budget each December.

		Year	Source
% GDP spent on health	7.5%	2007	IDA
% of this spent by governm't	78.0%	2005	OECD

Oral healthcare

		Year	Source
% GDP spent on oral health	0.33%	2004	OECD
% of OH expenditure private	47%	2004	CECDO

Public health insurance

Dental health care for almost all adults is provided mainly by general dental practitioners, who are mostly self-employed and working in their own premises. There is also a public dental service for children up to the age of sixteen, and others who cannot afford private care or have restricted access to dental services and have special needs. For general practitioners care is mostly charged on a fee per item basis, but there are two ways in which patients are eligible for state subsidised treatment and the total cost of treatment is calculated differently under each. These are:

Department of Social and Family Affairs Dental Treatment Benefit Scheme (DTBS)

All employees who make Pay Related Social Insurance (PSRI) contributions, and their spouses, may receive subsidised dental treatment. This scheme is run centrally by the Department of Social and Family Affairs. The number of adults entitled to claim benefit under this Scheme was about 1.5 million in 2008 (+approx 400,000 dependent spouses) – 45% of adults. The Scheme is distinct from the Voluntary Health Insurance Scheme described in *Government and Healthcare in Ireland* and insured employees and their spouses may receive wholly or partly subsidised dental care for a limited range of treatments.

Prior approval from the Department to treat is not required under this Scheme. In 2008, 1441 dentists held a contract with the Department of Social and Family affairs to operate the DTBS.

The number of people who used DTBS scheme based on number of claims received in 2007 was 648,682 (+ 43,138 dependant spouse claims)

Department of Health and Children Dental Treatment Services Scheme (DTSS)

Whereas the dental care benefits from the Department of Social and Family Affairs are available on demand, dental care provided under this HSE Scheme is budget-limited. This means-tested Scheme was introduced in 1994, as part of the national *Dental Health Action Plan 1994-98*, and covers about 30% of adults. A range of basic treatment items is available for eligible adult under this Scheme. Prior approval for treatment is required from the HSE for complete endodontic, prosthetic or periodontal treatment. In 2007 approx 267,000 patients were treated with approx €59m in fees being paid to contracting dentists.

There is no difficulty for patients to access care on the DTSS, although if there is a shortfall in the budget allocation, practitioners may be asked to prioritise the treatment needs of patients.

About 69% of the population regularly receive dental care and patients would normally attend annually for their oral examinations. There is limited domiciliary (home) care, provided mainly by the public service.

Public (Community) Dental Service

Children and adults with Special Needs are also treated by the HSE Dental Service. They work, in the main, with children and special needs groups. All children up to 16th birthday are entitled to care from the HSE Dental Service. However, pre-school children receive what amounts to an advisory service with emergency dental care available on demand. Schoolchildren are targeted in schools in certain classes each year for preventive advice and are screened or examined depending on the resources available to that Local Area Service. Their outstanding treatment need is addressed at that point. The overall strategy is based on this targeted approach together with the application of fissure sealants on first and second permanent molar teeth.

Children and adults with special needs are also treated by the HSE Dental Service. Oral Health Promoters are employed to focus on at-risk groups, parents and carers with preventive advice.

Private Care

There are very few private insurance schemes to cover dental care costs. Those that do exist tend to be employer based, for example those for the police service. Under these schemes the patient pays for treatment and then claims a partial subsidy.

There are currently no free-standing private dental care plans in Ireland - schemes where the dentist or a group of dentists bear most of the risk.

The cost of paying privately for a limited number of items of dental care or via insurance premiums is tax-deductible under current taxation law.

The Quality of Care

For treatments where some or all of the cost is shared with the State, the standard of dental care is mainly monitored by the funding body. The Central Payments Boards of the Department of Social and Family Affairs and the HSE do this in two ways. Firstly, the claims patterns of dentists are monitored to see if they differ significantly from existing practice norms. Secondly, the Department of Social and Family Affairs uses examining dentists to check the quality and quantity of dentists' work. These checks are done at random or in response to particular complaints, but the dentist has to be contacted beforehand and the examination arranged by mutual agreement. In addition each dentist's work is routinely monitored at least once in a 5 to 7 year period in order to assure the quality of the treatment carried out.

In the case of private work not covered under either of the State Schemes the only other control on the quality of care is through patient complaints. In the first instance complaints are normally addressed to the dentist directly. If the complaint or misunderstanding cannot be resolved, it might become necessary to instigate civil litigation. The Irish Dental Association often acts as an advisory body when such complaints arise. Ultimately, the Irish Dental Council has a statutory responsibility to promote high standards of professional education and to ensure high standards of professional conduct amongst dentists.

Health data

		Year	Source
DMFT at age 12	1.10	2004	CECDO
DMFT zero at age 12	51%	2004	CECDO
Edentulous at age 65	41%	2007	IDA

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Additional data provided by the Irish Dental Association (IDA) for 2004 are:

DMFT at age 5 1.3
DMFT at age 8 0.4
DMFT at age 15 2.6

Mean no. of natural teeth present 16-24 yrs 28.1 (2007)
Mean no. of natural teeth present 35-44 yrs 25.2
Mean no. of natural teeth present 65yrs+ 8.5

Generally, epidemiological surveys are carried out by the HSE and the Department of Health & Children and public dental surgeons carry out the fieldwork.

Fluoridation

Water Fluoridation was introduced to the public water systems in Ireland in the 1960s. The amount of fluoride added to the drinking water in Ireland is controlled by law and must be in the range of 0.6 – 0.8 ppm fluoride.

There are currently no milk fluoridation or salt fluoridation schemes and a small number of supervised school-based fluoride mouthrinsing schemes.

It is recommended not to use fluoride tooth paste for children under 2 years of age in Ireland.

Parents are encouraged to supervise their children up to seven years of age while brushing their teeth so as to only use a pea size amount of paste and not to swallow it.

Education, Training and Registration

Undergraduate Training

To enter dental school students must obtain the required number of points in the Leaving Certificate Examination. No other vocational entry is possible.

Year of data:	2008
Number of schools	2
Student intake	84
Number of graduates	64
Percentage female	60%

A small number of Irish students study dentistry in the UK.

Quality Assurance of the 5-year curriculum is monitored and checked by the Dental Council.

Qualification and Vocational Training

Primary dental qualification

The title on qualification is Bachelor of Dental Science (B Dent Sc) from the University of Dublin (Trinity College); and Bachelor of Dental Surgery (BDS) from University College, Cork.

Vocational Training (VT)

There is no mandatory post-qualification vocational training. A voluntary scheme has been in operation for some years.

The aim of this vocational training in dentistry is to provide a transitional year for the newly qualified dental graduate to help prepare him/her to assume responsibility for the running of a general dental practice or a public dental service clinic and to acquire more efficiency in the skills and competencies required in the delivery of comprehensive primary dental care. It aims to provide a supportive environment for the new graduate in which he/she can adapt to the demands of general dental practice or the public dental service. It should enable the new graduate to obtain an understanding of the opportunities, methods and limitations of health promotion, prevention, early diagnosis and management in a general practice or public clinic setting.

The scheme lasts twelve months and involves a combination of private and public service practice. Each trainee on the scheme is placed with suitable trainers in both private practice and in the public service - two days per week in each location. Trainees also attend weekly academic sessions. It was intended that the intake of trainees to join the Scheme in August 2008 would be 16 trainees in various locations.

Registration

In order to practice dentistry in Ireland one must be registered with the Dental Council of Ireland (the Competent Body). Full registration includes:

i. Graduates in dentistry from a university in Ireland.
ii. Nationals of EEA Member States who graduate within the EEA with a scheduled dental degree/diploma.
iii. Nationals of EEA Member States who qualify for registration under the provisions of the Directive 2001/19/EC.

Cost of registration (2008)	€ 150

Language requirements

For citizens of EEA countries holding EEA dental qualifications there are no formal linguistic tests or other tests in order to register to practice dentistry in Ireland. However, employers are free to conduct appropriate language tests.

Further Postgraduate and Specialist Training

Continuing education

Whilst participation in continuing education is currently not mandatory, it is actively encouraged through a voluntary credits system. However, CPD is becoming mandatory for all dentists from January 2010. Course organisers apply for credit points for their courses and these are then allocated to course participants. A dentist who has accumulated a target number of points in a calendar year is entitled to a CDE Certificate.

There is an extensive system for the delivery of continuing education, through courses provided by the Postgraduate Medical and Dental Board, the Dental Schools, the Royal College of Surgeons, the Irish Dental Association, and various societies.

Specialist Training

There are two recognised specialties in Ireland.

- Oral Surgery
- Orthodontics

To become a specialist, 2 years of general professional training must be undergone after primary qualification, and this is followed by 3 years of full-time specialist training. To be a consultant may involve a further 3 years of higher training. The training takes place in university teaching hospitals in Ireland, or other such recognised training establishments – often in the UK or other EU countries.

The trainees would provide dental care during their training and would normally be paid as appropriate.

On completion of training as a specialist they would normally receive a Certificate of Completion of Specialist Training in orthodontics or oral surgery, issued by the competent authority (the Dental Council) and be entered onto the appropriate Specialist Register. They may also receive a diploma from one of the Royal Colleges of Ireland or the UK, such as a "Fellowship" or "Membership" or a Master's degree or PhD from a university.

Workforce

Dentists

Year of data:	2008
Total Registered	2,578
In active practice	1,990
Dentist to population ratio*	2,221
Percentage female	33%
Qualified overseas	634

* this refers to "active" dentists (and these figures are approximate)

Movement of dentists across borders

The number of new registrations in 2007 was 217, 108 male and 109 female. These comprised 82 Irish graduates, 115 EU and 20 non-EU registrants. Of the EU registrants, the most (30) were from Poland.

There are no reports of unemployed dentists.

Specialists

In Ireland, two dental specialties are officially recognised by the regulatory body.

Year of data:	2008
Orthodontics	110
Endodontics	
Paedodontics	
Periodontics	
Prosthodontics	
Oral Radiology	
Oral Surgery	35
Dental Public Health	
OMFS	5

Oral surgeons work mainly in hospitals and universities. Most orthodontists work in private practice, although some work in hospitals, universities and the Public Dental Service.

There are other traditional specialist areas of dentistry such as Paediatric Dentistry, Periodontology, and Endodontics, where practitioners have undertaken further training and have limited their practices to their speciality.

Patients see specialists on referral only.

There are various associations and societies for specialists - these are best contacted through the Irish Dental Association.

Auxiliaries

Other than dental chairside assistants (or dental nurses), there are three main types of dental auxiliary:

- Dental hygienists
- Oral health educators
- Dental technicians

There are no legal denturists in Ireland (there is reported illegal practice).

Year of data:	2008
Hygienists	338
Technicians	350
Denturists	0
Assistants	1,800
Therapists	0
Other	0

The figures for technicians and assistants are approximate.

Dental Hygienists

Hygienist training is undertaken at both Dublin and Cork Dental Schools, over a period of 2 years. To enter this training an applicant must have an appropriate Leaving Certificate result and be successful in an interview. Qualification is by way of a diploma, which is a registerable with the Dental Council before they can practise.

Working in all situations where dentists work, hygienists may only practise under the supervision of a dentist. This does not mean that a dentist must be present throughout treatment but rather that a dentist will have prescribed the treatment plan and must be responsible for the treatment.

A hygienist is usually paid either on a percentage of income or by an hourly rate. Health Board hygienists are paid by salary.

Oral health educators

Oral health educators give advice to individuals or groups on oral health care. This takes place with or without the supervision of a dentist. There is no registerable qualification for oral health educators although courses in Oral Health Promotion are available.

Dental technicians

Dental technicians (are also known as Dental Crafts persons) are a recognised form of laboratory worker. Training is provided by a four year apprenticeship, or a three year course at the Dublin Dental Hospital/Trinity College, leading to a Diploma in Dental Technology. There is no register. All work must be done with the prescription of a dentist.

Technicians normally work in commercial laboratories, although some work in practices. They construct prostheses for insertion and fitted by dentists and they invoice the dentist for the work that is done. They would normally be salaried.

Laboratories have to be registered with the Irish Medicines Board. This requirement arises from the provisions of the EU Medical Devices Directive.

Clinical Dental Technicians

In 2008 the Dental Council approved the grade of Clinical Dental Technician. The approval of the Minister for Health & Children is awaited before this grade can be implemented.

Dental Assistants (Nurses)

Dental nurses assist the dentist at the chairside. Many first of all undergo formal training in one of the dental schools after leaving secondary school with an appropriate Leaving Certificate result. They obtain a recognised qualification. Others are trained 'on the job' and may or may not attain formal qualification through night school. There has been voluntary registration with the Dental Council, since 2002.

Practice in Ireland

Year of data:	2008
General (private) practice	1,400
Public dental service	360
University	34
Hospital	36
Armed Forces	8
Limited practice	148
Administrative	4
General Practice as a proportion is	70%

To accept patients and receive remuneration under the Department of Social and Family Affairs Dental Benefits Scheme and the Department of Health and Children's Dental Treatment Services Scheme, dentists must contract with the Dental Section of the relevant Government Department in the case of the DTBS and with the HSE in the case of the DTSS.

Working in General Practice

Dentists who practice on their own or as small groups, outside hospitals or schools, and who provide a broad range of general treatments are said to be in *General Dental Practice*. Nearly three quarters of dentists work in this way.

Most dentists in general practice are self-employed and earn their living partly through fees from patients, and partly from government subsidised treatment schemes.

Fee scales

For care carried out under the Department of Health scheme there is a standard fee scale covering routine treatment items or different types of common treatment. The patient pays nothing and the dentist claims the total fee.

For care carried out under the Department of Social and Family Affairs scheme there are four ways in which the dentist receives payment. Firstly, for preventive and common treatments such as examinations and diagnoses, and scaling and polishing, a prescribed fee is claimed by the dentist for each item. Secondly, for some treatments there are prescribed fees, of which the government and the patient pay a set proportion each; for example for dentures 50%. Thirdly, for more complex and protracted forms of treatment such as complex fillings, periodontology and endodontics, the government pays a set amount and the patient pays the remainder as agreed with the dentist. Lastly, for crowns and bridges, inlays and orthodontics, the patient agrees the fee with the dentist and pays the whole cost.

In order to claim government subsidies under the two schemes, dentists need to join the schemes.

Joining or establishing a practice

There are no rules which limit the size of a dental practice in terms of the number of associate dentists or other staff. Premises may be rented or owned, and may be in shops, offices, houses or purpose built premises, subject to planning permission from the local authority. There is no state assistance for establishing a new practice, so generally dentists must take out commercial loans or hire-purchase agreement from banks. Alternatively, a substantial minority of dentists work for a period in the UK in order to finance the establishment of their own practice on their return. There is no constraint on where a new practice may be opened.

There are no standard contractual arrangements prescribed for practitioners working in the same practice. Dentists, however, cannot form limited companies. Incorporation is outlawed by the Dentist Act 1985. Corporate Bodies are precluded by law from the practice of dentistry.

Working in the Public Dental Service

There is a public dental service which mostly provides services to pre-school and primary school children, but also to others who are institutionalised, medically compromised or otherwise limited in their ability to access a general dental practitioner. The HSE employ salaried dentists, including a small number of orthodontists. These services are generally provided in HSE clinics but in some areas dentists in private general practice do sessional work, often as a means of building their practice numbers.

The public dental service is operated by the Health Service Executive (HSE). Public Dental Surgeons (HSE employees) are responsible for providing treatment to children under 16 years of age, adult medical card holders and patients with special needs.

The public dental service employs all dentists as *Clinical Dental Surgeons Grade 1*, *General Dental Surgeons*, or *Senior Dental Surgeons* with special skills in various specific disciplines, including treatment of patients with special needs. *Principal Dental Surgeons* also have administrative and management responsibilities. Working in the public dental service requires no additional training, but many have postgraduate qualifications. For senior dental surgeons

however, three years experience in the public dental service or the hospital dental service is expected and five years for principal dental surgeons.

Proposals for restructuring to enhance Public Dental Services, agreed between the Irish Dental Association and government, were implemented during 2000-02. Arising out of this restructuring an additional 60 Senior Dental Surgeon posts were created. The management role of Principal Dental Surgeons was also enhanced and they took on additional regional duties.

Within the public dental service there is a greater opportunity for job-sharing - working on a permanent part-time basis with the retention of pension rights. There tend to be a higher proportion of female dentists working in the public dental service than in the other forms of dental practice.

The quality of dentistry in the public dental service is assured through dentists working within teams which are led by experienced senior dentists. The complaints procedures are the same as those for dentists working in other situations. In addition, Health Boards have their own complaints-handling procedures.

Working in Hospitals

A small number of dentists work in hospitals, other than dental hospitals. They are employed as salaried employees or on a private fee basis by the national or regional government, or one of the private health companies or religious orders which own some hospitals. There are usually no restrictions on outside practice, and public health dentists and private practitioners often provide some care within hospitals.

Dentists who work within hospitals may be employed as *dental surgeons*, *senior house officers*, *registrars* or *consultants*, in the following specialist areas, Oral and Maxillo-Facial Surgery, Orthodontics and Paediatric Dentistry, Restorative Dentistry, Radiology and Oral Pathology. These are the traditional hospital and academic specialities that have existed for many years. As described earlier, to reach consultant level requires both basic specialty training (3 years), to obtain accreditation, and higher specialty training of 3 years, to obtain fellowship status.

The quality of dental care in hospitals is assured through dentists working within teams under the direction of experienced consultants. The complaints procedures are the same as those for dentists working in other settings.

Working in Universities and Dental Faculties

A small number of dentists work full-time in the two dental faculties, as employees of the universities. About 100 dentists work part-time. Most full-time staff have contracts which exclude the possibility of private practice.

The main academic titles within an Irish dental faculty are those of *Professor*, *Senior Lecturer* and *Lecturer*. Those above lecturer level will usually have a *fellowship* (of one of the Royal Colleges of Ireland or the UK) and a PhD. There is a University Promotions Scheme, which sets standard procedures for making appointments. Apart from these there are no other regulations or restrictions on the promotion.

A typical full-time faculty member of staff will have as much time committed to administration and treating patients as to research and teaching.

The quality of clinical care, teaching and research in dental faculties is assured through dentists working within teams, and under the direction of experienced teaching and academic staff. The complaints procedures are the same as those for dentists working in other situations.

Working in the Armed Forces

Only a very small number of dentists serve full-time in the Armed Forces and it has not been given how many are female.

Professional Matters

Professional association and bodies

There is a single national association, the Irish Dental Association (IDA)

	Number	Year	Source
Irish Dental Association	1,350	2008	FDI

The IDA represents all sections of the profession, and about three quarters of active dentists are members. Its aims are to promote the science of dentistry, to maintain the honour and integrity of the profession, to promote the attainment of optimum oral health for Irish people and to represent the profession in all dealings and negotiations with Government, HSE and all other relevant bodies.

Ethics

Ethical code

All dentists in Ireland have to work under a *code of professional behaviour and dental ethics* which is administered by the Dental Council of Ireland. It covers relationships and behaviour between dentists, contracts with patients, consent and confidentiality, continuing education, advertising and the quality of treatment. This includes a duty to provide emergency care for patients outside normal surgery hours.

Fitness to Practise/Disciplinary Matters

Any person can apply to the Dental Council for an inquiry into the fitness of a registered dentist to practise dentistry on the grounds of:

- alleged professional misconduct
- alleged unfitness to practise because of physical or mental disability

Each application is given due consideration and if there is a prima facie case for an inquiry such inquiry will be held. If, following an inquiry, a charge of professional misconduct is proven or the dentist is deemed unfit to practise by reason of physical or mental disability the Council may suspend the dentist's registration, attach conditions to registration or erase his/her name from the Register. These sanctions are subject to approval by the High Court.

If a complaint by a patient regarding any aspect of State funding services is upheld, a financial penalty or a warning is the most likely form of sanction. In some more serious cases a dentist may only carry out work after prior approval of all treatment plans. Occasionally the dentist may get referred to the registering body, or lose their right to practise in the state-assisted system. At all stages dentists have a right of appeal within the complaints procedures, to the Minister of Health and Children, via the HSE or to the Minister of Social and Family Affairs.

As far as the relationship of the dentist with their employees and with other dentists is concerned, whilst there may be no specific contractual requirements between practitioners working in the same practice dentists are strongly advised to have some. A dentist's employees are protected by the national and European laws on equal employment opportunities and anti-discrimination, maternity benefits (18 weeks in the public sector), occupational health, and health and safety.

Advertising

The Dental Council is obliged under legislation to give guidance to the dental profession generally on all matters relating to ethical conduct and behaviour. A new Code of Conduct for Advertising and Public Relations has been approved by the Dental Council and was implemented in late 2008. This will permit advertising by the profession as long as it is factual and does not mislead the public.

The EU Directive on Electronic Commerce was implemented in January 2003.

Data Protection

Ireland fully implemented the Directive on Data Protection during 2003.

Corporate Dentistry

Dentists are not allowed to form corporate bodies (companies). Corporate Bodies are precluded by law from engaging in the practice of dentistry.

Indemnity Insurance

Liability insurance is provided for HSE Public Dental Surgeons and is compulsory for general practitioners participating in either the Department of Social and Family Affairs or the Department of Health and Children Schemes.

While it is not compulsory for other dentists, it is strongly recommended and is, in fact, held by virtually all of the practising profession. It provides cover for advice, legal costs and unlimited indemnity. There are different prices for different types of dentist and a general dental practitioner pays approximately €2,200 to €2,950 annually. This will also cover them for a limited period whilst working abroad.

Tooth whitening

In 2008, in addition to dentist-provided treatments tooth whitening was being carried out by non dental professionals in a non surgery environment, due to the lack of specificity of the regulations on the matter.

The IDA and IDC were awaiting clarification by the EU on matters in relation to who can apply these products at or above certain limits of concentration and about the availability of these products over the counter.

Health and Safety at Work

A known Hepatitis B carrier cannot work in a hospital or HSE facility in a clinical capacity. For all clinical workers an appropriate antibody titre is desirable. Hepatitis inoculation is highly recommended for GPs. Hospitals and HSE monitor their own staff.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Radiological Protection Institute of Ireland
Electrical installations	Local government, Health and Safety Departments
Waste disposal	Local government, Health and Safety Departments
Medical devices	Irish Medicines Board
Infection control	Irish Dental Council

Ionising Radiation

Training in radiology is part of the undergraduate curriculum and no further training or continuing education or training is needed for dentists.

Qualified dental nurses and hygienists can train to provide these services but there is no validation of this training. Dental Nurses who have registered with the Dental Council can take radiographs as long as they have attended a course which has been approved by the Dental Council.

EU Directive 97/43/ Euratom was transposed into Irish Law by SI 478 (2002). This law requires dentists to adhere to best practice in radiology. All dentists must acquire a licence from the RPII (Radiological Protection Institute of Ireland) for an x-ray unit on their premises.

Hazardous waste

The EU Hazardous Waste Directive has been fully transposed into Irish law. However, the detailed regulations have not yet been implemented and the installation of amalgam separators was not yet mandatory in 2008.

Financial Matters

Retirement pensions and Healthcare

For state-employed dentists, the dentist contributes about 5% of earnings, plus 1.5% widows and orphans contribution. Retirement age is 65 years. Full pension entitlement is predicated on 40 years service after which time a lump sum of 150% of final salary and an annual pension of 50% of final salary is paid.

All other dentists can arrange private pension schemes, contributing up to a maximum of 30% (depending upon age) of *net relevant income* to a *money purchase plan*. The retirement age in Ireland is 65. Self-employed dentists may practise beyond 65 years of age.

The government funds approximately 80% of health care costs with remaining costs being paid for privately. VHI and BUPA pay for private hospital care up to the level at which an individual is insured. Sickness benefit usually comes from the state in the case of an employed person, or from private health insurance in the case of a self employed person.

Taxes

There is a national income tax (dependent on salary), and Pay Related Social Insurance (PSRI). The highest rate of income tax is 42% on earnings over about €35,000 (married person), €28,000 (single).

VAT

VAT/sales tax: Payable at 21% on some goods; including dental equipment and consumables.

Various Financial Comparators

Zurich = 100	Dublin 2003	Dublin 2008
Prices (excluding rent)	82.8	102.1
Prices (including rent)	89.2	107.7
Wage levels (net)	66.1	94.3
Domestic Purchasing Power	76.5	87.5

Source: UBS August 2003 and January 2008

Other Useful Information

Main national association and information centre:	*Competent Authority:*
Irish Dental Association, *CUMANN FIACLÓIRÍ na hÉIREANN* Unit 2 Leopardstown Office Park, Sandyford Dublin 18 IRELAND Tel: +353 1 2950072 Fax: +353 1 2950092 Email: info@irishdentalassoc.ie Website: www.dentist.ie	The Dental Council of Ireland 57 Merrion Square Dublin 2 IRELAND Tel: + 353 1 676 2069 Fax: + 353 1 676 2076 E-mail: dentalcouncil@eircom.net Website:
Postgraduate education:	*Publication:*
The Postgraduate Medical and Dental Board of Ireland Corrigan House, Fenian Street, Dublin 2, IRELAND Tel: ++ 353 1 676 3875 Fax: ++ 353 1 676 5791 Email: info@pgmdb.ie Web: http://www.pgmdb.ie	Journal of the Irish Dental Association – address as above, for the IDA

Dental Schools:

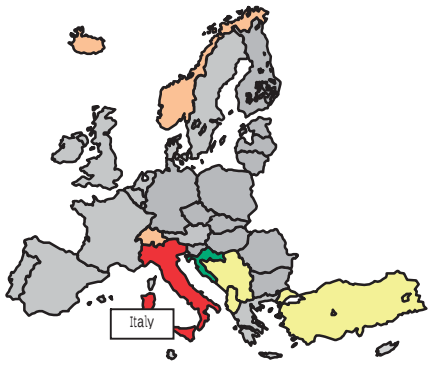
City: Dublin

Name of University: Trinity College
The Dean
Dental School
Trinity College
Lincoln Place
Dublin 2
IRELAND
Tel: +353 1 612 7306
Fax: +353 1 671 1255
Email: info@dental.tcd.ie
Website: www.tdc/ie/dentalSchool
Dentists graduating each year: 35
Number of students: 200

City: Cork

Name of University: Cork
The Dean
University Dental School and Hospital
National University of Ireland, Cork
Wilton
Cork
IRELAND
Tel: +353 21 454 5100
Fax: +353 21 434 3561
Email:
Website: www.ucc.ie/ucc/denthosp/
Dentists graduating each year: 29
Number of students: 220

Italy



Date of last revision: 1st October 2008

In the EU/EEA since	1957
Population (2008)	59,618,114
GDP PPP per capita (2007)	€24,596
Currency	Euro
Main language	Italian

General public healthcare is funded largely through general taxation, with small co-payments by patients limited to specific classes of pharmaceuticals, specialist visits and diagnostic services, with various exemptions (medical conditions and income levels). Oral healthcare may be limited to emergency treatment only and most dentistry is therefore provided through liberal, private practice.

Number of dentists:	54,190
Population to (active) dentist ratio:	1,242
Members of Dental Associations (two):	40%

The use of dental specialists is limited and the development of clinical dental auxiliaries is limited to hygienists.
Continuing education for dentists has been mandatory since 2002.

Government and healthcare in Italy

Italy is a democratic republic, on the north side of the Mediterranean Sea. Italy is one of the founder countries of the EU. The capital is Roma.

Italy has a central government elected by (mainly) proportional representation. The country is divided into twenty one regions. Each region has an elected parliament or council which can raise local taxes. Regions are responsible for a range of functions including agriculture, the environment, planning, the arts and sanitation. The Regional powers are through ongoing revisions of the Italian Constitution and federalist legislation.

Healthcare is currently a constitutional right for all citizens. The budget for health services is decided nationally and funds are allocated via the Regions on a per capita basis. The central government establishes health coverage, (namely, the typology of services guaranteed under the NHS provision) called LEA - Essential Levels of Assistance. Its priorities are through the National Health Plan and the national budget. The whole process is based on consultation and, in reality, on the agreement with the regional governments through the so-called *"Conferenza Stato/Regioni"* (State/regional conference).

Even if the resources are public (taxation and state budget), the NHS and the Regional budget are produced by national and local taxation, together with a very small amount of self financing through the application of tickets, co-payments and services provided on a private payment basis. Some innovations (for example, which specific taxes and in what percentage can be levied by the local authorities, regions and municipalities) follow the implementation of Federalist legislation, while the entire process of delegation of powers and responsibilities to the regions is still ongoing.

The political responsibility of the regional health service is on the *"Assessore alla sanità"* (Health Commissioner, who is a member of the Regional Government.). The institutional and organizational structure of each of the 20 regional services is made by *"Aziende sanitarie locali"* (local health public enterprises or firms) and *"Aziende ospedaliere"* (hospital public enterprises). Each region appoints a general manager to manage its health local and hospital enterprises. The general managers are supported by other technical (medical and administrative) bodies.

Hospitals are mainly paid for the services provided (Italian DRGs: MMGs), while the other sectors (general practice, specialists, etc.) are paid through services tariffs or a per capita quota. The third component of the NHS is the "Public Health Service", mainly public hygiene, prevention, etc. The various services are provided in the following way:

Hospital care, primary care, specialist care, actually, all services guaranteed under the LEA (Essential levels of services) are provided free of charge. There are two exceptions: tickets applied to a certain class of drugs (all those out of class A, are guaranteed to everybody free of charge, class B 65 of the charge and class C the full charge) and a co-payment applied to specialist services, namely visits (for example, a visit to a cardiologist, a neurologist, etc.) and laboratory and diagnostic services. Emergency care is free at the point of delivery but, in some regions if the patient is not hospitalised he has to pay for the services received, because the emergency was deemed to be inappropriate. Persons who are considered "frail", by their economic condition or specific health conditions, those aged under 6 and over 65, are exempt of every ticket and co-payment.

		Year	Source
% GDP spent on health	9.0%	2006	OECD
% of this spent by governm't	77.1%	2006	OECD

Oral healthcare

In principle, there is a comprehensive oral health care system, which functions within the National Health Service. Only implants are formally excluded. However, in reality, the service provided depends on local priorities for health and thus varies enormously, even from town to town within a region. In many areas, only emergency treatment is provided. So, in practice, publicly provided dental treatment comprises mainly extractions and only occasionally restorations. Considering that there is an extensive under-provision even in the areas where there a public duty to deliver dental care, dentistry is in point of fact a private sector service. In the last few years, however, there are signs of an increase of public supply both in the form of new models of delivery and of joint public/private financing (especially in Lombardia, Piemonte, Veneto, Emilia and Romagna).

LEA

The revision of the LEA made in 2008 (Livelli essenziali di assistenza = Essential Level of Assistance) redefined and updated the range of services and treatments offered by the SSN (= NHS)

For dental care the relevant national regulations define the criteria upon which the LEA are determined and regulate the Integrative Funds of the NHS, and the definition of LEA.

Such national regulations state that the oral health care, on NHS charge, is limited to:

1. Dental health care programmes dedicated to the age of development (0-14 years)
2. Dental and Prosthetic care to subjects with particular conditions of vulnerability.

The evaluation of the current interventions at regional level, lead to the activation of following programmes for the 0-14 years group:

- the monitoring of cavities and malocclusions
- the treatment of cavity pathology
- the correction of the most risky orthognathodontic pathologies (Grade 5 of the IOTN index).

Receivers
All citizens in the age of development (0-14 years).

Treatments:
1. Dental visits: to all subjects in the age group, without limit of frequency, for diagnosis
2. Other treatments, including extractions, periodontal surgery, reconstructive oral surgery, scaling, etc.
3. Dental and Prosthetic care to people with particular conditions of vulnerability.

Two different categories of 'vulnerability' can be defined:
1. "Sanitary" vulnerability: conditions of sanitary kind which make dental treatments essential or necessary;
2. Social vulnerability: conditions of social and economic disadvantage generally related to the low income and/or to marginality or social exclusion which prevent access to private dental treatments.

SANITARY VULNERABILITY
To define the conditions of sanitary vulnerability two different criteria are adopted:

- First one takes into account the diseases and the conditions they are frequently or always associated with and complications of dental nature. (for example: abiopalatoschysis and other familial malformations, some rare diseases, drug addiction, and so on.)
- Second one takes into account the diseases and the conditions in which the health conditions could worsen or be compromised by concurrent dental pathologies.

Receivers:
In this aspect, the following six conditions are defined:
1. patients who are waiting for transplant and post-transplant
2. patients with severe immunodeficiency
3. patients with cyanogenic familial heart diseases
4. oncoemathological pathologies in children
5. patients under radiotherapeutic treatment for neoplasias
6. severe bleeding

However, characteristics and features of each pathology should be defined in details as well as the period of the benefit concession (ie the length of post-transplant assistance).

Moreover, the modalities and the ways where these subjects can be identified need to be punctually defined.

Treatments:
Considering the extent and the gravity of the pathologies, people with the so-called sanitary vulnerability all dental treatments prescribed by the individual sanitary plan and included in the general nomenclature are guaranteed treatment, with the exception of prosthetics and aesthetic interventions.

SOCIAL VULNERABILITY
Among all the conditions of social vulnerability three different situations are identified where the access to dental treatments is hindered or prevented:

1. social exclusion
2. poverty
3. low-middle income.

Receivers:
The Regions and other self-ruling Provinces are asked to choose instruments for the evaluation of the socio-economic situations and the criteria to select the social vulnerable populations as receivers of specific dental performances.

Treatments:
all socially vulnerable subjects are guaranteed:
1. dental examinations
2. dental extractions
3. fillings and root canal therapies
4. provision of removable appliances (but not including prosthetic appliances)
5. application of dental appliances to subjects from 0 to 14 years of age with a IOTN index = 5 (but not including the cost of the fabrication)

6. deep pulpotomy in immature root apices for 0 to 14 years group.

GENERAL POPULATION
Finally, to all citizens, included the ones who are not part of the indicated protection groups the following treatments are guarantee:

1. dental examinations, at the end of the early diagnosis of neoplastic pathologies of the oral cavity
2. immediate treatment of odontostomatologic urgencies - treatment of severe infections, bleeding, severe pain, including pulpotomy (with direct access)

In most regions orthodontic or prosthetic treatment is not normally covered by the public system. Since the amount of treatment in the Public Health Service is limited by local priorities and the budgets that are available, most care is in fact provided from Private Dental Practice.

		Year	Source
% GDP spent on oral health	1.40%	2004	Manual
% of OH expenditure private	97%	2004	Manual

Public expenditure on dentistry was estimated in 2003 to be only approximately €500 million. Public dental expenditure, however, has increased slowly in the past few years and it is a very dynamic component of the regional public budget, because in the main the regions are trying to increase supply. Private dental expenditure is estimated to be about €10 billion.

In 2006 an average Italian family spent €1,300 per year on oral health care.

Private insurance for dental care

There are some private healthcare insurance plans, but largely they exclude routine dental care. Most, however, include hospital-based oral surgery on an "item of care basis". There are no private dental care plans.

This market is changing however, because there is a trend to develop dental plans as a part of the coverage provided by supplementary health insurance.

Quality of Care

There is no formal direct monitoring in either the public or private sector, other than patient complaints. Both public and private practices are nevertheless "authorised" by District Health Service (ASL) Inspectors, which means that have to obey to certain professional and structural standards.

Beside mandatory authorisations, some regions have developed and applied rules of accreditation. In Italy, accreditation means that practices hold higher levels of structural, professional and technological characteristics.

Regional (Lombardia) and national surveys in the early years of this century revealed that patients have high confidence in their dentists and are satisfied with their services, including the fees paid for treatment.

Access

Patients in Italy do not have problems of access to private dentists. But, patients have access problems in the public sector, with under-provision (even if the treatment is guaranteed to be available) or waiting lists.

Half of the population attends a dentist at least once a year. Intensity of treatment, that is the number of dental visits per persons per year, is estimated however to be low comparing to international standards. Re-examinations for adult patients occur usually on an annual basis.

Health data

		Year	Source
DMFT at age 12	1.13	2006	OECD
DMFT zero at age 12	No data		
Edentulous at age 65	No data		

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There is no water fluoridation in Italy but there are many springs of natural fluoride of volcanic origin in various regions.

Since 1980 ANDI has held a "Month of Dental Prevention", every October. ANDI dentists' examinations are free of charge in that month. During the visit the dentist explains the importance of oral and dental care prevention and distributes a tube of flouride toothpaste, a tooth brush and floss to the patient.

Education, Training and Registration

Undergraduate Training

To enter dental school a student has to have completed secondary education (high school) and have a diploma, at the ages of approximately 18 to 19 years. There is an entrance examination to dental school and a "numerus clausus" is applied to each school.

Year of data:	2008
Number of schools*	34
Student intake	850
Number of graduates	800
Percentage female	30%

* Two more schools are not in this table as they had not yet enrolled any students in 2008. Two others (included here) had not yet graduated any students.

All dental schools are located in universities as Faculties of Dentistry in Colleges of Medicine. They are all state owned, except the University Cattolica in Rome. The dental course is 5 years in length. Students in the private dental school are responsible for paying their own fees. Foreign students are estimated to be about 50 in number.

Quality assurance for the dental schools is provided by the Ministry of Education, with some joint responsibility with the Ministry of Health.

Qualification and Vocational Training

Primary dental qualification

The primary degrees which may be included in the register are:

- *University degree in Dentistry and Dental Prosthesis* with
  - a *Degree to practice dentistry and dental prosthesis*.

  or (until January 2003)
- *a University degree in medicine and surgery* accompanied by the
  - *Specialization in the dental sector* with
  - *a Degree to practice medicine and surgery*

From January 2003, the EU Directives were fully implemented by the Italian Government, and only a university degree in Dentistry is acceptable for first registration as a dentist in Italy.

Until 2003 there was a confused situation in Italy: from 1897, by law it was mandatory to have a university degree in medicine and medical surgery (6 years) to practice dentistry. The first (5-year) university degree in dentistry was introduced in 1924, but a law of 1926 confirmed that the medical university degree was still necessary to practice dentistry. Traditionally, therefore, dentistry was a specialty of medicine, with or without formal training in dental subjects.

A Presidential Decree of 1980 introduced (again) the 5-year university dental degree, according to the EC Directives but a further law in 1985 confirmed that two ways of training (through a medical degree and a specialisation of "Stomatology", or a dental degree) could lead to registration as a dentist. In 1991 the European Court ruled that the Italian law permitting medical doctors to practice dentistry was illegal and that all medical doctors already practising dentistry must be enrolled in a Dental register.

The Stomatology specialisation was abolished by a Decree in 1993 and in 1995 the European Court ruled that physicians who practiced dentistry according to Italian laws were *ultra viraes*. In 1998 the Commission's view that physicians had to have attended proper dental courses was ratified in Italian law.

Vocational Training (VT)

There is no post qualification vocational training in Italy.

Registration

To register as a dentist, an applicant must have a degree or diploma in dentistry recognised by the Ministry of Health (Foreign Affairs) and by one dental faculty, and be a citizen from an EU or other appropriate country. The registration list is held by the *Federazione Ordini dei Medici Chirurghi e degli Odontoiatri* - the competent authority for dentistry. The registration process is the same for all dentists, and there are no regulatory tests. The amount of the annual registration fee varies as it is decided by each provincial branch medical/dental board.

Language requirements

There are no formal language requirements to register.

Further Postgraduate and Specialist Training

Continuing education

Since 2002 there has been a formal requirement for continuing education for dentists. The validation rules for mandatory continuing education set by the Italian Ministry of Health stipulate that dentists must undertake 150 units of CPE within a 3-year period (2008-10), including a minimum of 30 and a maximum of 70 each year.

Specialist Training

In Italy only two specialties, Orthodontics and Oral Surgery, are recognised. In each case formal training lasts for three years and takes place in a University. The titles upon qualification are respectively:

- Diploma di specializzazione in 'Ortognatodonzia'
- Diploma di specializzazione in 'Chirurgia Odontostomatologica'

Trainees are paid during the period of training for their specialisation, when specialisation follows the first degree. Resources were made available by the Ministry of Health and are a component of the overall financing of the NHS. New university reform has introduced Masters and PhD degrees to Italy.

Workforce

Dentists

Year of data:	2007
Total Registered	54,190
In active practice	48,000
Dentist to population ratio*	1,242
Percentage female	34%
Qualified overseas	550

In October 2007, approximately 14,190 dentists had been trained according to the EU Directives, approximately 9,000 were graduates in medicine with dentistry as a specialty (the old system) and 30-31,000 were medical graduates without formal specialist training in dentistry. It is not clear how many restrict their work to dentistry only, and how many practice both medicine and dentistry.

There is some reported unemployment amongst dentists in Italy, because of supply-demand imbalance, above all in southern Italy. There is also what is called "underemployment", that is to say dentist with a very low number of patients has insufficient to earn enough in fees to cover the expenses of keeping open the practice or to earn a basic reasonable income.

Movement of dentists across borders

In 2007, there were over 500 foreign graduated dentists working in Italy. An unknown quota comes from other European countries - above all, those close to the Italian borders. Another quota comes from outside the EU, following increases of immigration. Additionally, it is known that there is movement across the northern border of Italy and that this is on the increase. Italian graduates tend to go to the French speaking countries when working abroad, but some go also to the UK and the US.

Specialists

In Italy, two specialties, Oral Surgery and Orthodontics are recognised. Most specialists work in private practice and see patients on referral from private practitioners. The ratio of specialists to other dentists is estimated to be very low (no more than 5%).

Year of data:	2007
Orthodontics	1,900
Endodontics	
Paedodontics	
Periodontics	
Prosthodontics	
Oral Radiology	
Stomatology	9,000
Oral Surgery	50
Dental Public Health	
OMFS	640

As stated above, stomatology is where a medical practitioner has dentistry as a specialty and so is not a specialty in the generally accepted sense.

There are many regional associations and societies for specialists. These are best contacted via one of the national dental associations.

Auxiliaries

Other than chairside assistants, there are two kinds of recognised auxiliaries. They are:

- Dental Hygienists
- Dental Technicians

Year of data:	2007
Hygienists	4,000
Technicians	11,520
Denturists	0
Assistants	52,000
Therapists	0

Dental Hygienists

Education and training is provided for this group by universities and lasts for three years, leading to a diploma which must be obtained before a dental hygienist may legally practice. Numerous Clausus to access is established and an exam of admission has to be passed. Other two years of special training in specific oral social topics might be added. About 70% are female. There is no register.

Hygienists can only work under the prescription of a dentist who must be present in the same practice at all times. Their duties (defined by Decree in 1999) include oral hygiene instruction, scaling and dietary advice. Hygienists are unable to administer local anaesthesia.

Hygienists in Italy are normally salaried; however, most of them work as liberal professionals and in these cases their incomes may vary individually. Law number 43/2006 governs the profession.

Dental Technicians

Dental technicians are trained in independent professional (technical) schools over 4 or 5 years, to diploma/certificate standard. The qualification has to be registered with the *Camera di Commercio* of each Province.

Technicians cannot work at the chairside, or treat patients, and are only legally allowed to manufacture prostheses from a dentist's prescription.

They are salaried or professionals who own their private laboratories, deriving their income from the provision of services to dentists. The majority of them are associated in a syndicate.

There is also a considerable amount of illegal practice in Italy by dental technicians, some of which is thought to be condoned by medical practitioners, who cover for the technicians concerned.

Chairside Assistants

Dental chairside assistants' education and training is normally provided by individual dental practitioners, but they may receive a Certificate of a Regional School, if they have attended for a 1-2 years training course (in Lombardy and Trentino Alto Adige Universities and Hospitals, and sometimes by the dental associations).

Their duties are restricted to assisting the dentist at the chairside, including (for example) sterilising instruments, mixing filling materials and undertaking administrative duties.

Practice in Italy

Year of data:	2007
General (private) practice	44,400
Public dental service	2,200
University	400
Hospital	300
Armed Forces	100
General Practice as a proportion is	93%

Working in General Practice

In Italy, most dentists who practice on their own or as small groups, outside hospitals or schools, and provide a broad range of general treatments are said to be in "Private Practice".

They are self-employed and charge fees almost exclusively as 'items of service', the levels of which are controlled by market forces. There are thought to be about 45,000 dentists who work in private practice, but this includes many medical physicians and general practitioners who have some dental equipment in their office. The Ministry of Finance lists as dentists those who have a specific fiscal dentistry code and the numbers of these dentists is less than three quarters of those registered.

As employers, private dentists contract with their staff on terms that are negotiated centrally. This contract includes pay, hours of work, sickness, holidays, maternity leave, pensions and social security payments. It is part of a national social agreement, is not exclusive to dental practice and is very strictly applied. Benefits other than pay are funded by workers' and employers' contributions. The structure of practice is changing, although slowly. Some dentists join and build big practices, and multi-specialty dental practices. The public sector is very active in this trans-formation, even if change is driven by private professionals.

Joining or establishing a practice

There are no controls on the establishment of dental practices other than opposition through local planning regulations, but premises must be inspected by a Public Health Official before use. Newly qualified dentists usually work as assistants or in the Public Dental Service. A few of these then become partners but most (60%) buy an established practice and the rest (30%) start new practices. No central funding is available for the purchase of practices and loans must be obtained from banks or other commercial institutions.

Fee scales

According to the law for liberalisation that abolished dental minimum fees, no minimum fees are scheduled in Italy. In November 2007 ANDI produced and published a new private scale of dental fees, the "Nomenclature & Fees Booklet", which is described as a voluntary benchmark.

Working in the Public Dental Service

The Public Dental Service exists to a varying extent in most regions as an alternative to private practice. It thus provides the only government funded primary care. Every region has a number of clinics each of which is managed by a Clinical Officer who directs a number of Heads of Departments, at least one of whom will be a dentist if dental services are provided.

This individual will then be responsible for the staff within the department. Apart from medical and dental care, social services and environmental health support is provided, and unusually, veterinary care. There is no formal structure below Head of Department and no titles, but there are salary differences largely dependent on length of service.

Theoretically, all groups in society are eligible to attend the service, but in reality it is largely used by the lower middle class, who cannot afford private care. In a few regions, school screening programmes have been introduced, together with some prevention and oral health promotion. In general, these activities are exceptional and not standard. All public service dentists are salaried.

Working in Hospitals

Some dentists are employed in hospitals, either full or part-time, to treat emergency cases or perform general treatments on hospitalised patients. Each hospital has a Director (*Primario*), an Aide (*Aiuti*) and Assistant Dentists or Volunteers who work without salary in order to gain experience. Most of these staff have no specialist training, and promotion is obtained by national competition, when curriculum vitae are considered by local committees.

Working in Universities and Dental Faculties

Dental school staff are all salaried, and either work full-time, or 30 hours per week supplemented by private practice. The number of staff in each of the 30 publicly funded schools is prescribed by the Ministry of Health and Education, as is the proportion in each grade.

Progression through the grades is by national competition, as in hospitals. The hierarchy is: full professor, associate professor, researcher (lecturer).

Working in the Armed Forces

Some military hospitals have dental beds and ambulatories. It is unknown what proportion of AF dentists is female.

Professional Matters

Professional association and bodies

	Number	Year	Source
ANDI	21,824	2008	ANDI
AIO	7,033	2008	FDI

There are two main national dental associations, the Associazione Nazionale Dentisti Italiani (ANDI) and the Associazione Italiana Odontoiatri (AIO).

The origins of ANDI lie in the historical right of doctors to practise dentistry with or without specialisation. This right was removed after the implementation of the Dental Directives in 1985. When new dentists started graduating according to the EC Directives, AMDI (of which ANDI was then a part) changed its constitution to allow them to become members.

ANDI has an Executive Board formed by the President, Secretary and Treasurer who are elected every three years by the General Assembly. The GA elects the national councillors of Executive Board.

ANDI has its own Head Office located in centre of Rome with a full time staff of 9 employees. From May 2008 all the activities carried out by ANDI Headquarters have been certified according ISO-9001 Certification.

ANDI has 21 regional branches and 99 provincial branches with their own offices and employees.

ANDI Publications are distributed free of charge to all members and Institutions.

In 1984, AIO was formed to provide separate representation for this new class of university trained dentists, if they wished.

AIO has an Executive Board comprising the President, Secretary and Treasurer, who are elected every three years by the General Assembly. The GA elects the national Councillors of the Board.

AIO has its own Headquarters in Turin with one employee. AIO has 30 provincial /district branches in the Italian provinces. AIO Publications are distributed free of charge to all members.

Both ANDI and AIO represent all the different bodies within the dental profession - private practitioners, state employed dentists, university teachers and dental specialists.

The AIO and AISO (Italian Dental Student Federation) are founding members of the FOI (Italian Dental Confederation).

Ethics and Regulations

A national body looks after the registration and ethics of dental practitioners, the *Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri*.

It was founded in 1946 with the purpose to coordinate the provincial Orders and to supervise nationally the professional behaviour of doctors and dentists; to encourage and support actions for increasing their professional competence and to cooperate with Public Bodies to solve national health questions.

The Provincial Orders that the National Federation regroups and represents unitarily, develop different functions and the more important are :

1. Keep the Roll
2. To maintain the independence and dignity of the Orders and of the members
3. To promote the cultural progress of the members

It has disciplinary powers as regards the members.

Italian law defines the care a dentist may provide as: *"All acts for prevention, diagnosis and treatment of defects and diseases of the mouth, teeth, jaws and adjoining tissues, congenital or acquired."*

Ethical Code

Italian dentists have an ethical code which is identical to the medical code. The code is administered in each Province by a committee of dentists who are elected every three years. By law there are five members in each provincial committee. There is no consumer or other representation, but legal advice may be available. In each triennium, the Presidents of the Provincial Committees meet to elect five members to a National Committee for ethics, which then appoints its own President.

Fitness to Practise/Disciplinary Matters

Each ethical body has disciplinary powers and patients can complain to them about the care that they have received. Both the patient and the dentist can be legally represented during any hearings.

If found guilty of a breach of the code, a dentist can be warned or admonished, temporarily suspended up to a maximum of six months or permanently suspended for bringing the profession into disrepute. Warnings can be given for failure to provide an estimate of the cost of treatment.

Dentists can appeal to a central appeals committee which has a state judge as a member. Patients can appeal to the National Ethical Committee and/or take civil action against the dentist. If such an action is successful then the case is referred back to the disciplinary process.

The above system applies to both the private and the public sector. In practice some dentists have been temporarily suspended, but very few permanently.

Standards

There is no formal monitoring in either sector other than patient complaints. In private practice these would be directed to the appropriate ethical committee but in the Public Service they are first investigated by a clinical officer who theoretically has the power to suspend or fire the dentist concerned. In practice this never happens and cases are instead considered by a Regional Board of Specialists who in extreme cases may refer them to the Ethical Committee.

Data Protection

Italy has complied with the Data Protection Directive and personal data are protected under the new rules of the privacy code. Patients have to sign a release form, in order

to make available data for professional and scientific reasons.

Advertising

Dental services can be advertised according the Code of Ethics and dentists can only inform the general public of their title and area of practice.

There is no specific Italian position relating to the Advertising, Electronic Commerce and Data Protection Directives..

Insurance and professional indemnity

Liability insurance is not compulsory for dentists but insurance is provided by private general insurance companies (addresses available from the dental associations), or the dentists themselves. Exact cover and the cost of the insurance depends on the contract and the type of practitioner.

Corporate Dentistry

Dentists can join together and for professional companies, namely companies where the only partners are dentists. Non- dentists can be members of these professional companies, but clinical matters must be the responsibility of a Dental Director.

Tooth whitening

Tooth whitening is considered a medical device depending on the percentage content of whitening agent, as established by EU Directive.

Health and Safety at Work

In the case of accidental inoculation or wound from patients at risk, public health services are available for the private practitioners, single dentists or Dental Associations and are linked to private insurances for *professional* diseases, which are not compulsory, but the proper protocols in this matter (of the Public Health Service) must be followed.

Ionising Radiation

Radiation protection is regulated by law. Training in radio protection is mandatory for undergraduate dentists with updates from the dental associations.

The competent person and therefore responsibility is always of the dentist. The equipment must be registered and every one two years it is mandatory that an XR Qualified Expert should check the equipment. And, continuing education and training of the dentists is necessary every 5 years.

Hazardous waste

Clinical waste is stored for a month at the practice and given to a sanitary waste company at the end of every month. X-Ray liquids and amalgam are normally disposed of once a year. There is a specific book where these operations should be always written and described - about stored quantities

Amalgam separators are not compulsory by law.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Regional government Assessorato Sanità
Electrical installations	Government Ministero Industria)
Infection control	Government (Ministero Salute)
Medical devices	Government (Ministero Salute)
Waste disposal	Regional regulation

Financial Matters

Retirement pensions and Healthcare

Pension premiums are paid at between 12.5% and 20% of gross earnings for self-employed people. Those employed pay 8.89% which is increased to 32.7% by the employer. The right to join the 'private providence institution' (called ENPAM) has been recognised. The contribution is 12.5% and this provides cover for sickness, maternity leave, pensions and social security.

Retirement pensions in the public sector are typically 80% of a person's salary on retirement. Retirement ages are 63 (women) and 65 (men).

In the public sector dentists can practice until the age of 70. In private practice the decision when to work and retire depends upon an individual dentist.

Taxes

The highest rate of income tax is 45% on earnings over about €75,000. Currently self-employed people pay 5% extra tax on their gross annual income, as a contribution to the public health system.

VAT/sales tax

VAT is payable at various rates depending on the type of goods. Dentists pay 19% on most materials and equipment, but VAT is not payable on treatment.

Other taxes are also payable for the creation of waste, advertising and the use of X-rays.

Various Financial Comparators

Zurich = 100	Rome 2003	Rome 2008
Prices (excluding rent)	73.4	80.6
Prices (including rent)	79.7	82.4
Wage levels (net)	33.4	59.0
Domestic Purchasing Power	44.3	73.3

Source: UBS August 2003 and January 2008

Other Useful Information

Main national associations:	*Information Centre:*
Associazione Nazionale Dentisti Italiani (ANDI) Lungotevere Raffaello Sanzio 9 I - 00153 Roma ITALY Tel: +39 06 5833 1008 Fax: +39 06 5830 1633 Email: esteri@andinazionale.it Website: www.andi.it	Federazione Ordini dei Medici Chirurghi e degli Odontoiatri, Piazza Cola di Rienzo 80/A Roma ITALY Tel: +39 06 362 031 Fax: Email: webmaster@fnomceo.it Website: www.fnomceo.it
Associazione Italiana Odontoiatri (AIO) Via Cavalli 30 10138 Torino ITALY Tel: +39 11 4336917 Fax: +39 11 4337168 Email: aioto@tiscalinet.it Website: www.aio.it	
Competent Authority:	*Publications:*
Ministero della Salute Divisione Ospedaliera Ufficio No 6 Via Dell' Industria 20 I 00144 Roma Lungotevere Ripa 1 Roma Tel: +39 06 59941 Fax: +39 06 59942 417 Email: ecmsupporto@sanita.it Website: www.ministerosalute.it	ANDI and the AIO both have national journals: AIO: *Prospettiva Odontoiatrica* ANDI: *ANDI Informa* There are also numerous scientific journals

Dental Schools:

Name of school: Ancona UNIVERSITÀ POLITECNICA DELLE MARCHE - ANCONA Istituto di Scienze Odontostomatologiche Facoltà di Medicina e Chirurgia Via Tronto,10 - 60020 Torrette di Ancona ITALY Tel: +39 71 2206219/20 Fax: +39 71 2206221 Email: odonto@univpm.it Dentists graduating each year: 24 Number of students: 120	Name of school: Bari UNIVERSITÀ DEGLI STUDI DI BARI The Dean of the Dental School DIPARTIMENTO DI ODONTOSTOMATOLOGIA E CHIRURGIA P.zza Giulio Cesare,11 70124 Bari ITALY Tel: +39 80 5478762 Fax: e-mail g.favia@doc.uniba.it Dentists graduating each year: 35 Number of students: 175
Name of school: Bologna UNIVERSITÀ DEGLI STUDI DI BOLOGNA DIPARTIMENTO DI SCIENZE ODONTOSTOMATOLOGICHE Via San Vitale 59 - 40125 Bologna ITALY Tel: +39 51 278011 Fax: +39 51 235208 E-mail: carlo.prati@unibo.it Dentists graduating each year: 28 Number of students: 150	Name of school: Brescia UNIVERSITÀ DEGLI STUDI DI BRESCIA Dipartimento di Sp Chir Sc Radiol e Medico-Forensi Clinica Odontoiatrica P.le Spedali Civili, 1 - 25123 Brescia ITALY Tel: +39 394544-3995780-383424 Fax: +39 30 303194 Email: sapelli@master.cci.unibs.it Website: www.med.unibs.it/didattica/cl/cl_prin.html Dentists graduating each year: 20 Number of students:100
Name of school: Cagliari UNIVERSITÀ DEGLI STUDI DI CAGLIARI CORSO DI LAUREA IN ODONTOIATRIA E PROTESI DENTARIA Via Binaghi, 4/6 – 09121 Cagliari ITALY Tel: +39 70/537411 Fax +39 70/537416 e-mail: vpiras@unica.it Dentists graduating each year: 20 Number of students: 100	Name of school: Cantazaro [New school] UNIVERSITÀ DEGLI STUDI DI CATANZARO - "MAGNA GRECIA" CORSO DI LAUREA IN ODONTOIATRIA E PROTESI DENTARIA Viale Europa - Campus Universitario di Germaneto - 88100 Catanzaro ITALY Tel: +39 9613697215 Fax: +39 9613697276 email: giudice@unicz.it Dentists graduating each year: none yet Number of students: 30
Name of school: Catania UNIVERSITÀ DEGLI STUDI DI CATANIA DIPARTIMENTO SPECIALITÀ MEDICO-CHIRURGICHE Azienda Policlinico - Via S. Sofia, 78 95125 Catania ITALY Tel. and Fax +39 95/3782759 E-mail: M.Caltabiano@unict.it Dentists graduating each year: 22 Number of students: 120	Name of school: Chieti UNIVERSITÀ DEGLI STUDI DI CHIETI Dipartimento di Scienze Odontostomatologiche Via dei Vestini, 31 - 66100 CHIETI ITALY Tel +39 871 3554070 Fax +39 8713554070 e-mail: scaputi@unich.it Dentists graduating each year: 42 Number of students: 210
Name of school: Ferrara UNIVERSITÀ DEGLI STUDI DI FERRARA DIPARTIMENTO DISCIPLINE MEDICO CHIRURGICHE DELLA COMUNICAZIONE E DEL COMPORTAMENTO SEZIONE DI ODONTOIATRIA Corso Giovecca, 203 – 44100 Ferrara ITALY Tel. +39 32-205277 Fax. +39 202329 Email: g.calura@unife.it	Name of school: Firenze UNIVERSITÀ DEGLI STUDI DI FIRENZE DIPARTIMENTO DI ODONTOSTOMATOLOGIA Segreteria del C.L.O.S.P.D. Via del Ponte di Mezzo, 46/48 50127 Firenze ITALY Tel. +39 55/331130 Fax +39 55/331130 Email: odontopdm@odonto.unifi.it Dentists graduating each year: 22 Number of students: 110

Dentists graduating each year: 13 Number of students: 70	
Name of school: Foggia [New school] UNIVERSITÀ DEGLI STUDI DI FOGGIA Dipartimento di Scienze Chirurgiche c/o Azienda Ospedaliera Universitaria Ospedali Riuniti-Foggia - Viale Pinto, 71100 Foggia ITALY Tel./fax +39 881 588041 – e-mail: presidenza.odontoiatria@unifg.it Dentists graduating each year: none yet Number of students: 35	Name of school: Genova UNIVERSITÀ DEGLI STUDI DI GENOVA CORSO DI LAUREA IN ODONTOIATRIA E PROTESI DENTARIA Presidenza Facoltà di Medicina e Chirurgia Via L. Battista Alberti 4 - 16132 Genova ITALY Tel. +39 10/3537235 or 7370-7362 Fax. +39 10/3537352 Email: giorgioblasi@unige.it Dentists graduating each year: 30 Number of students: 150
Name of school: Insubria UNIVERSITÀ DEGLI STUDI DI INSUBRIA Corso di Laurea Specialistica in Odontoiatria e Protesi Dentaria Clinica Odontoiatrica - Via Piatti, 10 - 21100 - Velate (Va) ITALY Tel. +39 332 825625 Fax +39 332 825655 Email angelo.tagliabue@uninsubria.it Dentists graduating each year: 19 Number of students: 100	Name of school: L'Aquila UNIVERSITÀ DEGLI STUDI DI L'AQUILA CORSO DI LAUREA SPECIALISTICA IN ODONTOIATRIA E PROTESI DENTARIA Clinica Odontoiatrica: Edificio Delta 6 Località Coppito - 67100 L'Aquila ITALY Tel.: +39 862433836 Fax: +39 862433826 Email: roberto_gatto@virgilio.it Dentists graduating each year: 25 Number of students: 120
Name of school: Messina UNIVERSITÀ DEGLI STUDI DI MESSINA CORSO DI LAUREA SPECIALISTICA IN ODONTOIATRIA E PROTESI DENTARIA Policlinico "G. Martino" 98100 Gazzi – Messina ITALY Tel. +39 90/ 2216901 Email: cordasco@unime.it Dentists graduating each year: 24 Number of students: 120	Name of school: Milano UNIVERSITÀ DEGLI STUDI DI MILANO CORSO DI LAUREA IN ODONTOIATRIA E PROTESI DENTARIA Istituto di Clinica Odontoiatrica e Stomatologica Via della Commenda, 10 - 20122 Milano ITALY Tel. +39 2/50320237 or +39 2/50320238 Fax +39 2/50320239 Email: istitutoclinicaodonto@unimi.it Dentists graduating each year: 50 Number of students: 200
Name of school: Milano UNIVERSITÀ DEGLI STUDI DI MILANO - BICOCCA Dipartimento di Neuroscienze e Tecnologie Biomediche CLINICA ODONTOIATRICA Azienda Ospedaliera S. Gerardo ITALY Tel. +39 39.233-2301/2143/3485 Fax +39 39/2333482 e-mail: marco.baldoni@unimib.it Dentists graduating each year: 19 Number of students: 100	Name of school: Modena UNIVERSITÀ DEGLI STUDI DI MODENA E REGGIO EMILIA Istituto di Clinica Odontoiatrica Policlinico: Via Del Pozzo, 71 41100 Modena ITALY Tel. +39 59/4222326-361181 Fax +39 59/373428 – Email – segr.clopd@unimore.it Dentists graduating each year: 14 Number of students: 60
Name of school: Napoli UNIVERSITÀ DEGLI STUDI DI NAPOLI Dipartimento di Scienze Odontostomatologiche e Maxillo-facciali Via Pansini, 5 – 80131 Napoli ITALY Tel. +39 81/7462192 Dipartimento: Tel. +39 81/7462089 Segreteria: Tel. +39 81/7462088 – Fax: +39 81/7462197 E-mail: martina@unina.it	Name of school: Napoli UNIVERSITÀ DEGLI STUDI DI NAPOLI - IIA FACOLTÀ CORSO DI LAUREA SPECIALISTICA IN ODONTOIATRIA E PROTESI DENTARIA Via S. Andrea delle Dame 6 - 80138 Napoli ITALY Tel. +39 81/5665476 Fax +39 81/5665477 Email : gregorio.laino@unina2.it Dentists graduating each year: 24 Number of students: 120

Dentists graduating each year: 21 Number of students: 100	
Name of school: Padova UNIVERSITÀ DEGLI STUDI DI PADOVA Dipartimento Integrato Interaziendale di Odontoiatria Via Venezia, 90 – 35100 Padova ITALY Tel. +39 49 8213999 - 8218669 Fax +39 49 8070364 Email: gafavero@tin.it Dentists graduating each year: 28 Number of students: 150	Name of school: Palermo UNIVERSITÀ DEGLI STUDI DI PALERMO Dipartimento di Scienze Stomatologiche " G.MESSINA " Corso di Laurea in Odontoiatria e Protesi Dentaria Policlinico " P. Giaccone "- Via del Vespro, 129 90127 Palermo ITALY Tel. +39 91.6552208 Fax +39 91.6552203 e-mail: ggallina@odonto.unipa.it e-mail: gallina.giuseppe@tiscalinet.it Dentists graduating each year: 20 Number of students: 100
Name of school: Parma UNIVERSITÀ DEGLI STUDI DI PARMA Dipartimento di Scienze Otorino-Odonto-Oftalmologiche e Cervico-Facciali Sezione di Odontostomatologia Osp. Riuniti - Via A. Gramsci, 14 - 43100 Parma ITALY Tel. +39 521292759 or +39 521702033 Fax +39 521292955 Tel. +39 521986722 e-mail: mauro.bonanini@unipr.it Dentists graduating each year: 10 Number of students: 60	Name of school: Pavia UNIVERSITÀ DEGLI STUDI DI PAVIA DIPARTIMENTO DI DISCIPLINE ODONTOSTOMATOLOGICHE "SILVIO PALAZZI" CORSO DI LAUREA IN ODONTOIATRIA E PROTESI DENTARIA Policlinico S. Matteo p.le Golgi 2 - 27100 Pavia ITALY Tel. e Fax +39 382-423516 Tel +39 382-516203 e-mail: discodon@unipv.it e-mail: guseppe.resta@unipv.it Dentists graduating each year: 20 Number of students: 100
Name of school: Perugia UNIVERSITÀ DEGLI STUDI DI PERUGIA CORSO DI LAUREA IN ODONTOIATRIA E PROTESI DENTARIA Policlinico Monteluce - 06100 Perugia ITALY Presidenza: Tel. +39 75/5855804 Segreteria: Tel. +39 75/5855808 or +39 75/5855809 Email: urbani@unipg.it Dentists graduating each year: 15 Number of students: 75	Name of school: Piamonte [New school] UNIVERSITÀ DEGLI STUDI DEL PIEMONTE ORIENTALE "A. AVOGADRO" SCDU Odontoiatria e Stomatologia Ospedale Maggiore della Carità di Novara Viale Piazza d'Armi 1 – 28100 Novara ITALY Tel. +39 321/3734871-3734872 Fax: +39 321/3734843 e-mail: odonto@maggioreosp.novara.it Dentists graduating each year: Number of students: none yet
Name of school: Pisa UNIVERSITÀ DEGLI STUDI DI PISA CORSO DI LAUREA IN ODONTOIATRIA E PROTESI DENTARIA Dipartimento di Chirurgia: Via Roma 67, 56126 Pisa ITALY Tel. +39 50/555131 050 or +39 553423 or +39 50/993391 Fax +39 50/555232 Email: m.gabriele@med.unipi.it Dentists graduating each year: 14 Number of students: 75	Name of school: Roma UNIVERSITÀ DEGLI STUDI DI ROMA "LA SAPIENZA" FACOLTÀ DI MEDICINA E CHIRURGIA I^ Policlinico Umberto I Dipartimento di Scienze Odontostomatologiche Viale Regina Elena, 287/A - 00161 Roma ITALY Dip: +39 6/44230812 Fax +39 649976603 Email: antonella.polimeni@uniroma1.it Dentists graduating each year: 60 Number of students: 300
Name of school: Roma UNIVERSITÀ DEGLI STUDI DI ROMA "TOR VERGATA" CORSO DI LAUREA IN ODONTOIATRIA E PROTESI DENTARIA Policlinico "Tor Vergata" Viale Oxford, 81 00133 Roma	Name of school: Roma (PRIVATE) UNIVERSITÀ CATTOLICA DEL SACRO CUORE ISTITUTO DI CLINICA ODONTOIATRICA Largo "A. Gemelli", 8 - 00168 ROMA ITALY

ITALY Tel. +39 6/20900270 Fax +39 620900269 Email: alberto.barlattani@uniroma2.it Dentists graduating each year: 33 Number of students: 160	Tel. +39 6/30154079 - +39 6/30154286 Fax +39 6/3051159 e-mail: iclod@rm.unicatt.it Dentists graduating each year: 24 Number of students: 120
Name of school: Sassari UNIVERSITÀ DEGLI STUDI DI SASSARI ISTITUTO POLICATTEDRA DI CLINICA ODONTOSTOMATOLOGICA Viale San Pietro 43/c - 07100 Sassari ITALY Tel. +39 79/228507 Fax +39 79/228541 Centralino Università: Tel. +39 79/228211 Email: dental@uniss.it Dentists graduating each year: 19 Number of students: 100	Name of school: Siena UNIVERSITÀ DEGLI STUDI DI SIENA DIP. DI SCIENZE ODONTOSTOMATOLOGICHE Viale Bracci – Policlinico Le Scotte ITALY 53100 Siena – Segreteria: Tel. +39 577/585771 Direzione: Tel. +39 577/585772 or +39 577/42383 Fax +39 577/586155 Email: ferrarimar@unisi.it Dentists graduating each year: 24 Number of students: 120
Name of school: Torino UNIVERSITÀ DEGLI STUDI DI TORINO Corso di Laurea Magistrale in Odontoiatria e Protesi Dentaria C.so Dogliotti, 38 – 10126 Torino ITALY Tel. +39 116334045-4055-4043 Fax +39 116636489 Email: fcl-med-clopds@unito.it Dentists graduating each year: 40 Number of students: 200	Name of school: Trieste UNIVERSITÀ DEGLI STUDI DI TRIESTE U.C.O. di Clinica Odontoiatrica e Stomatologica Ospedale Maggiore Via Stuparich, 1 - 34125 Trieste ITALY Tel +39 40/3992263 Fax +39 40/3992665 – Email r.dilenarda@fmc.units.it Dentists graduating each year: 16 Number of students: 75
Name of school: Udine UNIVERSITÀ DEGLI STUDI DI UDINE Dipartimento di Scienze Chirurgiche Azienda Ospedaliero-Universitaria " S. Maria della Misericordia" di Udine P.le S. Maria della Misericordia - 33100 Udine ITALY Tel. +39 432-559455 Fax: +39 432-559868 Email: maxillo.universitaria@aoud.sanita.fvg.it Dentists graduating each year: Number of students: none yet	Name of school: Verona The Dean Clinica Odontoiatrica UNIVERSITÀ DEGLI STUDI DI VERONA Dipartimento di Scienze Morfologico-Biomediche Sezione di Chirurgia Maxillo-Facciale e Odontostomatologia Univ. degli Studi di Verona - Policlinico G.B. Rossi Piazzale L.A. Scuro, 10 - 37134 Verona ITALY Tel. +39 45581212 - +39 458124251 Fax +39 458027437 Email: pierfrancesco.nocini@univr.it Dentists graduating each year: 20 Number of students: 100
New hygienist school	
Name of school: Milano UNIVERSITÀ VITA SALUTE SAN RAFFAELE - MILANO CORSO DI LAUREA IN IGIENE DENTALE Via Olgettina 48, 20132 Milano ITALY Tel. +39 2/26432970 - +39 2/26432994 Fax: +39 2/26432953 Email: gherlone.enrico@hsr.it Dental Hygienists graduating each year: Number of students: none yet	

	Number of Undergrads 2008	Annual Graduates 2007
Ancona	120	24
Bari	175	35
Bologna	150	28
Brescia	100	20
Cagliari	100	20
Cantazaro (new school)	30	0
Catania	120	22
Chieti	210	42
Ferrara	70	13
Firenze	110	22
Foggia (new school)	35	0
Genova	150	30
Insubria	100	19
L'Aquila	120	25
Messina	120	24
Milano	200	50
Milano Bicocca	100	19
Modena	60	14
Napoli	100	21
Napoli	120	24
Padova	150	28
Palermo	100	20
Parma	60	10
Pavia	100	20
Perugia	75	15
Piemonte (new school)	0	0
Pisa	75	14
Roma	300	60
Roma	160	33
Sassari	100	19
Sienna	120	24
Torino	200	40
Trieste	75	16
Udine (new school)	0	0
Verona	100	20
Public total	3,905	771
Roma (Private)	120	24
Overall total	4,025	795

Latvia

Date of last revision: 1st October 2008

In the EU/EEA since	2004
Population (2008)	2,270,894
GDP PPP per capita (2006)	€14,797
Currency	Latvian Lat (LVL) 0.7 LVL = €1.00 (2008)
Main language	Latvian

Medical services thus provided are free for patients, through the Health Compulsory Insurance State Agency (HCISA). Oral healthcare for adults is funded through private practice. State funded healthcare is largely limited to the treatment of children and persons who are called up for military service.

Number of dentists:	1,457
Population to (active) dentist ratio:	1,655
Membership of Dental Chamber:	100%

There is a well developed use of specialists for advanced dental care, and the development of dental auxiliaries is also well developed and advanced.
Continuing education for dentists is mandatory

Government and healthcare in Latvia

The Republic of Latvia, lies on the eastern shores of the Baltic Sea. With the Baltic Sea in the west, Latvia shares land borders with Estonia in the north, Russia and Belarus to the east and Lithuania to the south. Latvia comprises an area of 64,589 sq. km.

In 1991 Latvia regained its independence as a state. There was a brief period of independence between 1918 and 1940. The new Constitution of 1991 established the principles of the State, setting Latvia as a democratic parliamentary republic – with a unicameral 100 member Parliament (Saeima), President (elected by Parliament), Prime Minister and Council of Ministers. Parliamentary members have a 4-year term of office, elected on a general, direct and proportional basis. Latvia has four administrative regions – Kurzeme, Zemgale, Vidzeme and Latgale. There are 26 rural districts and 496 local municipalities and parishes. About 70% of the population resides in urban and 30% in rural areas.

The capital, Riga, is on the Northern shore, on the Gulf of Riga. About one third of the total population resides in Riga.

The Ministry of Health is responsible for health care by making a public procurement of medical services. The budget for healthcare is built on taxes and state investment. Parliament decides annually the amount of public funds to be spent on healthcare. The sums are divided among medical institutions by the Health Compulsory Insurance State Agency (HCISA), and its regional branches, which conclude contracts with them under the supervision of the Ministry of Health. Medical services thus provided are free for patients, while all the other medical services are receivable for a fee paid by an insurance company or the patient himself/ herself. Children under the age of 18 and those who are called up for military service, are exempt from charges.

		Year	Source
% GDP spent on health	5.9%	2007	LDA
% of this spent by governm't	68.6%	2007	LDA

Oral healthcare

In 1991, with independence, new knowledge and experience became available after 50 years of isolation, even in dentistry. Before independence, dental care in Latvia was provided free of charge to the whole population – state provision.

Subsequently, care for adults is privately financed and public finance through the Sickness Funds is for children up to the age of 18 (with the exception of orthodontic treatment). In 2007, the average cost per child was 19.98 LVL (€29) per year and covered approximately 56% of all children in Latvia. Orthodontic diagnostic and treatment planning is financed through the Sickness Funds, but treatment must be paid for by the patient (the child's parents).

Regional sickness insurance institutions, according to contracts, finance this service upon a mixed principle: Oral Health promotion and education according to the number of children (the capitation principle); Dental care, including professional dental hygiene is paid for according to the work done – the principle of "the estimation of manipulation", which is item of service fees.

Dental care is also state financed for adults who are victims of the Chernobyl nuclear catastrophe (by government resolution ("Health care strategies in Latvia 1996"). The oral health care system for the Latvian population is administered under the Ministry of Health and Pauls Stradins' Clinical University Hospital (Pauls Stradins' CUH) Centre of Dentistry and Facial surgery (Centre of Dentistry), which plan, direct and monitor the oral health sector.

The Centre of Dentistry has set a common amount of services to be provided, which do not overlap with programmes provided for by insurance companies. The Centre of Dentistry has developed a common method of calculation of the full price for a service complying with the commonly approved medicinal technologies in dentistry. Taking into account available state financial resources and the limits of what the state can afford to pay, future necessary financial resources are calculated.

Direct patient payment forms a major part of the oral health care finance for the adult population. Private insurance is now more popular, but such policies are usually obtained by higher social classes. There is an agreement with the private insurance companies to follow criteria in accordance with recent technologies. This should assure high quality control in the insurance system in the future.

In 1994, in recognition of high caries levels, a National Preventive Programmeme in Dentistry was created in close cooperation with the Centre of Dentistry and WHO Collaborating Centre in Continuing Dental Education, in the Latvian Institute of Stomatology. During the period from 1994 to 1999, in cooperation with the Sickness Funds, local governments, school councils, dental and general medical staff, 22 local district Oral Health centres were established in Latvia. Assessment of effectiveness for preventive and curative work is based on regular accounting of oral health data in definite age groups, these are worked out "Evaluation criteria" and were introduced in 1998.

Prevention in Latvian dentistry is based on the principles of health promotion and education, developing whole population strategy.

Oral examinations would normally be undertaken every 12 months. It is not known what percentage of the population receive oral healthcare regularly (in a two-year period) but 56% of under-18s are known to visit a dentist at least once a year. As Latvia is a small but densely populated country, there is reported same problem with access to oral healthcare for patients.

		Year	Source
% GDP spent on oral health	0.24%	2007	LDA
% of OH expenditure private	70%	2007	LDA

Quality of Care

The competent authority which maintains dentists' registration and dental practice accreditation (every five years) is the State Agency of Health Statistics and Medical Technologies, in cooperation with Centre of Dentistry. Since 2001, this agency has been working in accordance with national regulations – with instructions regarding working space, units, and dental technologies, imposing minimum requirements standards for dental practice. A document of evidence based methods and technologies, was worked out in 2002 and was introduced from July 1st 2003, in all registered dental practices. This document is intended to motivate all dental staff to attend CPE courses.

The quality of work is evaluated by the HCQCI inspectors and experts of the dental associations. In the framework of evaluation, documentation and current clinical situation is analysed. Experts for the Professional Certification Commission are nominated by the associations.

Health data

		Year	Source
DMFT at age 12	3.20	2007	LDA
DMFT zero at age 12	23%	2007	LDA
Edentulous at age 65	No data		

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

The level of fluoride in drinking water is low 0.2 – 0.5 mg/l. Fluoride-containing tablets dissemination programmes were functioning successfully in some regions of Latvia in during the fifteen years to 2008. However, currently only fluoride tablets are ordered for children at risk. There are different preventive programmes for children and teenagers, with the distribution of free fluoride toothpaste and toothbrushes.

Education, Training and Registration

Undergraduate Training

To enter dental school there are certain requirements:

1) the candidate must be a high school graduate,

2) gain a high school diploma with an examination grade in physics,

3) pass an entrance examination (with tests in chemistry, biology, and composition in Latvian),

4) there is competition among applicants.

Year of data:	2008
Number of schools	1
Student intake	35
Number of graduates	30
Percentage female	87%

There is one dental faculty, which is located in the Riga Stradinš University and is publicly funded. The length of the undergraduate curriculum is 5 years. Since 1993 there was a new dental education programme for students and dental hygienists, which was worked out and introduced to comply with EU requirements.

Quality assurance for the dental school is provided by Faculty Council, chaired by the Dean (there is no external verification, although the school has been assessed within the EU's Dent-Ed Project).

Qualification and Vocational Training

Primary dental qualification

The primary degree which may be included in the register is: *zobarsts (dentist)*.

Vocational Training (VT)

Graduates can only register in Latvia when they have completed 24 months' salaried, supervised training, working full-time as a dentist under the supervision of an experienced dentist (part-time working takes longer). Following this the applicants must pass the test of professional certification. Trainees are known as "*Stagier*". Remuneration depends on the place of training, but it may not be less than the minimum wage set in the labour legislation.

Diplomas from other EU countries are recognised and EU/EEA qualified dentists do not have to undertake Vocational Training to register.

Registration

The register is administered by Pauls Stradinš Clinical University Hospital Centre of Dentistry and Facial surgery. The Centre of Dentistry, by order of the Ministry of Health, is responsible and accomplishes (performs) the registration of dental personnel in the joint State Register of medical practitioners.

There is no fee for registration.

To register a dentist must have a recognised degree or diploma and have completed the 24 months supervised training (except graduate from other EU/EEA countries).

Language requirements

There are is a formal requirement to have knowledge of Latvian at the highest level, in order to register. Non-Latvian dentists with an EU Diploma are recognised, but knowledge of the Latvian state language is also required. This is tested according to an opinion of the Municipal Language Commission.

In 1992 a mandatory requirement was introduced for all dentists and auxiliaries who had been registered in Latvia to have a new certification exam. During the period (1992 – 2003) 1,707 dentists (including 99 dental therapists) had passed this re-certification.

Further Postgraduate and Specialist Training

Continuing education

Since 2001 it has been a mandatory requirement for all registered dentists to complete a minimum of 250 hours of CPE every 5 years, whilst they practice. Auxiliary personnel have the same requirements only the number of credit hours may be different.

The Latvian Dental Association, working in collaboration with the Faculty and Institute of Stomatology at Riga Stradinš University, the State Dental Centre, the Latvian Physicians' Society and the Latvian Dental Hygienists' Association, and representatives from industry organise professional education for all the dental team members. This cooperation promotes exchange of information in dental professional development, to improve technologies, dental care and dental education.

Specialist Training

Dentists have the right to apply for doctorate studies (by competition), which are completed by a successful defence of one's doctoral dissertation.

Training is provided within the Riga Stradinš University's Faculty of Stomatology. In 2007 there were 15 dentists undertaking specialist training, 10 of whom were female. Trainee specialists are paid during training.

Education, Training and Registration

Dentists

Year of data:	2008
Total Registered	1,457
In active practice	1,372
Dentist to population ratio*	1,655
Percentage female	88%
Qualified overseas	63

* this refers to "active" dentists

There is no reported unemployment amongst dentists in Latvia.

Movement of dentists across borders

According to data from the Latvian Dental Association, since 1998 certificates for good practice have been issued to 2% of Latvian dentists. There is a small number of dentists not qualified in Latvia who practise there.

Specialists

In Latvia five other dental specialities are recognised, besides Oral Maxillo-facial Surgery.

Patients normally only attend specialists on referral from a primary practitioner.

Year of data:	2008
Orthodontists	73
Endodontists	31
Paedodontists	56
Periodontists	35
Prosthodontists	285
Oral Radiologists	
Oral Surgeons	75
OMFS	23

Auxiliaries

The system of use of dental auxiliaries is relatively well developed in Latvia and much oral health care is carried out by them.

Year of data:	2008
Hygienists	261
Technicians	923
Denturists	0
Assistants	1,722
Therapists	0
Other	0

Salaries are paid on the basis of contracts concluded with the employers. It is against the law to receive remuneration without a valid contract. There are no set amounts for limits set for private practice, subject only to the law on minimum wages.

Auxiliary personnel have similar requirements as dentists for continuing education - only the number of credit hours may be different.

Dental Hygienists

Training as a dental hygienist takes place at a special academical school at the Riga Stradinš University. There is a competitive examination to gain entrance. Graduates of the school receive a diploma. The title is legally protected and there is a registerable qualification which dental hygienists must obtain before they can practice. Dental Hygienists are an integral part of the oral health care team. They work in the private sector and also in Public Health (Local 22 Oral Health Centres).

The register is held by the Centre of Dentistry.

Dental hygienists work in all services only under the prescribed instructions of a dentist.

Dental Therapists

Dental therapists in Latvia were trained until 1976 – they are providing basic oral health care for children. The procedures they can undertake include a full repertoire of preventive therapies, the restoration of primary (deciduous) and young permanent teeth with appropriate biomaterials, performance of pulpotomies, placement of stainless steel crowns and extraction of primary (deciduous) teeth.

Dental therapists are permitted to work in the offices of dentists in the private sector – providing basic care for adults, but also under supervision of a dentist.

The register is held by the Centre of Dentistry.

Dental Technicians

Training as a dental technician takes place at Riga 1st Medical School under the supervision of Ministry of Education and Science. There is a competitive examination to gain entrance. On qualification they receive a diploma.

The title is legally protected and there is a registerable qualification which dental technicians must obtain before they can practice. A register is held by the Centre of Dentistry. Their duties are to prepare dental prosthetic and orthodontic appliances to the prescription of a dentist and they may not work independently.

Individual technicians are normally salaried and work in commercial laboratories which bill the dentist for work done.

Dental Chairside Assistants (Nurses)

Training as a dental assistant also takes place at Riga 1st Medical School, under the supervision of Ministry of Education and Science. There is a qualification and they may register with the Centre of Dentistry.

Practice in Latvia

A dental practice may be included in the structure in medical practices, hospitals and other institutions. Many dentists practice in more than one sphere of practice.

Year of data:	2008
General (private) practice	2,219
Public dental service	538
University	80
Hospital	
Armed Forces	16
General Practice as a proportion is	74%

Working in General Practice

Dentists practice in *individual dental practices* – by registering with the Latvian Doctors Society, as well as in *limited liability companies*, by registering with the State Enterprise Registry.

Dentists can choose to work in the state system, fully liberal private dentistry or both systems. The amount of work within the state system depends on the desires of the patient. If the treatment is carried out in the state system the dentist is paid fixed item of service fees.

During a first visit a patient receives a full diagnosis and explanation on further potentially necessary treatment modalities and expenses. If the patient agrees to all or chooses one of the variants recommended, a full treatment plan is signed by both parties during the same or the next visit.

All dentists, including those privately practising, have to obtain a professional's certificate. All equipment has to be tested to be in accordance with the compulsory requirements. Financial rules and the quality of work for all dentists, including privately practising dentists, are controlled by state institutions. The requirements are the same for all.

Offers of private insurance companies, along with state health insurance, are applicable to adults. The amount of accessible care depends on respective programmes. There is no insurance applicable only to dentistry.

Fee scales

The Centre of Dentistry sets the fees in the state system. Adult pay a pre-determined charge, which is 15% of the set treatment fee for the dentist, but persons in need of emergency care (especially when there is danger to life) are exempt from these charges.

There is no regulation of private fees, which are set by the dentist on the basis of demand. But in limited liability enterprises, or other organisations it is set by the employer, taking into account labour legislation on the minimum wage.

Joining or establishing a practice

There are no rules which limit the area of establishment or size of a dental practice, or the number of associated dentists or other staff working there. The state offers no assistance for establishing a new practice, and generally dentists must take out commercial loans from a bank. When starting a new practice private dentists have to comply with regulations which provide for compulsory (minimum) rules on design, construction and equipment, including the number and size of rooms. The dentist is then responsible for attracting new patients to the practice.

Dentists may purchase an existing practice, together with its "list" of patients. General practices are usually sited in apartments and ex-government clinics.

Working in the Public Dental Service

State financed dentistry services in state owned facilities are provided for in two institutions – the Centre of Dentistry and Stradinš University's Institute of Stomatology and are accessible to everybody. The service is mainly available to children, including children with pathologies, oral-maxillofacial surgery treatments and for any person who needs emergency health care. There are no treatment charges.

There is equipment for providing full domiciliary services in homes, so dentists offer pain relief at home and then undertake definitive treatment with the assistance of the regional social services in social or medical institutions.

There are regional oral health centres established and working. Their basic aims include extensive information, motivation in the mass media, school and kindergarten programme, including practical instructions for teeth cleaning. Also, they work out strategy for support and promotion of oral health in regions; organise preventive activities and analyse their effectiveness; and they analyse the fulfilment of municipally based programmes.

Working in Hospitals

There are 138 public or municipal hospitals and 2 private hospitals in Latvia. The Centre of Dentistry contains an oral-maxillofacial clinic, in which the professionals undertake consultations and medical help for all of the State and carry out the necessary treatment in the hospital. Regionally these specialists work in the two largest cities – Liepaja and Daugavpils.

Dental practice in hospitals also enhances accessibility for in-patients, but the amount of work and the payment rules are the same as for other dental practices.

Working in the University Dental Faculty

Dentists who work in the dental school are salaried employees of the university. They are allowed to combine their work in the faculty with part-time employment or private practice elsewhere.

The main academic title within the dental faculty is that of Professor. Other titles include Associate Professor, Assistant Professor (Docents) and Assistants (clinical instructors). There are no formal requirements for postgraduate training but senior teachers and professors will have completed a PhD, and most will also have received specialist clinical training.

Apart from these there are other regulations or restrictions for promotion. A Professor, as a salaried employee, would

be an elected person with a Doctoral degree and not less than 3 years' work experience in the position of Associate Professor. An Assoc. Professor, as a salaried employee could be an elected person with a Doctoral degree or a person with at least 10 years' practical work experience in the corresponding branch. A Professor and Assoc. Professor are elected by the Board of the Professors.

Assistants are elected by the Board of the Faculty. They can be elected persons with a Doctoral degree or a Masters degree, with 6 years' experience. Assistants without a postgraduate degree can be elected twice in the time following their primary degree.

The quality of clinical care, teaching and research in dental faculties is assured through dentists working in teams under the direction of experienced teaching and academic staff. The complaints procedures are the same as those for dentists working in other settings.

Working in the Armed Forces

A handful of dentists work full time for the Armed Forces - half are female.

Professional Matters

Professional association and bodies

There is a single main national association, the *Latvian Dental Association*.

	Number	Year	Source
Latvian Dental Association	1,860	2008	FDI

The organisation is representative of dentists (only) and has an elected board and President. There is a central office with part-time staff.

The Dental Association, as well as other professional associations (for oral-maxillofacial surgeons, dental nurses, dental hygienists and dental technicians) undertakes the duties of:

- control and improvement of qualification of specialists,
- setting of professional criteria and certification,
- approval of the classification of criteria for service manipulations.

The Centre of Dentistry, which is appointed by the state, has the duties of:

- enforcement of dental care strategy,
- registration of medical persons,
- drafting of various legal acts and norms in dentistry,
- setting of medicinal technologies, criteria of manipulations and economical prognosis for a more efficient distribution of resources allocated for dental care,
- setting of the amount of public procurement.

The Minister of Health appoints the director of the Centre and the Latvian Dental Association has no role within it.

Ethics and Regulation

Ethical Code

The relationship between patients and dentists is based on a business relationship in the circumstances of competition. Although the dentist is liable for the method of treatment used and the result, the most important factor is the mutual trust between the patient and the dentist.

In accordance with legislation, a dentist has the right to refuse to treat a particular patient, except in cases where the patient's life is in danger.

Fitness to Practise/Disciplinary Matters

In cases of complaints, tests are performed by Health Care Quality Control Inspection (HCQCI) through the involvement of experts from the professional associations. Tests are conducted mainly in cases of complaints, which most of the time are connected with the collection of financial compensation. There is a certain procedure for protection of the rights of patients.

A person can turn to the HCQCI as an independent state institution, with claims according to the procedure for the review of claims. According to the procedure, documents are reviewed by both parties, involving patients' representatives and experts from the professional associations, who evaluate the factual situation. The claims are analysed on the basis of medical indications. In cases where the claim is unsound, the HCQCI provides a detailed explanation of the situation at hand and provides a justification for its decision. In cases when claim is sound, the HCQCI issues a conclusion on the violation, providing for a chance of settlement and elimination of faults. Claims are submitted to a court if no solution has been reached, or a court judgment is needed for financial compensation for the aggrieved party.

The professional organisation may assign the dentist to extra after-diploma training or, in special cases, may decide on revoking the professional's certificate. Dentists have the right to appeal to the Latvian Doctors' Society's Certification Commission.

Data Protection

There are both Personal Data Protection and Medical Treatment Laws. Latvia has adopted the EU Directives.

Advertising

Advertising is permitted, but comparison of skills against other dentists is not allowed. Dentists are permitted to use the post, press or telephone directories, without obtaining prior approval.

Dentists are allowed to promote their practices through websites but they are required to respect the usual rules of "legal, decent, honest and fair". The CED Code has not been adopted.

Insurance and professional indemnity

The law provides for compulsory civil liability insurance for practising dentists. Private commercial insurance companies provide this insurance, and guarantees compensation for an aggrieved patient.

This insurance does not cover dentists for working overseas.

Corporate Dentistry

Dentists in Latvia are permitted to incorporate their practices into limited liability companies. Non-dentists can fully or part- own these companies.

Tooth whitening

Tooth whitening is regulated under the Medical Devices legislation, so is undertaken by dentists. It is also performed by the dental hygienists, under the supervision of dentists and in accordance with their assignment.

Health and Safety at Work

Requirements are set by Ministry of Health. Dentists and their assistants must be vaccinated against Hepatitis B. Compliance with the requirements is controlled by the State Sanitary Inspections. There is compulsory use of means of protection at work such as facial masks, protective glasses and gloves, which are provided for by the state under regulation of the Cabinet of Ministers.

Ionising Radiation

Dentists' operations with radiation equipment are licensed. The licence must be renewed every three years. There is a State Register of radiation equipment, furthermore postgraduate training of competent dentists in the field of radiation protection is held annually. Operations with the radiation equipment are determined by the Law on Radiation Protection and are realised and controlled by the Radiation Protection Centre.

Hazardous waste

Operations with hazardous waste are determined by the Law of Hazardous Waste. The necessity (need) and installation of the amalgam separator are determined by the Regulations issued by the Cabinet regarding the adequacy of medical institutions. Dental practices must have an agreement with companies stating that they are authorized to collect these wastes.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	The State Radiation Security Center
Electrical installations	The head of the practice
Infection control	State Environmental Health Centre
Medical devices	Health Statistics and Medicinal Technologies Agency
Waste disposal	State Environmental Health Centre

Financial Matters

Retirement pensions and Healthcare

The age for retirement is set at 62 year for women and for men. The system of pensions in the country is the same for everybody and those working in the sphere of dentistry are no exception. There is no special age limit in dentistry. The amount of pension depends on social taxes paid and social funds accrued.

Taxes

Medical services have a tax exemption. Income tax is set at 24% from any and all types of income.

VAT/sales tax

VAT of 5 % is applied for all medical equipment, instruments and materials included.

Various Financial Comparators

Zurich = 100	Riga 2003	Riga 2008
Prices (excluding rent)	54.2	59.8
Prices (including rent)	49.9	56.1
Wage levels (net)	16.2	15.0
Domestic Purchasing Power	32.5	26.7

Source: UBS August 2003 and January 2008

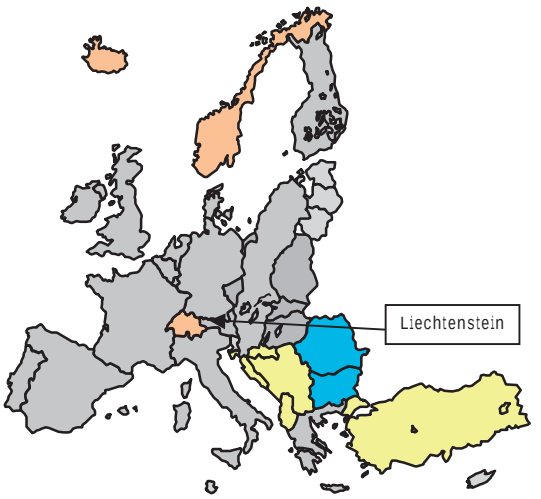
Other Useful Information

Main national association and Information Centre:	*Competent Authority:*
Latvian Dental Association 20 Dzirciema Str LV-1007 Riga LATVIA Tel: +371 67455058 Fax: +371 67459948 Email: gzigurs@acad.latnet.lv Website: www.lza-zobi.lv	Center of dentistry and facial sorgery of Pauls Stradiņš clinical university hospital LV-1007 Riga LATVIA Tel: +371 67455584 Fax: +371 67459948 E-mail: vzc@latnet.lv Website: www.vzc.lv
Major Specialist Association:	*Main Professional Journal:*
Latvian Medical Association Tel: +371 6722 0661 Fax: +371 6722 0657 E-mail: lab@arstubiedriba.lv Website: www.arstubiedriba.lv/	Journal "Zobarstniecibas raksti" Tel/Fax: +371 6745 5058 E-mail: gzigurs@acad.latnet.lv

Dental Schools:

For dentists:	*For hygienists:*
Ingrida Cema Riga Stradiņš University Faculty of Stomatology 20 Dzirciema Street Riga LV - 1007 LATVIA Tel: + 371 67409136 Fax: + 371 6781 5323 E-mail: iicema@latnet.lv Website: www.rsu.lv www.st-inst.lv	Riga Stradiņš University Academical School of Dental Hygienists LV-1007 Riga LATVIA Tel: +371 29227044 Fax: +371 6781 5323 E-mail: esenakola@latnet.lv Website: www.st-inst.lv *For technicians and assistants:* Riga 1st medical college Tel: +371 6737 1147 E-mail: medskola@dtc.lv Website: www.rmk1.lv

Liechtenstein



The Principality of Liechtenstein was established in 1719; it became a sovereign state in 1806. Since 1919 the Principality has been in customs and monetary union with Switzerland (the Swiss franc is the national currency). The country is mountainous, sandwiched between Austria and Switzerland and its area is a mere 160 sq km. The population is 35,365 (2008) and the capital is Vaduz. The country is a constitutional monarchy, and there is a unicameral Parliament (*Landtag*) of 25 seats, elected by proportional representation for four-year terms.

Despite its small size and limited natural resources, Liechtenstein has developed into a prosperous, highly industrialised, free-enterprise economy with a vital financial service sector and living standards on a par with the urban areas of its large European neighbours. The Liechtenstein economy is widely diversified with a large number of small businesses, and dental products being a major export material.

Liechtenstein has been a member of the European Economic Area since May 1995.

Healthcare

The main form of healthcare provision is mandatory insurance against the effects of diseases including accidents, similar to the system in Switzerland. The system is established by law, and is compulsory for everyone living in Liechtenstein, who pay a basic annual fee of approximately CHF 2,400 (€1,483). The patient pays 50% and the employer the other 50%. In addition the government pays approximately CHF 1,600 (€990) for each person.

		Year	Source
% GDP spent on health	9.2%	2004	OECD
% of this spent by governm't	76.1%	2004	OECD

		Year	Source
DMFT at age 12	3.40	2004	OECD

Training

Liechtenstein's dentists are usually trained in Switzerland or Austria.

Registration

Dentists from Liechtenstein or from EU/EEA partners, with a diploma from an EU/EEA University must (by a new law in 2003) be registered by the *Amt für Gesundheitsdienste*, a public authority. The annual registration fee in 2008 was CHF 1,000 (€620)

Workforce (active)

Dentists

All dentists in Liechtenstein work in general practice.

Year of data:	2008
Total Registered	41
In active practice	41
Dentist to population ratio*	866
Percentage female	20%
Qualified overseas	41

* active dentists only

Specialists

Year of data:	2008
Orthodontics	2
Endodontics	
Paedodontics	
Periodontics	1
Prosthodontics	
Oral Radiologists	
Oral Surgery	2
OMFS	

Auxiliaries

Clinical dental auxiliaries are trained in dentists' offices and go to school in Switzerland. They are registered with the *Berufsbildungsamt*, another public authority. There is no fee payable to register.

Year of data:	2008
Hygienists	5
Technicians	14
Denturists	
Assistants	80

Hygienists are trained in Switzerland, in the EU or the USA.

Dental technicians and chairside assistants mainly are trained in Switzerland, and register with the *Berufsbildungsamt*. There are approximately 80 trained chairside assistants and 14 dental technicians. There is no fee for registration.

Professional Matters

	Number	Year	Source
Liechtenstein Dental Association	26	2008	LDA

The Liechtenstein Dental Association also had 46 guest members in 2008. There are also guest members, who practise outside Liechtenstein. The Association handles ethical issues and continuing education.

For further information, please contact the President of the Liechtenstein Dental Association.

The President
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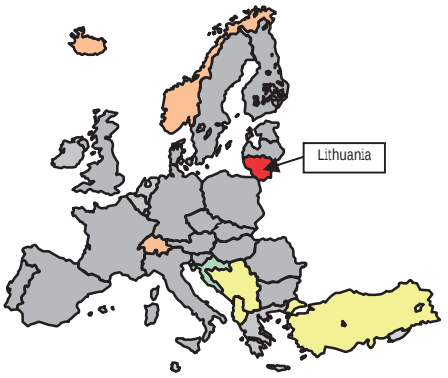
Date of last revision: 1st October 2008

Lithuania



Date of last revision: 1st October 2008

In the EU/EEA since	2004
Population (2008)	3,366,357
GDP PPP per capita (2006)	€15,373
Currency	Litas (LTL)
	3.45 LTL = €1.00 (2008)
Main language	Lithuamian

The system of the State Social Insurance in Lithuania covers nearly all residents: as the insurers, the insured, or the beneficiaries. The system is based on the principle of *solidarity* of generations Some patients (children, the elderly and the disabled) may receive some or all of their oral healthcare free but adult patients must pay part or all of the cost of their treatment. Most of this dental care is undertaken in general practice.

Number of dentists:	3,010
Population to (active) dentist ratio:	1,118
Membership of Dental Chamber:	100%

There is a well developed use of specialists for advanced dental care, and there are also dental hygienists as clinical auxiliaries Continuing education for dentists is mandatory.

Government and healthcare in Lithuania

The Republic of Lithuania lies on the eastern shores of the Baltic Sea, as one of the "Baltic States". With the Gulf of Finland in the north, and the Baltic Sea in the west, Lithuania shares land borders with several countries – Latvia, Russia, Belarus and Poland. The Lithuania Republic is a small country in terms of population and land area coverage (65.3 sq km). The capital is Vilnius.

The State of Lithuania gained its independence in 1990 (having also been independent from 1918 to 1939) and is a democratic republic. The powers of the State are exercised by the Parliament (*Seimas*), the President of the Republic and Government, and the Judiciary. The Seimas is unicameral, with 141 seats (71 members are directly elected by popular vote and 70 by proportional representation). Members serve for four-year terms. The President is elected by popular vote, for five-year terms of office.

The country is administered by 10 counties (*apskritys*).

In 2007 (3rd Quarter), average monthly earnings were 1949 litas(€565) and unemployment was about 4.3% of the workforce.

The system of the State Social Insurance in Lithuania covers nearly all residents: either as the insurers, the insured, or the beneficiaries. The system is based on the principle of *solidarity* of generations. The employed population supports pensioners, the disabled and unemployed persons by paying social insurance contributions. Hence, the budget of the State Social Insurance Fund depends contributions, whereas the rate of contributions relies on the general economic capacity of the state, the number of working people, the amount of the work income and, finally, on the honesty of those who pay the contributions.

In Lithuania, there is a distinction in the social security system between social insurance (covering working people), social assistance (for all residents) and special state schemes (covering privileged groups such as servicemen and some scientists). The two main principles of social policy in Lithuania are universality and solidarity. Universality means that all residents are entitled to services/benefits provided by social security. Solidarity is a principle based on solidarity between workers and pensioners, and between workers and those individuals who are unable to work because of illness, disability or other reasons. Approximately 15.5% of the population was over 65 years in 2008.

		Year	Source
% GDP spent on health	5.9%	2006	HIC
% of this spent by governm't	72.4%	2006	HIC

"HIC" is the Lithuanian Health Information Centre

The social insurance system is administered by a number of organisations:

The Ministry of Social Security and Labour

The main function of MSSL is in the area of social policy, including social insurance, employment and labour relations, and consists of analysing the current social situation, drafting laws and governmental decrees, presentation of these to the Seimas and the Government and the maintenance of international and public relations.

The State Social Insurance Fund Council

The State Social Insurance Fund Council supervises the State Social Insurance Fund (SSIF). The Council (established by agreement in 1995) is a tripartite governing board chaired by the Minster of Social Security and Labour.

The responsibilities of the Council include monitoring of legislation, advice and recommendations to the government, annual reviews and advice on operational issues.

The State Social Insurance Fund Board (SoDra)

The State Social Insurance Fund Board is the central institution that administers the State Social Insurance Fund and whose main task is to manage the funds and accounts of the State Social Insurance Fund, ensure the collection of contributions and allocation of benefits and their delivery to beneficiaries.

SoDra, which employs over 3,300 people, is responsible for the administration of the SSIF through its central office in Vilnius and 52 territorial offices.

Voluntary social insurance

There is also voluntary social insurance which includes pension and sickness/maternity allowances.

Oral healthcare

Regulation of healthcare

Dental care (aid) practice, as other medical practice, is regulated by the main general laws which are passed by the Parliament of Lithuania. That is the "Law on Health System", the "Law on Health Care Institutions" and the "Law on Patients' Rights and Damage". The legislation allows for dentistry being a specific medical area, so special laws have been passed – that is the "Law on Dental Practice" and the "Law on the Dental Chamber". Dental care (aid) is also regulated by legal acts passed by the Minister of Health and the Lithuanian Dental Chamber (see later for the Dental Chamber).

		Year	Source
% GDP spent on oral health	0.19%	2006	Chamber
% OH expenditure private	No data		

There are no available data for how much of the expenditure on dentistry is private.

Notwithstanding the relatively high number of dentists, the state of oral health of the citizens of Lithuania is described by the Dental Chamber as "not quite satisfactory". This is not related to the quality of the dental service, but to the socio-economic situation. The greatest problems are caries, periodontitis and malocclusions.

Many in the population suffer from periodontal diseases. Despite the better living conditions, economic progress, increased information, periodontitis remains one of the most problematic issues of dentistry. According to the research in thirteen Lithuanian towns and districts, it is estimated that plaque induced gingivitis prevails among children – in about 69 % of 6-14 years old children. Most adults suffer from chronic periodontitis – about 92 % of the citizens aged among 25-64 years old have gingivitis and periodontitis. And one third of Lithuanians needs complex treatment of it.

The prevalence of malocclusion is widely spread in Lithuania. Among examined schoolchildren aged 9-11 years about 80 % needs correction.

Public compulsory health insurance

The national health insurance system scheme offers reimbursement of the cost of some dental treatment. In 2007, 147.1 million Litas (€42.7 million) from the compulsory health insurance fund (SSIF) were allocated to dental care. About two thirds of this was for primary dental care.

In 2007 there were 195 public and 1,011 private clinics (registered with the Chamber). However, the Chamber believes that in reality there are up to 800 more clinics. Only 377 clinics had contracts with the SSIF; the other clinics were outside the state system

Dental care expenses may be reimbursed from state or municipal funds, mandatory health insurance funds, and supplemental health insurance funds and from (voluntary) contributions by patients. Only the essential dental care services are provided free of charge.

Patients have the right to a free choice of dentist. Public oral health care is free of charge, for children and teenagers under the age of 18 years, and prosthodontic care for pensioners and the disabled. For adults between 18 and 65 dental care in the public dental service, if the dental office is contracted with the SSIF, dentistry is partly financed by the fund and partly (for expenditure on dental materials) by co-payments by patients.

Due to the lack of financial resources "free of charge" prosthetic treatment is very limited.

Private insurance for dental care

This does not exist in Lithuania.

The Quality of Care

The quality of dental care is monitored by the Lithuanian Dental Chamber in different ways and emphasis is placed on quality improvement and assurance. Quality improvement is achieved through continuing education and the development of standards and certification.

The *State Inspectorate of Medical Audit* (SIMA) is the institution of health care services inspection. SIMA's main functions are to represent and defend patients' rights to effective, accessible and safe health care, and to implement state inspection and examination of accessibility, usability and efficiency of health care services in health care institutions independently of their subordination and property. SIMA receives its regulatory authority from state laws and is a government agency under the Ministry of Health. The Chamber is involved with patient complaints about the quality of care.

Health Data

		Year	Source
DMFT at age 12	2.40	2001	OECD
DMFT zero at age 12	16%	2001	OECD
Edentulous at age 65	11%	2001	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no fluoridation schemes and distribution of free fluoride toothpaste to children.

Education, Training and Registration

Undergraduate Training

The original title for dentistry, *stomatology*, was changed to *odontology* in 2003.

For admission to an odontology course the completion of a General Certificate of Secondary Education is the minimum required. All persons having secondary, higher or high education and able to prove it with documents recognised in the Republic of Lithuania have right to be admitted to the first year of basic and continuous studies. Admission to the study programme is carried out according to joint regulations of the Faculties of Odontology in the the two universities: Vilnius University and Kaunas Medical University. Admission takes place by competition, and priority is given to those who have higher ranking in competition queue. There are no entrance examinations, students are selected according to the grades of the secondary education final examinations, and annual marks averages. Each year the admission system is updated and upgraded.

The undergraduate training programme is for 5 academic years. Teaching languages are English and Lithuanian. Teaching is undertaken by academic staff full or part time university teachers who hold contracts with the university and the National Health Service (usually it is a contract with the university hospital).

The new programme of basic training of odontologists was developed according to the best practices of Western universities in 1991-1994, after Lithuania became independent.

Year of data:	2006
Number of schools	2
Student intake	118
Number of graduates	117
Percentage female	74%

The responsibility for quality assurance in the faculties is by the Ministry of Education, the Chancellor of the University and the Dean of the Faculty.

Qualification and Vocational Training

Primary dental qualification

The professional title is *odontologist*, which is written down in the graduation Diploma.

Vocational Training (VT)

Graduates of the Faculties of Odontology are required to complete one-year training, *primary residency*, in order to be registered for independent practise. During the training, the dentist is a salaried employee.

This post-qualification training has a practical part (participant has to fulfil a list of prophylactic, diagnostic and treatment items) and a theoretical part (compulsory attendance on recommended courses and lectures). Graduates of primary residency obtain the qualification of *Odontologist of General Practice*, and are granted a license to practice.

Theoretical training - during the course of practical training - is provided in a number of different ways and establishments: in particular in specialised training courses organised (mainly) by the universities, dental associations, and on a daily basis in approved training posts.

The criteria for recognition of training establishments cover the service facilities available, the degree of supervision, the range of experience offered and the availability of time and facilities to study. The method of this training is apprenticeship, (occupation of a general practice odontologist post (dental unit) at a State Health Service hospital or a private dental clinic).

The teachers are normally experienced odontologists in General Practice. They are employed by the University; and therefore belong to the public service; very few are employed in private dental clinics. The majority are part-time teachers.

The University appointed teachers in the State Health Service hospitals and private clinics are responsible for the theoretical and practical training. At the end of the primary residency, the theoretical knowledge and practical skills are evaluated during the State Exam.

Registration

Access to the profession is regulated by the statutes and is restricted to the holders of the *Licence to practice* - odontologist of General Practice or odontologist specialist. (endodontologist, orthodontist, paedodontist, periodontologist, prosthodontist, Oral surgeon, Maxillofacial surgeon).

The Licensing Committee at the Lithuanian Dental Chamber is the official unit, responsible for organising and giving Licences to professionals. It maintains a register containing the dentists´ data, including qualifications and professional performance data.

Cost of registration (2008)	€ 17

There is also an annual fee of 150 Litas (€43.5) for subscription to the Chamber, which is mandatory.

Language Requirements

There is a requirement to have a general knowledge of the Lithuanian language before registration. For non-EU/EEA qualified dentists language tests are carried out by the National Centre of Examination and Teacher Professional Development. The test is general (rather than dentistry specific), written and oral. A certificate from a university or language institute is an acceptable alternative, if knowledge of language is B1 as set by the European Council for knowledge of languages.

Further Postgraduate and Specialist Training

Continuing education

The Lithuanian Dental Chamber coordinates the continuing education of dentists and oral care specialists. This function is performed by the Commission on Informal Education. It sets up main principles of the qualifying courses and the basic requirements for organisers.

In order to remain registered a dentist needs to attend the courses and obtain a certain number of professional training hours, which are 120 hours in 5 years for dentists and dental specialists.

Specialist Training

There are 3-year postgraduate specialist training courses (Residency), to obtain the specialist diploma - *License of Odontologist Specialist:*

- *endodontologist,*
- *orthodontist,*
- *pedodontist,*
- *periodontologist,*
- *prosthodontist,*
- *oral surgeon.*

For the oral maxillofacial surgeon specialty, there is 4-year postgraduate training for - *License of Maxillofacial Surgeon.*

Postgraduate specialist training courses are undertaken at the Kaunas University of Medicine or the University of Vilnius. The trainees are paid during training.

Workforce

Dentists

The active dental workforce is stable, but increasing slowly (in 2008). There is no reported real unemployment among dentists, although individuals may not be working for short periods.

Year of data:	2008
Total Registered	3,010
In active practice	3,010
Dentist to population ratio*	1,118
Percentage female	83%
Qualified overseas	35

*active dentists only

Movement of dentists across borders

Approximately 200 dentists asked for a "Certificate of Good Standing" to work abroad through the years from 2004 to the end of 2006, but there is no a reliable source of information how many of them left Lithuania.

Specialists

There are 7 kinds of specialists in Lithuania, as already identified:

Year of data:	2008
Orthodontists	73
Endodontists	31
Paedodontists	56
Periodontists	35
Prosthodontists	285
Oral Radiologists	
Oral Surgeons	75
OMFS	23

Dental specialists comprise about 20% of the total numbers of practising dentists.

There are two ways for patients to access specialists in Lithuania. The first is to ask for referral, from a general odontologist. All expenses in these cases will be covered by the insurance system. However, if patient wishes to go directly for a specialist consultation, this is acceptable, but he would then have to pay the fees himself.

Auxiliaries

In Lithuania dental auxiliaries are known as *Oral Health Care Specialists*. They must be registered with Lithuanian Dental Chamber and have Licences to practice. All these auxiliaries also need to obtain hours of continuing education.

There are three kinds of these: dental hygienists, dental technicians and dental assistants.

Year of data:	2008
Hygienists	261
Technicians	923
Denturists	0
Assistants	1,722
Therapists	0
Other	0

Dental Hygienists

Hygienists are permitted to work only provided they have a diploma. They are trained at the Collegiums of Panevezys, Utena and Klaipeda for 3 years and Kaunas University of Medicine for 4 years. Graduates of Kaunas University of Medicine receive a bachelor degree and the qualification of Oral Hygienist. The completion of studies at the Collegiums leads only to the qualification of Oral Hygienist.

Hygienists can practice as employee, employer or freelancer. They may accept payments from patients. They have competence to diagnose and plan treatment and their duties include scaling, cleaning and polishing, removal of excess filling material, local application of fluoride agents, the insertion of preventive sealants and Oral Health Education. They may give local anaesthesia.

There is a Lithuanian Dental Hygienist Association.

It was founded in 1999. The aims are: to ensure possibilities to improve qualification, represent its member, cooperate with other analytical organisations, provide preventive work of oral care, inform public about the dental hygienist academic and other achievements.

In 2008 it was reported by the Chamber that about a quarter of hygienists were members of the Dental Hygienists' Association.

Dental Technicians

Dental technicians train in the Colleges of Kaunas and Utena. In collaboration with the educational institutions, the Chamber endeavors that the curriculum for dental technicians includes more practice, during which the students can improve their skills.

Dental technicians train for 3 years and after studies they receive a diploma.

Technicians normally work in commercial laboratories, only a few are employees of dentists or of clinics. They construct prostheses for insertion by dentists. They have legal responsibility for their work but do not accept payments from patients.

Lithuanian Association of Dental Technicians suspended operation in 2004.

There are no reports of any (illegal) denturism in Lithuania.

Dental Assistants (Nurses)

Dental assistants (nurses) are permitted to work only when they have a diploma of Dental Assistant, are registered with Lithuanian Dental Chamber and have a Licence to practice. They train for 3 years in a College specifically for dental assistants. The Colleges are in Kaunas, Panevezys, Klaipeda, Utena and Siauliai. Dental assistants need to undertake continuing education. Courses on infection control and emergency care are obligatory.

New protocols on competencies, duties and responsibilities of dental assistants were adopted in the end of the year 2007. Besides assisting the dentist, they are permitted to undertake oral health education.

There is a Lithuanian Dental Assistant Association.

Practice in Lithuania

Year of data:	2008
General (private) practice	2,219
Public dental service	538
University	80
Hospital	
Armed Forces	16
General Practice as a proportion is	74%

Working in Liberal (General) Practice

The Ministry of Health establishes the cost of dental care services provided by state, district and municipal institutions.

The cost of dental care services in private practices is established by their owners. For dentists working within the SSIF it is obligatory (by law) that they undertake the treatment from a price list of items fully or partially covered by the insurance system - even for items which are fully paid for by the patient (see below for private practice).

Joining or establishing a practice

There are no stated regulations which specifically aim to control the location of dental practices. There are also no other factors which effectively restrict where dentists may locate. Any type of building (a house, apartment, shop or clinic) may be used which fulfils the legislative claims to dental practice. However, rules exist which define, for example, the minimum size of rooms for dental practice. There is no limit to the maximum number of partners etc.

The state offers no assistance for establishing a new practice and generally dentists can take out commercial loans from a bank. To establish a new practice private dentists have to gain the approval of the registration of local state authorities and a licence from health authorities. The new practice has to be insured - by any health insurance company.

Fully Private Practice

Dentists working outside the SSIF, in fully private practice, are not bound by any method of price calculation used in the SSIF. In the same way, private specialists may themselves make decisions about treatment prices. However, normally prices are higher than in general practitioners' clinics.

Working in Public Clinics

Approximately 20% of dentists work in municipal ambulatory dental departments (2008). These municipal ambulatory dental departments are contracted with the SSIF and adults' treatment is partly financed by the SSIF and partly (for expenditure on dental materials) by co-payments by patients. As mentioned earlier, some public oral health care is free of charge for children and teenagers, pensioners and the disabled. Many public clinic dentists also work part-time in private practice.

Specialists receive higher fees for their work in municipal polyclinics, because there is special index. The Insurance system also pays more to cover a larger proportion of the treatment price.

Working in Hospitals

The social status and guarantees for odontologists from General Practice, and Specialists, working in public hospitals and private service is the same according to the Lithuanian Law of Labour. It is based on a labour contract between the employee and employer, and the contractual requirements. The social guarantees of the employee do not differ whether the employer is a public or private institution.

Dentists who work in hospitals (university or big regional hospitals) are normally salaried employees. Hospitals usually are publicly owned, and the dental services provided are normally oral and maxillofacial surgery. These dentists will also assist in the education and training of dental undergraduates.

Working in Universities and Dental Faculties

There are 2 dental schools, in which dentists work. One of them is localized in Kaunas Medical University, as Faculty of Odontology and another is localised in the Faculty of Medicine at Vilnius University. Dentists work as full-time or part-time employees of the University. Their salary range is €300 to €700 per month. Combination of part-time teaching employment and private practice is permitted by the universities.

Staff members are graded as professors (20%), associate professors (30%), lecturers (5%) and assistants (45%). Between 60 and 70% of staff members are full-time teachers. The teacher/student ratio differs: minimum ratio is 1:5, maximum ratio 1:8. The qualified academic dental staff members provide supervision during clinical training.

The titles of university teachers are: assistant (title As.), docent (title Doc.), and professor (Prof.). For the positions of docent and professor it is necessary to pass "habilitation" - this involves a further degree (publication activities and a record of original research) and a public lecture in front of the Scientific Council of University. The study for a PhD is also required.

Working in the Armed Forces

Dentists serve full-time in the Armed Forces, of whom 75% were female in 2008.

Professional Matters

Professional associations

The Lithuanian Dental Association suspended its operation in 2004, when the Lithuanian Dental Chamber was established.

The Dental Chamber:

- implements self goverment of dentists and coordinates their activities;
- pursues the strategic tasks of dental care (aid) within the healthcare system;
- takes concern in development of dental activities in the Republic of Lithuania, education of patients, professional training of dentists and medical culture;
- prepares drafts of legal acts on the activities of dentists, dentists specialists and oral care specialists - to present them to the Ministry of Health

Odontologists are members of the Lithuanian Dental Chamber (*Lietuvos Odontologu Rumai*). Membership has been compulsory since July 2004, by law.

	Number	Year	Source
Lithuanian Dental Chamber	3,010	2008	Chamber

Also by law, representatives of the Lithuanian Dental Chamber are included in the special commissions, which examine complaints filed against dentists.

Ethics and Regulation

Ethical Code

There is an Ethical code, which was updated in 2007, administered by Lithuanian Dental Chamber. Dentists must work within the ethical code, which includes the relationships and behaviour between dentists, conduct with patients, consent and confidentiality, continuing education and advertising.

Fitness to Practise/Disciplinary Matters

A complaint may be made by a patient. This may be to:

- the health insurance company,
- the Dental Chamber,
- the State Inspectorate of Medical Audit (SIMA).

In case of violation of professional ethics or rules of dental practice, or causing damage to a patient, there is a range of penalties which is normally administered by the Ethical Committee of Dental Chamber - in Regional Departments of the Chamber. The Committee of Reimbursement of Damage at the Ministry of Health, the State Inspectorate of Medical Audit (SIMA) and the Dental Chamber are always involved in the investigation of complaints.

The penalties may include a reprimand, a penalty or even the loss of the license to practice (the dentist cannot be suspended immediately). Any serious break of the law can be referred to court and even result in imprisonment.

Data Protection

All odontologists must follow the requirement to protect patients' health data, according to the regulations of all the legal Acts and Odontologists' Competence regulating documents.

Advertising

Dentists are permitted to use press or telephone directories to advertise.

Dentists are allowed to promote their practices through websites, but they are required to respect the Code of Ethics and Code of Electronic Commerce (which embraces the CED Code of Ethics regarding internet sites).

Indemnity Insurance

Liability insurance is compulsory for dentists and oral hygienists. Insurance is provided by private insurance companies and covers costs up to a predetermined maximum, usually 50.000 Lt (approximately €14,500) in 2008. An average practitioner pays approximately 300 Lt (€87) annually for the insurance (2008).

The insurance does not cover for dentists to work outside Lithuania.

Corporate Dentistry

Anyone can own a dental practice, but a person, who is responsible for the organisation of the clinical treatment must be a dentist.

Tooth Whitening

Tooth whitening products are classified as a Medical Devices in Lithuania. However, there are some cosmetic products used for this also and these can be bought in specialised stores.

Health and Safety at Work

Requirements and regulations are set by the Ministry of Health. Compliance with the requirements is controlled and monitored by the responsible health authorities.

Regulations for Health and Safety:

For	*Administered by*
Ionising radiation	State Centre for Nuclear Security
Electrical installations	The State accredits electrical technicians
Waste disposal	Local government, Ministry of Health
Medical devices	Ministry of Health
Infection control	Ministry of Health and local authorities

Each employee must undergo periodic medical examination. There is compulsory use of means of protection at work such as facial masks, protective glasses and gloves.

Dentists and auxiliaries are recommended to be inoculated against Hepatitis B and later be checked regularly for sero-conversion.

Infection control is regulated by law and has to be followed by the dentist and his or her team. Non-compliance causes sanctions.

Ionising Radiation

There is a requirement to have a Licence for using radiation equipment and in every 5 year period persons who work with X-rays (dentists or dental assistants), need to attend 36 hours of courses on ionising radiation.

Hazardous Waste

The EU Hazardous Waste Directive has been incorporated into Lithuanian laws. It is actively enforced. Amalgam separators are not mandatory. Amalgam is not popular with patients or dentists.

Financial Matters

Retirement pensions and Healthcare

The normal age for retirement for women is 60 and for men 62 years, although dentists and their staff can work past then.

There is a state-funded system of pensions, of which dentists and their staff are a normal part. The pension would be about 50% of last declared income. This is the same for employed and self-employed dentists. Any additional insurance pension depends on the individual contract and the amount insured.

Taxes

There is a national income tax of 24% of income.

VAT

In the Lithuania Republic the VAT rate is 18%.

The main dental materials: filling materials, impression materials, instruments, gloves, anaesthetics, disinfectants are charged at 5% VAT. Some auxiliary materials, such as radiographic materials, instruments and equipment for laboratories are charged at 18% VAT. The cost of dental health care (and other health care too) is VAT free.

Various Financial Comparators

Zurich = 100	Vilnius 2003	Vilnius 2008
Prices (excluding rent)	48.8	52.7
Prices (including rent)	46.1	49.4
Wage levels (net)	10.1	15.0
Domestic Purchasing Power	23.4	29.4

Source: UBS August 2003 & January 2008

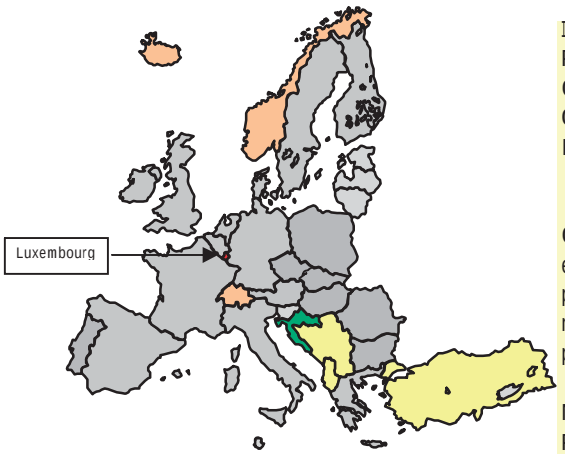
Other Useful Information

Competent authority and main associations:	
Lithuanian Dental Chamber K. Sirvydo str. 6, LT- 01101 Vilnius Tel: +370 5 2 12 25 10 Fax: +370 5 2 12 25 10 Email: info@odontologurumai.lt Website: www.odontologurumai.lt The Chamber in Vilnius manages a part of the database, registers information on temporary provision of the dental practice services, solves formal and informal educational issues, arranges improvement of professional skills and performs other functions provided by the legal Acts of the Republic of Lithuania and the Chamber.	Lithuanian Dental Chamber Eiveniu str. 2-064a LT- 50009 Kaunas Tel. +370 3 73269 41 Mob. +370 6 52222 50 Email: licencija@odontologurumai.lt Website: www.odontologurumai.lt The Chamber in Kaunas is responsible for licences and certification
Lithuanian Dental Hygienists Association Žalgirio str.115, LT-08217 Vilnius Tel: +370 61211514 Email: danguole.mieldaziene@fc.kauko.lt	Lithuanian Dental Assistants Association Rinktines str. No 4-13 Vilnius LT-09312 Lithuania Tel/fax: + 370 5 27353 77 Mobile: +370 6 98808 36
Ministry of Health of the Republic of Lithuania Vilniaus str. 33, LT- 01506 Vilnius Tel: +370 5 2 68 5110 Fax: +370 5 2 66 1402 E-mail: ministerija@sam.lt Website: www.sam.lt	*Main journal:* Stomatologija – Baltic Dental and Maxillofacial Journal Kanto 4-1, Kaunas LT-44296 Lithuania Phone/fax: +370 7 228307 Mobile: +370 6 1271707 Email: zilinskasj@takas.lt Website: http://www.sbdmj.com
Main information centre: Statistics Lithuania Gedimino ave 29, LT-01500 Lithuania Tel: +370 5 2364800 Fax: +370 5 2364845 Email: statistika@stat.gov.lt	*Lithuanian Health Information Centre:* WHO Collaborating Centre Kalvariju 153, LT-08221 Vilnius-42, Lithuania Tel: +370 5 2773301 Fax: +370 5 2773302 Email: lsic@lsic.lt

Dental Schools:

Kaunas University of Medicine Faculty of Odontology A.Lukšos – Daumanto str. 6, LT-50106 Kaunas Tel: +370 3 7 33 83 66 Fax. +370 3 7 33 83 65 E-mail: odontologijos.fakultetas@kmu.lt Website: www.kmu.lt Number of students: 656 96 graduated in 2007	Vilnius University Faculty of Medicine Institute of Odontology Zalgirio str. 115, LT - 2042 Vilnius Tel: +370 5 2 72 75 89 Fax: +370 5 2 72 85 69 E-mail: mf@mf.vu.lt Website: www.mf.vu.lt Number of students:114 21 graduated in 2007

Luxembourg



Date of last revision: 1st October 2008

In the EU/EEA since	1957
Population (2008)	483,799
GDP PPP per capita (2007)	€66,765
Currency	Euro
Main language	Luxembourgish French & German

General health care is funded by contributions from employers, employees and the government. Dentists work for fixed fees, with the patient obtaining (variable) reimbursement, using their social security number as proof of entitlement. 100% of care is provided in general practice.

Number of dentists:	363
Population to (active) dentist ratio:	1,344
Membership of Dental Association:	90%

Specialists are not recognised. Dentists do have chairside assistants. Apart from technicians, no other auxiliaries are recognised. Participation in continuing education is mandatory by law.

Government and healthcare in Luxembourg

Luxembourg is a Western European country sandwiched between Belgium, France and Germany. It is one of the smallest European countries in terms of both population and land area (2,586 sq km).

The year 963 is the starting point of the history of Luxembourg. The count Sigefroid made an exchange with the abbey of Treves and got the rock of "the Bock". He constructed on the ancient Roman castle called Lucilinburhuc (= small castle) a new castle. Around this castle a town fortress was developed during the centuries, which explains that the history of Luxembourg is dominated by foreign sovereignties, which wanted to control this important strategic point. After the Counts of Luxembourg arrived the Habsbourg from Spain, then the Bourgogne state, then the Netherlands. Following this, Luxembourg became an intermediate between the Kingdom of France and the German empire, and finally came the Habsbourgs from Austria.

The real creation of the Grand-duchy of Luxembourg was in 1815. The Vienna Act created two separate and independent entities: the Netherlands Kingdom and the Dukedom of Luxembourg. Since Guillaume I was the King of the Netherlands and Grand-duke of Luxembourg, this separation was not totally achieved. Guillaume considered Luxembourg as the 18th province of Netherlands rather than an independent state. But the subsequent period was characterised by gradual independence of Luxembourg. The Belgian revolution in 1830 caused a lot of problems and ended with the London treaty in 1839. Luxembourg lost more than half of its territory to Belgium at that time, but the treaty confirmed the statute of independence of the Grand-duchy of Luxembourg. Once more in 1867, the Treaty of London confirmed the perpetual independence of Luxembourg.

In 1921 the Grand-duchy created, together with Belgium, the "Union économique belgo-luxembourgeoise". In 1944 the governments of Belgium, Netherlands and Luxembourg commenced the foundation of the Benelux Customs Union. Luxembourg became the first European capital by hosting the siege of the CECA (communuaté européenne du charbon et de l'acier) the starting point of the European Economic Community (CEE). In 1957, Luxembourg became one of the six founding countries of the CEE (later the European Union), and in 1999 it joined the euro currency area.

The capital is Luxembourg City, in which several EU/EC departments are situated, (such as the European Court of Justice, the European Bank of Investment, the European "cour des comptes" etc).

There is a unicameral Chamber of Deputies or *Chambre des Députés* (60 seats; members are elected by direct, popular vote to serve five-year terms).

		Year	Source
% GDP spent on health	7.4%	2006	OECD
% of this spent by governm't	90.9%	2006	OECD

There is one healthcare scheme, the *Union des Caisses de Maladie*, which is made up of several sick funds. In the board of the *Union* the representatives of employees and employers have the same number of votes. The President of the "caisses" is a functionary sent by the government, so if the representatives of employees and employers do not find an agreement, the President with his one vote can determinate the outcome.

The evolution of the budget of the "caisses" is determined by law. It is funded by contributions from employers and employees, funded half and half by each. So, manual workers ("employees") pay 5.05% of salary for the sick fund and 8% for the pension fund; non-manual workers pay 2.8% and 8%, with the employer paying the same for the employees. Finally, state employees pay 2.7% for the sick fund and there is no specific contribution for the pension (this is regulated by convention).

The sick funds provide membership for different occupational groups, for example, civil servants, private employees and workers. There are no differential contributions between funds.

A social security number is required for access to health care. This number is used for reclaiming charges. For visits to the doctor or dentist the patient pays the fee and then reclaims it.

Oral healthcare

The provision of dental care is covered by a detailed Act of Parliament. Everybody in Luxembourg is entitled to dental care partly paid for by the *Union*, and all dentists must work within it (so there are no dentists who practice independently of the state system). Every dentist has an identification number, must use stationery from the sickness scheme and must charge the fees specified by the fund, unless a fee is not stated.

		Year	Source
% GDP spent on oral health	0.29%	2004	AMMD
% OH expenditure private	No data		

The *Union des Caisses de Maladie* and the different sick funds are responsible for reimbursements to the patient and is also responsible for negotiating the fees with the *Association des Médecins-Dentistes*. Some patients, because of the low reimbursements, subscribe to complementary private health insurances.

The *Contrôle Médical* gives prior approval for some treatments, and monitors care. Domiciliary care, when needed, is given.

There are a few private patients. Dental care is provided in general practice and there is no reported difficulty for access to care for patients.

Private insurance for dental care

It is possible to buy complementary private health insurance, for example to obtain health care abroad, including in some cases dental care. In the policies presently available, the insurance company takes the risk. The patient needs good oral health before cover can begin, and the premiums are linked to age. Premiums are paid directly to the company and the dentist has no role in promoting the policies. There is great variation in the cover they offer and the ways in which premiums are charged.

The Quality of Care

The standards of dental care are monitored by an independent body called the *Contrôle Médical* which employs three dentists who check the standard of care provided. Dentists whose pattern and cost of care is significantly different from the average may be investigated. An adverse report can lead to disciplinary processes for the dentist.

An independent body, the *Commission de Surveillance* investigates eventual complaints.

Health data

		Year	Source
DMFT at age 12	0.82	2006	MoH
DMFT zero at age 12	No data		
Edentulous at age 65	No data		

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no formal fluoridation schemes in Luxembourg.

Education, Training and Registration

Undergraduate and Vocational Training

There are no dental schools in Luxembourg and students must train outside the country. Likewise, there is no post-qualification vocational training.

Registration

To register as a dentist in Luxembourg, a qualified dentist must have a recognised degree from an EU university or the *"Diplôme d'Etat en médecine dentaire" of the Grand Duchy*. Applications must be made to the Ministry of Health, and dentists must be registered before they can legally practice.

Cost of registration (2008)	€ 200

Language requirements

There is a legal language requirement to ensure that the dentist understands patients. If a medical mistake occurs and it is due to not understanding the language the dentist engages in a civil responsibility.

Further Postgraduate and Specialist Training

Continuing education

Currently, a minimum amount of continuing education is required by law, but each dentist decides how much is needed for proper practise.

Historically, dentists either undertook their continuing education in Luxembourg (where AMMD organises continuing education) or they return to the dental school where they have been trained previously. They also can choose another dental school or courses.

Specialist Training

In Luxembourg no specialists are recognised and specialist training is not available.

Workforce

Dentists

Year of data:	2008
Total Registered	363
In active practice	360
Dentist to population ratio*	1,344
Percentage female	30%
Qualified overseas	363

Each year the total number of dentists increases by between 10 and 20. The dentist to population ratio and has reduced in recent years, especially because of immigration, despite the population increasing. Or, this population growth is increasing much less than in the former years.

The dental association believe that the number of practitioners had almost reached saturation point by 2003, and that Luxembourg has an excess of dentists over need.

Movement of dentists across borders

By 2008 only a handful of non-EU/EEA nationals were practising in Luxembourg. There is evidence that some relatively newly installed dentists leave the country again, sometimes after only one or two years practice.

Most of the requests of non-EU/EEA nationals to practise in Luxembourg are refused because of low qualifications.

Specialists

No specialists are recognised as such and practice as a specialist is not allowed. It is also not permitted to describe a practice as, for example, "limited to orthodontics" on practice name plates or stationery.

Auxiliaries

No dental auxiliaries are permitted to work with patients, except as chairside assistants to dentists.

Year of data:	2006
Hygienists	0
Technicians	75
Denturists	0
Assistants	330
Therapists	0
Other	0

All figures approximate

Dental Technicians

Dental technicians normally train in dental laboratories, with theoretical education and training taking place in special courses for technicians in a professional technical teaching school for other "artisan" professions. There is a special qualification (with diploma) for dental technicians. Only the diploma allows a qualified technician to own a dental laboratory.

Most technicians are salaried and work in commercial laboratories. Fees are charged to dentists for the services. A small number of technicians work as salaried employees in practices.

Chairside assistants

There is no formal training or qualification for dental chairside assistants in Luxembourg. The dentist is responsible for the training qualification of his chairside assistant.

Practice in Luxembourg

Year of data:	2008
General (private) practice	360
Public dental service	3
University	
Hospital	
Armed Forces	1
General Practice as a proportion is	100%

Working in General Practice

Dentists are said to be in *"general practice"* (all dentists practice this way). Practitioners work on their own or as small groups, outside hospitals or schools, and provide a broad range of care. They are nearly all self-employed and earn their living through charging the prescribed fees for treatments.

Fee scales

A scale of fees, the *Nomenclature des actes et services des médecins et médecins-dentistes*, is published by the *Union des Caisses Maladie*. For most items listed the fee stated must be charged. However for some items the dentist may, with prior approval from the *Contrôle Médical*, charge a higher fee. The list indicates whether or not prior approval is required for particular treatments. The *Contrôle Médical* is the body responsible for prior approval. Any items of dental care which are not listed in the Nomenclature may be charged at a reasonable rate. The patient pays the whole fee to the dentist and then reclaims the fee, or part of the fee, from their sick fund.

The sick fund's reimbursement for fixed and removable items covers a small part of the cost. The patient who wants to receive 100% of this sick fund reimbursement (and that is only a small part of the cost) must have attended a dentist at least once a year, the two years before treatment. Those who cannot satisfy this condition may only claim a smaller reimbursement. There are some items of care (prosthodontic) which will only be replaced under sick fund rules after a specific time period, for example a crown or bridge every 15 years. The *Contrôle Médical* keeps a database with records from the early 1980s to check this. The percentage of the population who attend at least once every two years is not published. Likewise, the number of patients a dentist normally sees is not known.

Joining or establishing a practice

There are no rules which limit the size of a dental practice in terms of the number of associate dentists or other staff. However, most dentists work as single practitioners and almost all own the practice in which they work. Practices must be owned by dentists and a few dentists sometimes join together to share facilities. The equipment and premises of a dental practice can be bought and sold but there is no provision for selling the right to the patients' records.

There is no state assistance for establishing a new practice, so dentists usually take out commercial loans from a bank. Dental practices are normally in houses or apartments and may not be located in commercial buildings, for example, in shopping malls or within the same building as another dental practice.

There are specific contractual requirements between practitioners working in the same practice. Employees (chairside assistants, but not the dentists) are protected by the national and European laws on issues such as minimum wages, maternity benefits, occupational health, minimum vacations and health and safety.

Working in Public Clinics

There is no public dental service in Luxembourg although the Ministry of Health employs 3 dentists (2 of them part-time) who do not themselves provide care for patients. They undertake preventive services for children to 12 years and epidemiological surveys.

At a local level, in some towns basic dental inspections and health education in schools are done by dentists in general practice. Children identified as needing dental treatment will then have to a visit the family dentist of their choice.

Working in Hospitals

In Luxembourg, hospitals are private and dental offices too. No dentist is working full time in a hospital. Some dentists practice occasionally special treatments - for instance treatments not possible under local anaesthesia (surgery, traumatology, disabled/handicapped people etc.)

The dentist and the hospital then charge the patient separately the fees for the care provided. To work in a hospital a dentist needs access to the hospital. Therefore, generally a dentist will ask a colleague who has the access to the hospital to do the sessions and to treat the patient.

Working in the Armed Forces

One dentist serves part-time in the Armed Forces in 2008.

Professional Matters

Professional associations

	Number	Year	Source
Association des Médecins et Médecins-Dentistes	290	2008	AMMD

The "*Association des Médecins et Médecins-Dentistes*" du Grand-Duché de Luxembourg (AMMD) is the single and only national medical and dental association. It was founded in 1904 and is a politically independent trade union regrouping all the doctors and dentists practising in the country. Even though membership is voluntary, it represents most Luxembourg doctors and dentists. The Association is administered by a board of 15 members, amongst which there have to be at least three specialists, three GPs and three dentists. The mandates come out of general elections held in the general assembly. The mandate covers a 4-year period. It is a more than 30-year-old tradition that the President is a specialist, the first of the two Vice-Presidents is a dentist, and the Secretary-General a GP. Inside AMMD, dentists have a special association for dentists, the" Association des Médecins-Dentistes".

The Association is the main negotiating body with the government and with the *Union des Caisses de Maladie*, for example, for the scale of fees, conventions and other regulations.

Ethics and Regulation

Ethical Code

Dentists in Luxembourg have to work within an ethical code which covers: relationships and behaviour between dentists, the contract with the patient, consent and confidentiality, and advertising. This code is administered by the *Collège Médical*. Members of the board include doctors, dentists and pharmacists. The *Collège Médical* will also arbitrate between dentists, if there is a relationship or behavioural problem.

Outside the sick fund system a patient may complain to the *Collège Médical*, but only about matters of professional behaviour rather than the quality or quantity of care. Within the sick fund a patient may complain to a *Commission de surveillance* which may transmit the complaint to a board headed by a judge.

For other problems, the Court of Justice is available for the complainant. Likewise, a dentist who has a complaint against upheld is may be referred to the Court. Ultimately, the right to practice can be removed. There is also an appeal mechanism.

Data Protection

Luxembourg has enacted the Directive on Data Protection and during 2003 the Association discussed with the government how the regulations would operate within medical and dental practice.

Advertising

Advertising is not allowed. The *Collège Médical* and the AMMD are analysing the situation, with a view to permitting, in the future, standardised websites.

Indemnity Insurance

Indemnity insurance is compulsory for all dentists working in Luxembourg. Some companies may cover and allow working in a location close to a cross border, but this is exceptional.

Tooth Whitening

Tooth whitening is considered a medical act and is therefore limited to dentists to provide.

Health and Safety at Work

There is no requirement on dentists to ensure that inoculations, for such as Hepatitis B are completed by their staff, but this is recommended.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	under the authority of the Health Administration, controlled by Private Company.
Electrical installations	No information available
Waste disposal	"Sharps" must be given to a pharmacy for disposal, clinical waste is to be incinerated.
Medical devices	under the authority of the Health Administration, controlled by a Private Company.
Infection control	The Health Administration

Ionising Radiation

There are specific regulations about ionising radiation. The EU Directive has been enacted. Equipment has to be inspected at least every 3 years (this is paid for by the dentist). Then there is a new authorisation for 3 years, until the next inspection.

Hazardous Waste

The EU Hazardous Waste Directive has been incorporated into law and is actively enforced. Amalgam separators are legally required.

Financial Matters

Retirement pensions and Healthcare

The retirement age in Luxembourg is 65 years. Contributions are at a rate of 8% from the employee and 8% from the employer. Dentists, doctors and lawyers belong to the same sickness fund, called the Sickness Fund for Private Employees.

To collect a full pension, the amount of which depends on how much has been paid in, the professional must have worked for at least 40 years. For any benefit, payments for at least 15 years must have been made. A dentist may retire and collect a pension from the age of 60, provided at least 35 years contributions have been made.

Dentists may continue working beyond the age of 65.

Taxes

The highest rate of income tax is about 50%

VAT/sales tax - 15% (TVA)

Various Financial Comparators

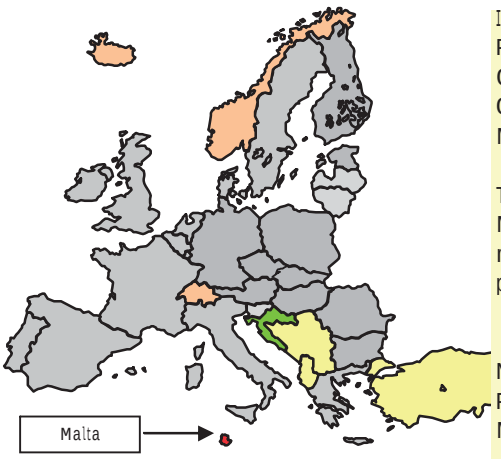
Zurich = 100	Luxembourg 2003	Luxembourg 2008
Prices (excluding rent)	78.2	93.2
Prices (including rent)	75.3	94.1
Wage levels (net)	75.4	85.5
Domestic Purchasing Power	88.6	90.9

Source: UBS August 2003 and January 2008

Other Useful Information

Main national association & information centre:	*Competent Authority:*
Association des Médecins-Dentistes Association des Médecins et Médecins-Dentistes (AMMD) 29 rue de Vianden L-2680 Luxembourg Tel: +352 444 033 Fax: +352 458 349 Email: secretariat@ammd.lu Website : www.ammd.lu	Médecin-Dentiste auprès de la Direction de la Santé Villa Louvigny Allée Marconi L-2120 Luxembourg Tel: +352 478 1 Fax: +352 467 962 Email: Website: www.ms.etat.lu

Malta



Date of last revision: 1st October 2008

In the EU/EEA since	2004
Population (2008)	410,584
GDP PPP per capita (2007)	€18,931
Currency	Euro
Main languages	Maltese, English, Italian

The State provides a free medical service to every citizen who lives in Malta. Those suffering from chronic diseases are entitled to free medicines. Polyclinics provide free comprehensive healthcare to all patients. Some (free) oral healthcare is provided in these clinics but most dentistry is performed in wholly private practice.

Number of dentists:	176
Population to (active) dentist ratio:	3,041
Membership, Dental Association of Malta	70%

There is a use of (overseas trained) specialists in both the public and private sectors. Dental hygienists are also available.
Continuing education is not mandatory.

Government and healthcare in Malta

The tiny island Republic of Malta, lies to the South of Sicily (Italy), in the Mediterranean Sea. Its total land area, spread over two main islands, is 316 sq km. The terrain of the islands is mostly low, rocky, flat to dissected plains, with many coastal cliffs.

The capital is Valetta.

In 1964 Malta gained its independence as a state within the British Commonwealth, and became a republic in 1974. There is a unicameral House of Representatives (of usually 65 seats, but additional seats are given to the party with the largest popular vote to ensure a legislative majority; members are elected by popular vote on the basis of proportional representation to serve five-year terms).

The Executive branch includes a President and Prime Minister, together with a cabinet appointed by the President, on the advice of the Prime Minister. The President is elected by the House of Representatives for a five-year term, following legislative elections. The leader of the majority party or leader of a majority coalition is usually appointed Prime Minister by the president for a five-year term.

The State provides free medical service, including hospitalisation, to every Maltese citizen who lives in Malta. Anybody who is suffering from chronic diseases, such hypertension, diabetes mellitus, asthma etc., is entitled to free medicines. A new central teaching hospital was opened in 2008 to replace the existing one.

Health centres spread around the islands provide comprehensive healthcare to non-paying patients, without distinction on income and wealth. Private hospitals exist and are providing treatment to paying patients who usually have medical insurance.

		Year	Source
% GDP spent on health	8.2%	2007	NSO
% of this spent by governm't	76.1%	2004	OECD

'NSO' is the National Statistics Office

Oral healthcare

In Malta, the responsibility for planning oral healthcare lies with the Ministry of Health. Dentistry, like the other medical professions, is governed by the Health Care Professions Act of 2002. The dental register is held by the Medical Council of Malta.

		Year	Source
% GDP spent on oral health	0.40%	2007	NSO
% OH expenditure private	22%	2006	NSO

It is not possible to identify the proportion of expenditure on oral healthcare that is private.

The Dental Department within the Ministry of Health looks after all the services provided in the main Dental clinic at St. Luke's Hospital and other Government institutions and Hospitals. There is no payment for any treatment carried out by the public dental service and school children are provided all their dental treatment at the school dental clinic.

Private practice provides the bulk of all dental treatment and patients pay directly for most of the dental treatment. Private medical insurance only covers certain procedures, such as surgical procedures. Private fees are fully "free market" in nature and they are determined in agreements between dentists and their patients.

The normal frequency for routine oral examinations is, on average, 6 monthly.

The Quality of Care

An annual check by health inspectors ensures that all dental clinics are set up and functioning according to requisite regulations.

Health data

		Year	Source
DMFT at age 12	1.30	2005	PHC
DMFT zero at age 12	49%	2005	PHC
Edentulous at age 65	8%	2002	HIS

PHC is Primary Health Care

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth.

Fluoridation

There are no fluoridation schemes in Malta. However, as part of a promotion for toothpaste, private dental clinics provide free fluoride toothpaste once a year for children.

Tap water in Malta and Gozo had natural fluoride present. However due to the introduction of reverse osmosis plants in 1987 the fluoride content in water in Malta has declined to negligible amounts whilst the water in Gozo has an average of 0.6 ppm.

Education, Training and Registration

Undergraduate Training

There is one dental school in Malta, which is in the Faculty of Dental Surgery of the University of Malta. The school is publicly funded.

Year of data:	2007
Number of schools	1
Student intake	8
Number of graduates	8
Percentage female	50%

The dental school derives the legislative framework under which it educates dental students from the Education Act. These regulations follow very closely the recommendations for the five-year dental course in the United Kingdom and so Malta has complied with the EU Directives from before admission of the country into the EU. The legal framework is a legal notice within the Act that prescribes curriculum and structure.

To enter dental school a student has to have completed secondary school (usually at the age of 18) and attained results (minimal grade C) in 2 advanced examinations (which must be Chemistry and Biology), and 3 subjects at intermediate level (with physics and a language subject being compulsory). There is a *numerus clausus* and those applying with the highest grades are accepted. The course opens on a yearly basis and up to two non-Maltese students per year are accepted. These two overseas places are not necessarily filled. The University Admissions Board controls the applications. 55% of clinical time is devoted to clinical training.

Quality assurance for the dental school is provided by the Medical Council.

Qualification and Vocational Training

Primary dental qualification

The primary degree, which must be included in the register of the Medical Council, is: Bachelor of Dental Surgery (BChD)

Vocational Training (VT)

There is a form of specific vocational training (VT), which is not compulsory. It is a two year rotational programme at the Dental department Mater Dei Hospital and peripheral Public Services Health Centres Dental Clinic including the School Dental Clinic. As far as possible students on qualification are encouraged to join the scheme but it is not compulsory and therefore a graduate dentist has a licence to practice after 5 years training course. However, because most general practice is single handed, a VT scheme based in practice would be difficult to implement.

Registration

Cost of registration (2008)	€ 35

Dentists are automatically registered with the Medical Council of Malta after graduation. Dentists are given a warrant to work by the Medical Council, which by law has a quasi-judicial board, as it has the power to erase dentists from the Register. It has never done so since it was formed in 1940.

Diplomas from other EU countries are automatically recognised since 1st May 2004, when Malta became a full member of the Union. However, there is a 7 year interim period until 2011, during which work permits are at the discretion of the Maltese Government.

Language requirement

Maltese is not needed as a language requirement for a foreign dentist to work in Malta.

Further Postgraduate and Specialist Training

Continuing education

Continuing education is not mandatory under Maltese legislation, but the Dental Association of Malta, together with the Faculty of Dental Surgery, has been organising regular lectures and courses which award CPE points to the participants.

Proposals for legislation to make CPE compulsory for renewal of a licence to work as a dentist had not come to fruition by 2008.

Specialist Training

There is no specialist training programme in Malta. However there are two training posts as part of the MFDS (UK). These are subject to the regulation of the FDS of the Royal College of Surgeons in London. The specialists who work in both private and public sector would have attained their specialist training overseas.

Following enactment of the Health Care Professions Act, the Medical Council Malta, in consultation with the medical profession, created a Specialist Accreditation Committee. This formulated policy on specialist lists for Malta trained specialists and those entering Malta with overseas diplomas.

Specialist lists for dentistry were created in March 2004. The Act recognises two dental specialties, (oral surgery and orthodontics) that are also recognised by the EU. The University of Malta has recommended that a further 3 specialities be recognised - restorative dentistry, child dental health and Dental Public Health, but this had not happened by 2008.

Workforce

Dentists

Many dentists practice in more than one sphere of practice. In 2007, 70% of dentists were below 40 and 15% of dentists over 50; it has been suggested that Malta is training more dentists than will retire in the first years of the millennium.

Year of data:	2008
Total Registered	176
In active practice	135
Dentist to population ratio*	3,041
Percentage female	25%
Qualified overseas	12

* this figure relates to *active* dentists

There are several dentists with other EU countries' qualifications working in Malta in 2008. Many are Maltese or are married to Maltese nationals, which gives them an automatic right to a working permit.

There is no reported unemployment of dentists in Malta.

Specialists

In Malta dental specialities have been recognised only since the Health Professions Act was fully implemented in 2004. Initially, orthodontics and oral surgery have been recognised.

However, a number of dentists have additional qualifications in specific areas of dentistry and patients may be referred to them from other dentists.

Year of data:	2008
Orthodontics	7
Endodontics	1
Paedodontics	2
Periodontics	2
Prosthodontics	1
Oral Radiologists	1
Oral Surgery	7
OMFS	2
Dental Public Health	2
Others	7

Auxiliaries

The system of use of clinical dental auxiliaries is limited to hygienists in Malta.

- Dental hygienists
- Dental technicians

Year of data:	2007
Hygienists	17
Technicians	34
Denturists	0
Assistants	75
Therapists	0
Other	0

Dental Hygienists

The title is legally protected and there is a registerable qualification which dental hygienists must obtain before they can practice. Training is for 3 years in the government hospital. The Board for Professions Supplementary to Medicine holds the registration of dental hygienists.

Dental hygienists work under the prescribed instructions of a dentist, in a clinic or private practice. Their work includes scaling and normal dental hygiene, and Oral Health Instruction.

Most registered dental hygienists work in the public sector but a handful work privately, usually on a part-time basis. Public sector hygienists are always salaried.

Dental Technicians

The title is also legally protected as Dental Technologist and there is a registerable qualification which they must obtain before they can work independently. Training is also for 3 years in the government hospital. The register is held by the Board for Professions Supplementary to Medicine.

Dental Technicians work in commercial dental laboratories, to construct prosthodontic and orthodontic appliances, to the prescription of a dentist, and they are not able to deal directly with the public. Although, legally, dental technicians must not have direct contact with the public, it is widely reported that people have their dentures repaired directly by them.

Most dental technicians work in the public sector but about a third work solely in private practice. Some of those who work in the public sector also work in private practice.

Like hygienists, dental technicians are normally salaried when working in the public sector.

Denturists

Denturism is illegal in Malta, but there are known to be some denturists practising.

Dental Chairside Assistants (DSAs)

By 2008, DSAs were not officially qualified and were trained by the dentists themselves. Those working in the public sector are usually trained general nurses but those working in the private sector usually have no qualifications and are trained by the dentist who employs them.

A two-year course for DSAs commenced in October 2007, with a total of 15 trainees.

In 2007, there were dental nurses working at a school dental clinic and in the main Dental Department of St Lukes' Hospital. The health centres usually have a general nurse assigned to the dental clinic and there are dental nurses in the dental department at Gozo General Hospital. There are 30 nurses working as DSAs in the public sector.

It is estimated that 70% of dentists in private practice have an assistant working with them.

Practice in Malta

Oral health services are provided in both the public and private sectors with 95% of the dentists working in the public sector also working in private practice. In 2008, over 20 dentists who were working in both sectors had dental postgraduate qualifications.

Year of data:	2008
General (private) practice	140
Public dental service	23
University	20
Hospital	17
Armed Forces	0
General Practice as a proportion is	80%

Working in General Practice

In Malta, dentists who practice on their own or as small groups, outside the hospital or polyclinic, and who provide a broad range of general treatments are said to be in *general practice*. Many GDPs also work in the public dental service until the early afternoon each day.

About 80% of private practitioners work in single dentist practices. There are some dentists who own a practice and have a dentist who also works in the practice and earns 50% of the amount that the patient pays for the treatment. This dentist does not contribute to the overheads and running of the practice. There are five group practices where the overall expenses are shared between the partners but the income from the patient fees is on a separate basis.

Fee scales

Most dentists in private practice are self-employed and earn their living through charging fees for treatments. There are no official fee scales and pricing is unregulated in Malta. The patient pays the dentist in full and some then reclaim partial reimbursement from their private insurance if possible.

Joining or establishing a practice

Any dentist holding a valid warrant issued by the Medical Council may open a dental surgery anywhere he or she decides. A permit from the Health Department and another one from the Malta Environment and Planning Authority are needed. Dentists in Malta are the only professionals who are taxed (€230 Euros a year) to be able to practise in their place of work.

Practices are normally sited in apartments or small houses converted into clinics. There are no rules which limit the size of a dental practice in terms of number of associate dentists or other staff. Premises may be rented or owned. There is no state assistance for establishing a new practice, so usually dentists take out commercial loans from a bank.

Working in the Public Dental Service and Hospitals

It is reported that about a dozen of the dentists working for the Dental Department have postgraduate training in a specialised field.

- In the main dental clinic at Mater Dei Hospital emergency consultation, major oral surgery under local anaesthesia or general anaesthesia, and normal consultations are provided for free to all patients. Some services, such as Restorative Dentistry and Prosthetics (mainly acrylic dentures) are provided only to patients in low income brackets. Extractions for all patients are free, when carried out under general anaesthesia. In 2003 there were 14 dentists working at the main Dental clinic at Mater Dei Hospital.
- There is a dental clinic in the sister island of Malta, Gozo in the Gozo General Hospital and in 2003 there were 3 dentists working there.
- There is 1 dentist working in a dental clinic in a retirement home (SVPR) providing free prosthetics and restorative treatment to those patients who are entitled to it.
- There are 8 Regional Health Centres which have a Dental Clinic which provides emergency dental care, restorative dental treatment to those who are entitled to it (patients in low income brackets and children below the age of 16) and preventive care. In 2003 there were 14 dentists working in these health centres.
- There is a School Dental Clinic which offers free treatment to all children below the age of 16 (child dental health and orthodontics). Referrals to the School Dental Clinic are via the regional health centres and the main dental department in the main hospital. Children who have a high caries rate, require orthodontic treatment and specialist paediatric care are referred to the school dental clinic. Orthodontic treatment which includes any form of removable appliance therapy is provided for free to all patients. Fixed appliance therapy is provided for free to those children who are considered as high priority, such as cleft lip and palate patients, patients with hypodontia, and those patients about to undergo orthognathic surgery. There were 8 dentists working at School Dental Clinic.

Funding for all the above departments is from government funds allocated to the health department. Treatment is free for Maltese citizens.

The provision of domiciliary (home) care is not very common in Malta, and is usually provided by public health dentists.

The quality of dental care is assured through dentists working in teams under the direction of experienced specialists. The complaints procedures are the same as those for dentists working in other settings.

Persons employed in the public service receive fixed remuneration (by salary), very often divided into several components such as seniority, specialisation, premium etc.

Working in University and Dental Faculty

Dentists work in the dental school on a part time basis, as salaried employees of the university. There are also medical staff who lecture to the dental students in their pre-clinical year. The dentists are allowed to combine their work in the faculty with employment or private practice elsewhere.

The main academic title within the Maltese dental faculty is that of University Professor. Other titles include lecturer, assistant lecturer and clinical demonstrators. Senior teachers and professors will have completed a PhD, and most will also have received a specialist clinical training. Apart from these, there are no other regulations or restrictions on promotion.

The quality of clinical care, teaching and research in dental faculties is assured through dentists working in teams under the direction of experienced teaching and academic staff. The complaints procedures are the same as those for dentists working in other settings.

Working in the Armed Forces

There are no full-time dentists in the Armed Forces. Members have all their treatment provided free by the state dental services.

Professional Matters

Professional associations

There is a single main national association, the Malta Dental Association (DAM). About 70% of active dentists are members.

	Number	Year	Source
Dental Association of Malta	102	2007	FDI

The Association represents private and public health dentists and combines this role by trying to emphasise to common, professional matters. It is not a trade union, but the Government of Malta recognises DAM as the valid representative of all Maltese dentists, for example for EU regulation talks, a new health care profession act, etc.

Ethics and Regulation

The Medical Council

The Medical Council of Malta consists of a legal practitioner, medical practitioners, dental practitioners and lay people. Some are nominated and some are elected. Dentistry is incorporated under the Medical Council with appropriate representation of the dental profession on the body. The Council meets as a single body and dentistry is not subservient to Medicine.

Ethical Code

Dentists are subject to the same ethical code as their medical colleagues. For example, they must only use proven techniques and must constantly update their clinical skills. There is also a special law to protect patients' rights, consent and confidentiality. The Medical Council judges infringements of malpractice. There are no specific contractual requirements for dentists working together in the same practice. The National and European laws on equal employment opportunities, maternity benefits, occupational health, minimum vacations and health and safety, however, protect a dentist's employees.

Fitness to Practise/Disciplinary Matters

Maltese dentists are governed by the Health Care Professions Act which came into being on the 21st November 2003. A complaint can be lodged by anybody, including lay people with an interest in the case. A simple letter will suffice to start an investigation. In the Public sector the complaint is lodged with Customer Care of the Health Department. In the Private sector it is the Medical Council of Malta which deals with such issues.

If a dentist has been convicted by any court in Malta of any crime punishable by imprisonment for a term exceeding one year, or of any of the crimes mentioned in specific articles of the Criminal Code, or has been guilty of professional or ethical misconduct in any respect or in any other manner has failed to abide by the professional and ethical standards, then his/her name can be erased from the register, or suspended, or cautioned, or have to undergo remedial training or have a financial penalty.

Data Protection

In 2002, a law, covering data protection came into force. In July 2003 a document was set up which defines the guidelines to be followed by a Data Controller within the Public Service, for the notification of an organisation's process – both computer as well as manual, existing as well as new. The document also provides instructions on filling in the Notification form. This notification form is to be sent to the Data Protection Commissioner.

See http://mohweb/healthweb/dataprotection.htm for more details.

Advertising

Advertising by dental surgeons is not allowed, although notification of a change of address or working hours is permitted by advertising in newspapers for a maximum of 3 days (but not TV). Post graduate qualifications may be announced, but without a photo. The Medical Council regulates and monitors this.

There is no specific mention of websites in the Ethical Code, but the principles in the Code would dictate that these are not allowable for Maltese dentists.

Insurance and professional indemnity

Indemnity insurance is not mandatory. There are a few dentists who are insured with the Medical Protection Society (UK) at an annual cost of about €1,400 per annum. The premium is more if the dentist does implants and oral surgery. A patient is entitled to lodge a complaint and demand compensation before a medical court or a common court.

Corporate Dentistry

There is no corporate dentistry in Malta.

Tooth Whitening

Tooth whitening procedures are limited to dentists.

Health and Safety at Work

There is legislation in the field of employee protection. Hep B vaccinations are mandatory in Malta and are provided free by the Health Department.

Ionising Radiation

There are specific regulations regarding radiation protection -one under the Public Health Act and the other the enabling Act of the Prime Minister.

An employer has the obligation to ensure that there is adequate training for his/her staff. There is no obligation for continuing education and training.

Hazardous Waste

The EU Hazardous Waste Directive is incorporated into law and actively enforced. Amalgam separators are legally required.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Private company
Electrical installations	Private company
Infection control	Department of Infection control of the Ministry of Health
Medical devices	Private
Waste disposal	Private (All private companies are licensed by the Health Department).

Financial Matters

Retirement pensions and Healthcare

The National Insurance premiums (4.6% of earnings) include a contribution to the national pension scheme. Retirement pensions in Malta are typically 60% of a person's salary on retirement. The official retirement age in Malta is 60, although the average age of retirement is 59.

Dentists practice, on average, to little over 60 years, although they can practice past this age.

Taxes

For the majority of the Maltese population general health care is paid for mainly through income tax.

There is a national income tax (dependent on salary or income). The maximum amount of tax that can be paid is 35%. National Insurance premiums are an additional 8.3% of salary or income.

VAT/sales tax

There is a value added tax, payable at a rate of 18% on purchases. Medicinals and certain dental equipment and filling materials are exempt from VAT. Approximately 70% of dental materials and equipment needed are VAT free. Patients do not pay any VAT on treatment, and dentists do not get refunds on purchases.

Other Useful Information

Main national association and Information Centre:	*Competent Authority:*
Dental Association of Malta, The Professional Centre, Sliema Road, Gzira GZR 06 MALTA Tel: +356 213 12888 Fax: +356 213 12004 Email: mfpb@maltanet.net Website: None	The Director General, Department of Health, Palazzo Castellana, 15, Merchants Street Valletta VLT 2000 MALTA Tel: +356 229 92436 Fax: +356 212 42884 Email: joseph.m.stafrace@gov.mt Website: http://www.sahha.gov.mt/pages.aspx?page=42
The Medical Council of Malta:	*Council for the Professions Complementary to Medicine:*
181 Melita Street Valletta CMR02 MALTA Tel: +356 212 55540 Fax: +356 212 55541 Email: medicalcouncil.mhec@gov.mt Website http://www.sahha.gov.mt/pages.aspx?page=87	181 Melita Street Valletta MALTA Tel: +356 212 55540 Fax: +356 212 55541 Email: cpcm@gov.mt Website: http://www.sahha.gov.mt/pages.aspx?page=84

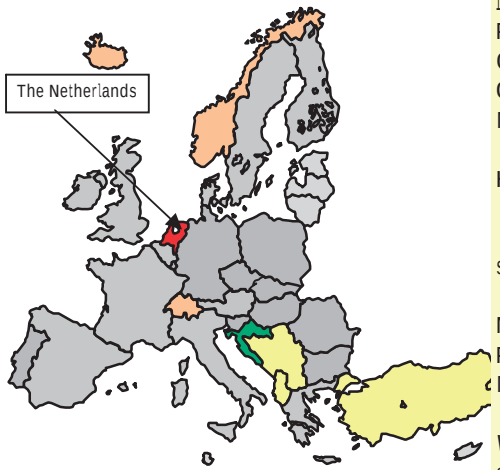
Publications:

The Probe
4 times a year newsletter, by the Dental Association of Malta.
Editor: Dr David Muscat.
E-mail: empire@maltanet.net

Dental School:

The Dean
Faculty of Dental Surgery
Medical School
MATER DEI HOSPITAL
Block A, Level O
B'Kara Bypass
MSIDA MSD2090
MALTA
Tel: +356 221019 or 225464
Fax: +356 235638
Email: simon.camilleri@um.edu.mt or
daniela.mifsud@um.edu.mt
Website: http://www.um.edu.mt/about/uom
Dentists graduating each year: 6 (+ up to 2 from overseas)
Number of students: 30 (+ some from overseas)

The Netherlands



In the EU/EC since	1957
Population (2008)	16,404,282
GDP PPP per capita (2007)	€31,913
Currency	Euro
Main language	Dutch

Health care is provided by a government-regulated system of health insurance. There are schemes which an individual may belong to, public schemes (sick funds), or private for higher earners. The public scheme is compulsory for those under 65 on low incomes.

Number of dentists:	10,901
Population to (active) dentist ratio:	1,866
Membership of the Dutch DA (NMT):	76%

Whilst the use of specialists is limited to orthodontics and maxillo-facial surgery, there is a broad use of dental auxiliaries.
Continuing education is not mandatory.

Date of last revision: 1st October 2008

Government and healthcare in the Netherlands

The Netherlands is a small but densely populated country on the southern edge of the North Sea. It is both a constitutional monarchy and a parliamentary democracy. There are 12 provinces and 443 (2007) municipalities and there is substantial decentralisation of government responsibility, especially in education, transport and health.

The Dutch Parliament consists of the House of Representatives (150 members, elected in direct elections by universal suffrage) and the Senate (75 members, elected by the members of the Provincial Councils). The capital is The Hague.

As from 1 January 2006 a new Health Care Insurance Act entered into effect. This act provides a compulsory basic insurance for all Dutch citizens. This basic insurance contains a standard package of necessary, mostly curative health care.

All other health care can be additionally insured or paid for privately.

Both the basic insurance and the additional insurances are underwritten by private insurance companies. Every individual person is free to choose a health care insurer, whilst, as far as it concerns the basic insurance health care insurers have a duty to accept applications from every individual seeking the insurance.

Insurance companies are expected to compete for customers by lowering their premiums.

Regarding supervision within the health care system, an important role is set aside for the National Health Care Authority, which guards both the content and quality of care, as well as the honest competition between insurance companies and healthcare providers.

		Year	Source
% GDP spent on health	12.6%	2007	CBS/CVZ
% of this spent by governm't	82.4%	2004	OECD

CBS is the Central Bureau of Statistics and CVZ is the College of Healthcare Insurances.

There is a predetermined budget for healthcare, set by the government.

Oral healthcare

Public Healthcare

Almost all dentistry is provided by dentists working in general practice. Approximately 69% of the population is registered in the public system.

Although dental treatment is provided under the private system, there is a national scale of maximum fees. Amounts are set each year by a government appointed body, the National Health Care Authority.

Dental care in the basic care insurance package contains preventive and curative treatment of all juveniles up until their 21th birthday, the cost of a full set of dentures, and care for specific groups of patients, for example persons with a physical and/or mental handicap.

All other oral health care, including all preventive and curative dental care for grown ups and all orthodontic care, can be additionally insured or paid for privately.

Patients will normally attend for their re-examinations about every 9 months. There is no formal system for domiciliary care.

In 2008, the total expenditure on healthcare costs (welfare excluded) was 43 milliard of which 2 milliard was spent on dental healthcare (4.7 %).

		Year	Source
% GDP spent on oral health	0.36%	2007	CBS/CVZ
% of OH expenditure private	74%	2007	CBS/CVZ

This second figure refers to expenditure outside the basic insurance.

The Quality of Care

The quality of dental care is monitored by the profession in different ways and emphasis is placed on improvement and assurance rather than control. Quality improvement is achieved through continuing education, peer review and the development of standards and certification. The Individual Health Care Professions Act (BIG Act) was introduced for the whole of health care and dentistry on December 1st 1997. Its purpose was to promote and monitor the quality of professional practice across the whole of health care and to protect the patient against inexpert and negligent treatment by professional practitioners. The Act has four significant consequences for dentistry, a change in the revised regulation of qualification, new registration by law, quality assurance and a revised disciplinary code. The act replaced a number of existing and out of date laws.

A Dutch Health Inspectorate makes occasional visits to practices. Their checklist for screening dental practices covers:

- clinical practice,
- infection control,
- waste disposal,
- radiation practice.

They are able to issue warnings and initiate disciplinary procedures (see later).

Quality Register

In 2007, the Stichting Kwaliteitsregister Tandartsen (Institute for a Quality Register for Dentists) was established with the objective of creating transparency in dentists' quality care, and thereby contributing to patient safety. In order to achieve this, the Stichting maintains a register of dentists who meet five Registration standards which, in broad outline, are the following:

- unconditional registration in the BIG register;
- observing the code of conduct and guidelines, both practical and otherwise;
- studying specialist literature (240 hours in five years);
- following extra training and refresher courses and consulting with colleagues;
- having a complaints procedure in place.

As from 1 July 2007, this Quality Register is available to the public.

Health data

		Year	Source
DMFT at age 12	1.00	2004	OECD
DMFT zero at age 12	57%	2004	OECD
Edentulous at age 65	17%	2004	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth.

Fluoridation

There are no water or other fluoridation schemes.

Education, Training and Registration

Undergraduate Training

To enter dental school a student needs diploma VWO (secondary education) with physics, chemistry and biology and no entry examination. There is no vocational entry, such as from being a qualified dental auxiliary.

Year of data:	2007
Number of schools	3
Student intake	300
Number of graduates	226
Percentage female	55%

Dental schools are parts of Colleges/Faculties of Medicine in the universities. All the dental schools are state-funded. The students have to pay to go to university. Training lasts for 6 years.

The Ministry of Education and Science monitors the quality of the training, and the Council of the Faculty is directly responsible.

Qualification and Vocational Training

Primary dental qualification

Upon qualification, the graduates receive the title "Bachelor of Science" after 3 years, then after the fifth year "Master of Science (MSc). In full the title is: '*Universitair getuigschrift van een met goed gevolg afgelegd tandartsexamen*'.

The title "dentist" is reserved to those who are registered in the "BIG" register (see below, "Registration").

Vocational Training (VT)

No post-qualification vocational training is necessary for entering into full, unsupervised practice.

Registration

In order to register as a dentist in the Netherlands, an applicant must hold a diploma from a Dutch dental school. A formal application with appropriate dental certificates must be made to the Ministry of Public Health Welfare and Sport (or *het ministerie van VWS*).

Dentists who have graduated outside the Netherlands can apply for recognition of their degree and ask for a declaration of professional quality, which may allow them to be registered in the national register.

After the introduction of the Individual Health Care Professions Act, people are able to call themselves dentists if they, on presentation of the required documents – including the full the title '*Universitair getuigschrift van een met goed gevolg afgelegd tandartsexamen*' (ie recognition and declaration of professional quality), have had themselves registered as such by the National Health Register (BIG-register). The title is legally protected. Its use without registration is punishable by law.

Cost of registration (2008)	€ 80

Language requirements

It should be noted that a reasonable command of the Dutch language is essential in order to practise in the Netherlands (although there is no absolute measure of this).

For dentists from outside EU/EEA this is measured by a committee under responsibility of the Ministry of Health.

Further Postgraduate and Specialist Training

Continuing education

Continuing postgraduate education is not compulsory for dentists. This is normally provided by universities and private organisations.

Specialist Training

In the Netherlands two dental specialties are recognised:

- Oral and Maxillo Facial Surgery
- Orthodontics

The Ministry of Health has delegated the responsibility for registration of all specialists to the Specialist Registration Board '*Specialisten-Registratiecommissie* (SRC)' - which is appointed by the Board of the NMT. However, any changes to the registration procedure have to be approved by the Ministry.

Orthodontic training lasts four years and takes place at two dental schools: Nijmegen and Amsterdam (ACTA). Trainees are paid by the university.

The title on completion of training is '*Getuigschrift van erkenning en inschrijving als orthodontist in het Specialistenregister*' (a certificate showing that the person concerned is officially recognised and that their name is entered as an orthodontist in the specialists' register), issued by the Specialists Registration Board.

Oral and Maxillo-facial Surgery requires four years at one of five training facilities in university hospitals. To undertake this training a student requires a medical and dental qualification. Students are paid by the hospital.

On completion of training the title given is '*Getuigschrift van erkenning en inschrijving als kaakchirurg in het Specialistenregister*' (a certificate showing that the person concerned is officially recognised and that his name is entered as an oral surgeon in the specialists' register), issued by the Specialists Registration Board.

Workforce

Dentists

The Dutch Dental Association (NMT) has reported that the active workforce is decreasing but in 2008 there was a balance between supply and demand.

Year of data:	2008
Total Registered	10,901
In active practice*	8,791
Dentist to population ratio**	1,866
Percentage female	28%
Qualified overseas	641

* dentists under 65 years with private or practice address in the Netherlands

** active dentists only

About 45% of the dentists in active practice are over 50 years of age.

Movement of dentists into and out of the Netherlands

About 6% of the dental workforce qualified outside the Netherlands. There is no major movement of Dutch dentists out of the Netherlands.

Specialists

There are 2 classes of dental specialists in the Netherlands:

- Orthodontics
- Oral Maxillo-Facial Surgery

The ratio of dental specialists to dentists is about 1:17.

Numbers under the age of 64 years who are registered to work are in the following tables:

Year of data:	2008
Orthodontics	261
Oral Surgery	
OMFS	214

Patients may attend specialists directly, but usually they go by referral from a primary dentist. Specialists can apply a different scale of fees from general practitioners.

Oral and maxillofacial surgeons work mainly in hospital and universities. Most orthodontists work in private practice, although some work in universities.

Year of data:	2008
Endodontics	60
Paedodontics	40
Periodontics	80
Prosthodontics	
Oral Radiologists	
Dental Public Health	

Some general practitioners focus on a special field within dentistry such as endodontics, periodontics and paedodontics. They are not specialists but general practitioners with a *special interest* (differentiation).

Auxiliaries

In the Netherlands there are dental assistants, dental technicians and two other groups who provide clinical oral health care, dental hygienists and denturists.

Year of data:	2006
Hygienists	2,260
Technicians	5,000
Denturists (2005)	290
Assistants (2004)	16,400
Therapists	0
Other	0

Dental Hygienists

In the Netherlands dental hygienists are paramedicals with independent status. As such, they form an official profession who are required to be qualified and have a diploma. They train in special hygienist schools (not associated with dental schools), for 4 years full time. On completion of training they receive a diploma. However, they do not have to register, even if they own their clinic.

Most are employees in dental practices, some work in hospitals and centres for paediatric dentistry. However, hygienists may practise in a dental hygiene clinic, independently from a dentist, but all the treatment undertaken must have been referred by a qualified dental practitioner. Some hygienists with extra skills work as orthodontic auxiliaries.

There is a course where dental hygienists are taught how to provide routine dental treatment eg fillings, extractions for children. When the course is completed, a hygienist may practise paediatric dentistry, but again, only after referral from the dentist.

The NMT has developed a working protocol for the above relationships and advises dentists and hygienists to comply with it.

Dental Technicians

Dental technicians train in special schools, for 2-4 years, part time. On completion of training they receive a diploma, but are not required to register. Most dental technicians work in dental laboratories. They are permitted to produce dental technical work to the prescription of the dentist, but cannot work in the mouth.

There are about 1,100 dental laboratories (2006 figures).

Denturists

Qualified denturists train for 3 years part-time, after completion of training as a dental technician. Training is provided by the Dutch Denturist Federation. On completion

of training they receive a further diploma. "Denturist" is a protected title, with an ethical/disciplinary system administered by the Denturist Federation.

Denturists are only allowed to provide full dentures and may work in independent practice.

Dental Assistants

There is 'certified training' available for dental assistants in the Netherlands but although there are approximately 30 training schools and a postal course, most assistants are trained by individual dentists in their practices.

Assistants have a wide range of duties but can only carry out 'reserved procedures' when authorised by a dentist who is satisfied that he/she is competent to do so. In all cases, the responsibility for the care provided remains with the dentist. Because of a shortage of dental hygienists, some assistants also carry out scalings but not root planing - this is permitted under the Individual Health Care Professions Act (BIG).

Practice in the Netherlands

Year of data:	2008
Gen practice (owners)	6,400
Gen practice (locums)	1,100
Public dental service	250
University	180
Academic (non-univ)	0
Hospital (all OMFS)	214
Armed Forces	50
General Practice as a proportion is	85%

All the above figures are approximate

Working in General Practice

Dentists who practice on their own or as small groups, outside hospitals or schools, and who provide a broad range of general treatments are said to be in *General Practice*.

Dentists in general practice are mainly self-employed.

Approximately 77% work in their own general practice - about 60% of which are "single-handed" practices. The remainder work in practices of two or three dentists, with a few larger groups. About 1,100 dentists work as locums. Within group practices responsibilities are shared, work is discussed and some dentists concentrate on different types of care.

The average number of patients visiting the dental practice each year is approximately 2,900 (2006).

Fee scales

There is a fee scale of maximum charges, and dentists bill every treatment. The maximum fees are set by the Health Care Authroity (NZA).

Joining or establishing a practice

There are no rules which limit the size of a dental practice in terms of the number of associate dentists or other staff. Premises may be rented or owned. There is no state assistance for establishing a new practice, so usually dentists take out commercial loans from a bank. The NMT has a special service for introducing young dentists as locums to established practices and recommends that new dentists work in several practices to gain experience before choosing which to buy.

Anyone can own a dental practice, and there is also provision for them to be run as companies. NMT has a service to help in the selling and buying of dental practices. It puts buyers and sellers in contact and also has business advisers. It is possible to sell the goodwill of a practice and often the equipment is sold, as well as the building.

The only restrictions on setting up practice are planning laws and it is not possible to open premises in residential areas. However the local councils often allow dentists to establish themselves in new estates and also designate areas as suitable for the dentist. There are no access problems for patients living in rural areas but there are some shortages of dentists working in inner city areas and some specific social groups are having trouble accessing dental care.

Private practices are mostly housed in separate practice buildings (about 72%) or in/next to the private house of the dentist (15%) (in 2006).

Working in Public Clinics

Apart from the extension of coverage of the public sick funds, to provide dental care for card-holding children and handicapped people, there is no separate public dental service in the Netherlands. There is, however, a small dental service for schools which is run as a private business. A public medical service provides some information on prevention, statistics and advises the Ministry of Health.

The Ivory Cross, which specialises in dentistry, is an organisation which is subsidised by the Ministry of Health and the NMT. It produces leaflets with general information on dental care, and also more specific information for the public, for example "amalgam in dentistry".

Very few dentists are employed in these public health clinics.

Epidemiological surveys are undertaken by TNO, Quality of Life, Leiden and St Radboud University Medical Centre, Department of Preventive and Restorative Dentistry, Nijmegen.

Working in Hospitals

There are no organised hospital dental services in the Netherlands, except for oral maxillo-facial surgery. In-patients receive their general care from their regular dentist.

Working in Universities and Dental Faculties

The dental schools are part of universities as dental faculties, in which about dentists work full or part-time as employees of the university. They are free to combine their work in the faculty with part-time work elsewhere, for example in private practice.

The main title within a Dutch Dental Faculty is that of university professor. Other titles include university assistant, university lecturer and university head lecturer. There are no formal requirements for postgraduate training but professors and university head lecturers must have a doctorate. Professors are appointed on the basis of their publications and teaching. Approximately 70% of an academic's time is spent teaching. In general salaries are lower than for dentists who are in practice.

Working in the Armed Forces

A few dentists serve full-time in the Armed Forces.

Professional Matters

Professional associations

Main national association is the *Nederlandse Maatschappij tot bevordering der Tandheelkunde* (NMT) or Dutch Dental Association.

	Number	Year	Source
Nederlandsche Maatschappij tot Bevordering der Tandheelkunde	6,650	2008	NMT

The NMT is an association according to private law. A dentist is free to become a member or not. Three quarters of dentists and dental specialists are members of the NMT. The NMT is governed by a board of four dentists who are appointed by the General Assembly. The GA exists of representatives of the Regional Boards. The NMT has as its objectives the promotion of dentistry in general and the advancement of the intents of the dental profession.

The Association publishes an advice booklet on 'Practising Dentistry in the Netherlands'.

There are several associations and societies for dentists with special interests. These are best contacted via the NMT.

Ethics

Ethical Code

Dentists in the Netherlands have to work within an ethical code which covers relationships and behaviour between dentists, contracts with patients, consent and confidentiality, continuing education and advertising. This code is administered by the NMT. Also, if a patient visits a dentist with a problem such as pain, then under Dutch law the dentist is obliged to see him. However, the dentist is not required to accept the patient on a regular basis.

The ethical code also states that when established patients (those who receive regular care from that dentist) face financial difficulties a dentist must continue to treat them. The dentist must make considerable efforts to obtain the money and to finish complicated treatment, for example endodontics, before discontinuing treatment, although this is not a formal part of the ethical code.

There are no specific contractual requirements between practitioners working in the same practice but a dentist's employees are protected by the National and European laws on equal employment opportunities, maternity benefits, occupational health, minimum vacations and health and safety.

Fitness to Practise/Disciplinary Matters

Patient complaints may be handled in three ways. There is a general disciplinary law for the health care professions. Under this law patients' complaints are considered by one of five regional medical disciplinary boards. Board membership is 2 lawyers (including the chairman) and 3 dentists. Sanctions may be a warning, a reprimand, a fine or suspension/removal from the register. Any appeal will be heard by a board of 3 lawyers (including the chairman) and 2 dentists.

The NMT also has a system, which conforms to legislation, where patients and colleagues can register a complaint against a member of the Association. Dentists who are not NMT members must set up their own complaints procedures.

As a last resort, the patient has the option of starting a civil lawsuit against the dentist.

Advertising

Dentists working in the Netherlands must follow rules of conduct which control advertising. After changes in the law in 1997 a rule was adopted for the advertising code established by the NMT, which reads as follows:

"In co-operating or engaging in publicity, the dentist shall ensure that such publicity is not in conflict with the law, the truth or good taste, is in accordance with the due care that befits a dentist, and does not infringe on the goal of a mutual relationship between colleagues that is based on courtesy and trust. Publicity may not be intended to attract clients".

A dentist may publish a website, but must ensure that this is according to the rules on advertising (these incorporate the principles of the CED Code of Practice).

Data Protection

Regulations are in place in the Netherlands which enact the Data Protection Directive. The CBP (College Bescherming Persoonsgegevens) is responsible for the administration.

Indemnity Insurance

Indemnity insurance is not compulsory for dentists and is provided by general insurance companies. The NMT has an arrangement with a company to provide more favourable premiums for its members.

General insurance covers damage to persons, property, capital liability (as the owner of dental premises) and employer liability. Prices are the same for all dentists who pay approximately €90 annually.

The indemnity insurance also covers dentists working in other European countries but only if their main activity as a dentist takes place in the Netherlands.

Corporate Dentistry

Dentists in the Netherlands may form limited liability companies and non-dentists may be members of the boards of such companies. Dentists can be in the minority on the Board.

Tooth whitening

Products containing up to 0.1% hydrogen peroxide are deemed as cosmetic products, and are not limited to supply by dentists.

Products containing above 0.1% peroxide are medical devices and thus are limited to supply by dentists (or hygienists).

Health and Safety at Work

Ionising Radiation

A practice needs a permit for using radiation equipment. The Health and Safety inspectorate of the Department of Social Affairs may also visit employers, but this rarely happens. They carry out surveys of risks but dentists are encouraged to undertake their own evaluation and the NMT has forms available for this.

Intraoral radiographs can only be taken by dentists. Panoramic xrays may be taken by hygienists who have been trained for the purpose. There is no continuing education requirement.

Hazardous waste

Amalgam separators have been required in practices by law since 1997. Disposal of clinical waste may be only using certified companies.

Regulations for Health and Safety

Based on Guidelines for Infection Control inoculation against Hepatitis B is mandatory for dental workers.

For	*Administered by*
Ionising radiation	Dutch Health Inspectorate
Electrical installations	No available information
Waste disposal	Dutch Health Inspectorate
Medical devices	No specific organisation. To a certain extent, the Dutch Health Inspectorate is involved.
Infection control	Dutch Health Inspectorate

Financial Matters

Retirement pensions and Healthcare

In the Netherlands there is a general law which provides all Dutch people over the age of 65 years with a monthly benefit. To supplement this most people take out a private pension. In general, a pension will be approximately 70% of final earnings.

Self-employed professionals are not covered by the public health system, and therefore have to take out private health insurance policies. The annual premium for such private insurance will be a standard (or 'nominal') amount - €1,000 to €3,000 per year,

Normal retirement age is 65, but dentists may practice beyond that, in private practice.

Taxes

There is a progressive tax on wages, profits, social security benefits and pensions. Thus there are tax brackets, each with their own tax rate. Mathematically, apart from discretisation (whole euros both for income and for tax), the tax is a continuous, convex, piecewise linear function of income:

- Part of the income from €0 to €17,319 - 33.65 % of €17,319 (€5,827)
- Part of the income from €17,319 to €31,122 - 41.4 % of €13,803 (€5,714)
- Part of the income from €31,122 to €53,064 - 42 % of €21,942 (€9,215)
- Above that: 52 %.

VAT

VAT is known as "btw" in the Netherlands and is 6% for dental materials or 19% for instruments and equipment.

Various Financial Comparators

Zurich = 100	Amsterdam 2003	Amsterdam 2008
Prices (excluding rent)	77.3	86.2
Prices (including rent)	81.0	88.2
Wage levels (net)	57.0	62.2
Domestic Purchasing Power	67.6	70.5

Source: UBS August 2003 & January 2008

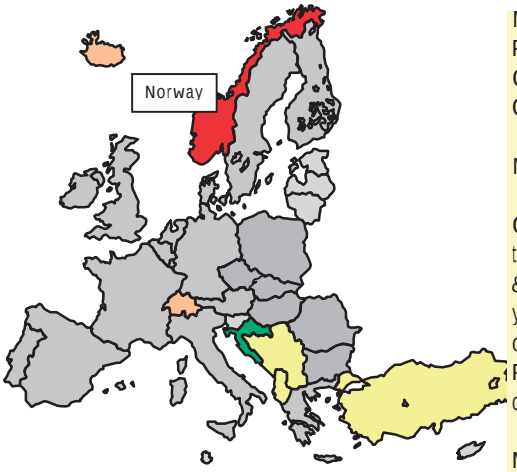
Other Useful Information

Competent Authority:	*Dental Association (including Specialist Training Board and main information centre):*
Ministerie van Volksgezondheid Welzijn en Sport Postbox 20350 2500 EJ 's-Gravenhage The Netherlands Tel: +31 70 34 07 911 Fax: +31 70 34 07 834 Email: Website: www.minvws.nl	NMT (Dutch Dental Association) Postbus 2000 3430 CA Nieuwegein The Netherlands Tel: +31 30 60 76 276 Fax: +31 30 60 48 994 Email: nmt@nmt.nl (NMT general) e.ledoux@nmt.nl Specialists Board) Website: www.nmt.nl
National Health Inspectorate:	*Other information centre:*
Staatstoezicht op de Volksgezondheid Inspectie voor de gezondheidszorg Address Postbus 16 119 2500 BC 's-Gravenhage The Netherlands Tel: +31 70 34 07 911 Fax: +31 70 34 05 140 Email: hi.higz@igz.nl Website: www.igz.nl	Ministerie van Volksgezondheid Welzijn en Sport Afdeling Buitenlandse Diplomahouders Postbus 16 114 2500 BC 's-Gravenhage The Netherlands Tel: +31 70 34 062 00 Fax: +31 70 34 05 966 Email: info@verwijspunt.nl Website: www.verwijspunt.nl
National Health Care Authority:	
Nederlandse Zorgautoriteit Address Postbus 3017 3502 GA Utrecht The Netherlands Tel: +31 30 29 68 111 Fax: +31 30 29 68 296 Email: info@nza.nl Website: www.nza.nl	

Dental Schools:

Amsterdam Academisch Centrum Tandheelkunde Amsterdam (ACTA) Louwesweg 1 1066 EA Amsterdam Tel: +31 20 51 88 888 Fax: +31 20 51 88 333 Email: onderwijsbalie@acta.nl Website: www.acta.nl Dentists graduated in 2007: 107 Number of students: unknown, but intake in 2007/2008: 158	Nijmegen Universitair Medisch Centrum St. Radboud Philips van Leydenlaan 25 Postbus 9101 6500 HB Nijmegen Tel: +31 24 361 88 24 Fax: +31 24 361 88 04 Email: e.jilsiak@dent.umcn.nl Website: www.kun.nl Dentists graduated in 2007: 67 Number of students: unknown, but intake in 2007/2008: 82
Groningen Universitair Medisch Centrum Groningen Academisch centrum Mondzorg Antonius Deusinglaan 1 9713 AV Groningen Tel: +31 50 36 33 092 Fax: +31 50 36 32 696 Email: acmg@umcg.nl Website: www.rug.nl Dentists graduated in 2007: 52 Number of students: unknown, but intake in 2007/2008: 60	

Norway



Date of last revision: 1st October 2008

Member of the European Economic Area	
Population (2008)	4,737,171
GDP PPP per capita (2006)	€44,362
Currency	Kroner (NOK)
	8 NOK = €1
Main language	Norwegian

General health services are funded through a form of national insurance, the Folketrygden, which is administered by NAV, the Norwegian Labour & Welfare Administration. Benefits include pensions, full salary for one year for long term sickness, unemployment benefit & health care. But, only priority groups receive dental health care free of charge from the Public Dental Health Service. Adults must pay the full cost for dental care (there are some exemptions).

Number of dentists:	5,735
Population to (active) dentist ratio:	1,102
Membership of the NDA:	98%

There is wide use of specialists for some care and the use of dental auxiliaries is very well developed.
Continuing education for dentists and auxiliaries is not mandatory.

Government and healthcare in Norway

Norway is a Nordic country, the most northerly in Europe. It is mountainous and virtually all of the centres of population are located on the coast. Norway is a constitutional monarchy, with a parliamentary democratic system.

The Storting (Norway's Parliament) has the legislative and budgetary power. In addition the Parliament also authorises plans and guidelines for the activities of the State through discussions of political issues of a more general nature. The parliament has 165 representatives and has a two chamber system for passing laws.

The capital is Oslo

General health services are funded through a form of national insurance, the Folketrygden, which is administered by the NAV, the Norwegian Labour and Welfare Administration. Benefits include pensions, full salary for one year for long term sickness, unemployment benefit and health care. Hospital care is free at the point of delivery, but patients are required to pay one third of the cost of a visit to their general practitioner for primary care.

		Year	Source
% GDP spent on health	8.9%	2007	Statistics Norway
% of this spent by governm't	84.0%	2007	Statistics Norway

The national budget is predetermined for one year at a time.

Oral Healthcare

Oral healthcare in Norway is divided into the public and the private sectors. Annually approximately NOK 2.8 billion (€355m) is spent on Public Dental Care but the exact figure was not known by the NDA in 2008.

		Year	Source
% GDP spent on oral health	0.41%	2005	Min of Health
% of OH expenditure private	75%	2005	NDA

Public Dental Health Service

The Dental Health Services Act of 1983 established the county as the prime authority responsible for oral health services, and each county has a chief dental officer. It also defined the counties' accountability for the Public Dental Health Service, and the coordination of this service with private dental practices.

The Public Dental Health Service is country-wide and is organised and funded by the counties. Approximately 30% of all active dentists work full-time in the public sector, the remainder working in private practice. The Public Service provides dental care to priority groups and in geographic areas with few private practitioners, to non-priority adults. The five groups, in order of priority, are:

- children and juveniles under 19 years
- the mentally handicapped
- people who due to long term illness are under care in institutions or at home for longer than 3 months (these groups can also receive domiciliary care)
- young people under 21 years of age
- other groups defined by the government, inter alia prisoners and drug and alcoholic addicts

Annually between 60% and 76% of the population in the priority groups (this varies between the different groups) receive screening and/or treatment and about 10% of the non-priority group adults also receive their care from the PDHS.

The Public Dental Service is free of charge, except for orthodontic treatment. However youth between 19 and 20 years must pay 25% of the costs. The elderly/disabled group pay reduced fees. Adults pay in full for oral health care, except for the exemptions mentioned above.

National Insurance System (NIS)

Several changes were made in the national insurance system for dentistry in January 2008. The entire system was updated and upgraded, making it both easier to understand for dentists and the general public, and making it easier for patients to be reimbursed. All rates were regulated, both the general rates and the reimbursement rates.

The following diagnoses release reimbursements: Rare medical diagnosis (from a list), cleft lip, jaw or palate, oral cancer, immune system depression, surgical orthodontic and periodontal treatment including rehabilitation, severe pathological attrition, hyposalivation, allergy to dental restorative materials, dental trauma, lack of ability for self care.

There is a "high cost protection". The maximum payment, the "roof', in this system is NOK 2,500 (€315), referring to the specified amount that is defined as "own risk" payment. In addition to some dental treatment, mostly surgical operations, periodontal treatment and treatment of conditions of the oral soft tissues, the maximum "own risk" amount could cover expenses for physiotherapy, therapy in specified training institutions and at certain overseas treatment clinics. This does not mean, however, that whenever a patient has paid NOK 2,500 (€315) for dental treatment, any amount exceeding this will be covered by the NIS. Only specified treatment as mentioned is included in the high cost protection system, and only the reimbursed amount is counted into the "own risk" amount.

There is also a family reduction, for families with more than one child in need of orthodontic treatment.

Dentists can now receive the reimbursement amounts directly from the NIS, instead of charging the entire amount to the patient, who then has to obtain reimbursement from the NIS. For the time being, this is a voluntary system.

Any tooth lost from marginal periodontitis after May 1st 2002 gives the patient a right to reimbursement for rehabilitation. The rates differ according to the treatment that is chosen. Reimbursement is given only once for each tooth lost, and as a general rule reimbursement is not given if the lost tooth is a molar.

All in all, the NIS does not cover dental expenses for more than a small part of the Norwegian population. Most adults still have to pay their dental treatment themselves, without any government funded financial support system.

Private Care

Oral healthcare for most adults is provided by private dentists. Approximately 68% of dentists work as private practitioners. They provide screening and treatment for the adult population.

About 80% of adults see a dentist on a regular basis, even though they may have to pay the full cost of the treatment. Patients normally attend once a year, on average. The majority of these 'regular' attenders (90%) obtain their care from general practitioners in private practice. In some circumstances the social security system may pay for those who cannot afford care (see above) and give reimbursements to others.

This state social assistance is provided at a municipal level, and there is considerable variation between municipalities in the way this is managed.

Private insurance for dental care

Dental insurance plays a very small role in the whole picture.

The Quality of Care

Standards in dental practice are governed by three different types of supervision. The Norwegian Board of Health Supervision is responsible for monitoring in the field of

dental care. The monitoring is carried out by the Chief Medical Officer in the counties. They normally use designated dentists to supervise and assess the dental medical standards, quality assurance programmes etc.

A Competition Authority is responsible for ensuring that prices are displayed and that quotations are given to patients and the *Labour Inspectorate* is responsible for monitoring employees' conditions, radiation protection, and waste disposal.

Guidelines for the use of dental materials were introduced by the Norwegian Directorate of Health in July 2003, recommending a reduction in the use of amalgam, still accepting amalgam as a dental material if preferred by the patient. From January 1st 2008, however, amalgam has been forbidden, due to regulations implemented by the Ministry of Environment, banning the use of mercury in all products.

Health data

		Year	Source
DMFT at age 12	1.40	2008	Statistics Norway
DMFT zero at age 12	47%	2008	Statistics Norway
Edentulous at age 65	22%	2002	Statistics Norway

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no water fluoridation schemes in Norway

Education, Training and Registration

Undergraduate Training

To enter dental school in Norway, applicants must have a general matriculation standard - this means completed higher secondary school, with advanced courses in mathematics, physics and chemistry.

Year of data:	2007
Number of schools	3
Student intake	153
Number of graduates*	110
Percentage female	50%

* there are no graduates yet from the new school in Tromso

The University of Oslo has a separate Faculty for Odontology. At the University of Bergen there is a joint Faculty for Medicine and Odontology. The University in Tromso has organised the dental education as an Institute for Clinical Odontology within the Medical Faculty.

There are no private dental schools. There are about 665 undergraduates in total (2008) for the 5-year course, although this is rising as Tromso reaches full capacity. After graduation the candidates may be authorised as dentists.

Qualification and Vocational Training

Primary dental qualification

The title upon qualification is: *Master of Dentistry*

Vocational Training

There is no vocational training in Norway.

Registration

Graduates must register with the Norwegian Registration Authority for Health Personnel. After the age of 75 years a dentist's registration can only be renewed if the practitioner is considered fit to continue practising. Registration can be suspended for other reasons such as serious mental illness, being away from practice for a long period of time, or for "unworthy behaviour".

Cost of registration (2008)	€ 116

Norway is part of the EEA Agreement. Thus dentists qualified in other EEA states may practice in Norway.

Language requirements

Although there are no formal linguistic or other tests for EEA-dentists, there is an ethical requirement to be able to communicate effectively with patients. An employer may, however, require language skills. The patient records must be kept in Norwegian or another Scandinavian language.

Further Postgraduate and Specialist Training

Continuing education

In order to maintain a certain level of professional standards the Norwegian Dental Association (NDA) offers postgraduate courses as "brush up" lessons for dentists in practice. However these courses are not mandatory. But, dentists have an obligation to treat the patients in accordance with the professional standard (based on the current knowledge and common accepted procedures at the time). This requires that the dentist adopts new knowledge. However there are no specific requirements concerning how.

Should the dentist give treatment with outdated methods it may result in a number of consequences - private lawsuits, as well as investigations and possible actions by the supervising authorities and the dental association.

Specialist Training

There is an organised three year full-time postgraduate training period for specialists in universities, in seven recognised dental specialities: endodontics, orthodontics, oral radiology, oral surgery, paediatric dentistry, periodontics and prosthodontics.

The universities in Oslo and Bergen run the programmes for graduate dentists who want to achieve authorisation as a specialist. The trainees are not paid. To register they must produce a written record of their training to the Specialist Registration Committee of the NDA, which maintains the register of specialists on behalf of the government.

Projects for decentralised, distant training at recognised specialist clinics have been done, but no formalised programmes have yet been set up. The Institute for Clinical Odontology in Tromso has accepted a mission for testing a specialist training programme for Clinical Dentistry.

Workforce

Dentists

Year of data:	2006
Total Registered	5,735
In active practice	4,300
Dentist to population ratio*	1,101
Percentage female	45%
Qualified overseas	1,000

* this is "active" dentists

The figures for the percentage of females and the numbers of dentists qualified outside Norway are estimated by the NDA.

Almost a quarter of Norway's dentists qualified overseas.

The dental workforce is said to be decreasing, so there is no relevant unemployment amongst dentists

In order to ensure that a sufficient number of new dentists a new dental school in Tromsø was established in 2004 – the first graduates will be in 2009.

Specialists

In Norway seven dental specialities are recognised:

Year of data:	2008
Orthodontics	192
Endodontics	40
Paedodontics	18
Periodontics	74
Prosthodontics	46
Oral Radiologists	6
Oral Surgery (incl OMFS)	59
OMFS	
Dental Public Health	

These are approximate numbers of "active" specialists, excluding those who have retired.

Oral surgeons work mainly in public hospitals and universities. Most are employed full time in hospitals but some work part-time in private practice. Most orthodontists work in private practice, although some work in the Public Dental Health Service (PDHS).

Most paediatric dentists work in the PDHS and most periodontists in private practice. There are associations and societies for specialists and for special interest groups: these are best contacted via the Norwegian Dental Association.

Patients may go directly to specialists, without referral from a primary dentist.

Auxiliaries

In Norway there are 3 types of dental auxiliary:

- Dental hygienists
- Dental technicians
- Chairside assistants (secretary)

All dental auxiliaries have to be registered with the Norwegian Registration Authority for Health Personnel.

Year of data:	2006
Hygienists	812
Technicians	708
Denturists	0
Assistants	3,112
Therapists	0
Other	0

Dental Hygienists

To be admitted to training as a hygienist the applicant must have completed higher secondary school. Dental hygienists undertake 3 years' education and training at Hygienist Schools, which are located in Oslo, Bergen and in Tromsø. They are part of the University and are located in connection to the faculties of Odontology - in Tromsø as part of a University college.

The Health Personnel Act from 1999 requires authorisation by the Norwegian Registration Authority for Health Personnel (SAFH) in order to use the title dental hygienist.

Dental hygienists normally work together with dentists, as salaried employees. However they may have their own private practice. They may diagnose as well as treat, and can undertake local infiltration anaesthesia if they have had special training.

Dental Technicians

Technicians undertake 3 years education and training at the University College in Oslo. They provide fixed and removable prosthetic work for insertion by dentists. They may not deal directly with the public, although they do take legal responsibility for their work. They normally work in commercial laboratories and charge the dentists for their services. Some work as employees in dental clinics.

Under the same law as hygienists, they have to register with the Norwegian Registration Authority for Health Personnel (SAFH).

Dental Chairside Assistants (Secretaries)

Dental assistants have to undertake 3 years education and training in high school. In the last year of high school dental chairside assistants have a special curriculum. Since 2008 only persons with a full education and training will be awarded the title.

Under the same law as hygienists, they have to register with the Norwegian Registration Authority for Health Personnel (SAFH).

Practice in Norway

Year of data:	2006
General (private) practice	2,904
Public dental service	1,090
University	234
Hospital	35
Armed Forces (2008)	23
General Practice as a proportion is	68%

Working in General Practice

Dentists who practise on their own or as small groups, outside hospitals or schools, and who provide a broad range of general treatments are said to be in *private practice*.

Most dentists in private practice are self-employed and earn their living through charging fees for items of treatment. There is no prescribed fee scale, but price cartels are forbidden. Every dentist must display the cost of twelve specified items of treatment on the wall in his/her waiting room, and must provide a complete list of prices. If the cost of treatment exceeds NOK 2,000 (€250) the dentist must provide the patient with a written quotation. If the treatment plan is then changed, the quotation may be changed and the patient informed. When the treatment is finished the dentist must give the patient a written description of what care has been provided.

There are no figures for how many patients a dentist would normally have on his regular "list", nor about the intervals at which re-examinations would normally be carried out for most adult patients.

Fee scales

Reimbursement for dental treatment by the National Insurance Scheme is slowly increasing. Treatment of periodontal diseases and surgical treatment that are refunded by the Scheme, received a big increase on 1st March 2003.

Patients losing teeth because of periodontal diseases have received reimbursement for prosthodontics, since October 1st 2003. Rehabilitation by bridges and implants is included for patients with diagnosis mentioned in the Oral healthcare section.

Orthodontics is paid for in a different way. Orthodontists normally work in private practice, and can now receive the reimbursement amounts directly from the NIS, for children the rest of the cost is paid directly to the orthodontist by the parents. There is an index of four grades of severity for orthodontic need. The level of fees is based on the index, with full reimbursement for correction of the most severe anomalies, and none for treatment of less severe malocclusions.

The dental association is represented in meetings initiated by the health department concerning regulations and reimbursement for orthodontic treatment.

Joining or establishing a practice

The government provides no assistance in funding the establishment of new practices and there are no restrictions on the location or the size. The practice has to be owned by a dentist, but a widow or widower may continue ownership for one year after the death of their spouse.

There are no specific requirements for the type of premises in which a surgery can be housed, so these may be in shops, offices or houses and even in rented clinics (see below) - as long as the clinic meets the necessary standards concerning hygiene, radiation protection and confidentiality for patients etc.

Standardised contracts, prepared by the NDA, are available for dentists working together in the same practice. Contractual arrangements include partnerships, limited companies and working totally independently but sharing some facilities such as waiting rooms. However, limited companies may only be owned by dentists and there may be tax advantages to practising in this way.

Working in the Public Dental Service

The Public Dental Health Service (*Den Offentlige Tannhelsetjenesten* or *DOT*) is organised on a county basis. It began as a school dental service based in clinics built in school grounds. Five groups are eligible for treatment and the counties are obliged to prioritise the provision of dental care for the groups in the order identified above, in the oral healthcare section.

Dentists working within the public dental service have the following titles and functions, Dental Officer (performing general dentistry), Special Dental Officer (specialist treatments), Regional Chief Dental Officer (both general dentistry and administration) and County Chief Dental Officer (administration). These dentists are all salaried.

Only a few counties employ specialists and most orthodontics is delivered in private practice.

A limited number of adults are treated by the Service. Some counties allow public dental service dentists to rent a clinic to provide dentistry to adults as private patients. However, the PDHS currently has a large number of vacancies and the government is addressing the problem of recruitment, to overcome geographical variation of supply.

Their income varies from county to county and depends on experience etc. For dentists with a position as head of clinic etc. the salary may be even higher.

Working in Hospitals

Oral surgeons normally work in hospitals as salaried employees, either full- or part-time with other duties elsewhere. To practise as an oral surgeon in a hospital it is necessary to have a specialist competency. There is no formal structure of staff grades for dentists.

There is no fixed salary for such positions.

Working in Universities and Dental Faculties

Dentists working in full time positions are employees of the University, but are free to combine their duties in the faculty with part-time work elsewhere, usually up to a maximum of six hours per week. Typical academic titles within a Norwegian dental faculty are Professor, Associate Professor II), PhD Research Fellow. A typical faculty staff member is supposed to spend 45% of their time on teaching, 45% on research and 10% on administration. PhD students on the other hand have light teaching responsibilities and no administrative duties.

Most academic posts require a minimum of a PhD together with further training in a particular speciality, and progression to higher grades is also based upon academic achievements. Clinical instructors, who work part-time, only need specialist training if they are instructing in a specialist discipline.

There is no fixed salary for such positions and so the salary varies a lot.

Working in the Armed Forces

About 20% of the dentists in the Armed Forces are female.

Professional Matters

Professional associations

	Number	Year	Source
Norwegian Dental Association	5,599	2008	NDA

There is a single main national association, the Norwegian Dental Association. Approximately 98% of active dentists are members and it represents both private and public service dentists. The national association consists of 21 local associations - primarily, there is one association for each county. All members of the NDA are also members of a local association.

The NDA is a democratic organization and every year there is an assembly where representatives from all the local associations take part. The assembly is the highest authority in the Association and during the annual assembly the guidelines to be followed in all matters of importance are decided. Every second year the assembly elects a board of 9 NDA members (President, Vice-president and 7 other members). The President is the chief executive of the NDA.

The NDA has a secretariat with 22 employees (2008). They carry out a number of tasks, such as legal services for members, salary negotiations for the public dental service, organisation of insurance for members, organisation of post-graduate ("brush up") courses for dentists, organisation of a pension system for members etc. Their other important tasks include the distribution of information to members, as well as to the public, Government and other authorities. They are also responsible for the publication of the Norwegian Dental Journal. They maintain contact with governmental bodies and authorities on questions concerning dentists and dentistry. The secretariat is led by a Secretary-general.

Ethics and Regulation

Ethical Code

Dentists in Norway work under an ethical code which covers relationships and behaviour between dentists, the contract with the patient, consent, and confidentiality. This code is administered by the Norwegian Dental Association. Much of the guidance on ethical behaviour is also codified in the Health Personnel Act.

Fitness to Practise/Disciplinary Matters

Cases concerning breaks of the ethical code are handled by the board of the local branch of the NDA. If the dispute is not settled the case is submitted to the NDA's Board for Dental Ethics. The Board may – in cases of infringement of the ethical code - take action in the following forms: a formal notice of disapproval, a decision that the dentist in question, for a period of two years, cannot be elected as a representative within the NDA. They may also advise the NDA Board to fine the member (to a maximum of 133,500 NOK - €17,000) or to exclude him/her from membership of the NDA.

Patients' claims are not handled. Liability is regarded as a separate question, and is not part of the Board's jurisdiction.

Governmental supervision

The Norwegian Board of Health Supervision is responsible for supervising Health and Social Services in Norway, including the dental service. They are also responsible for supervising the professional conduct of health personnel. Their supervision concerning personnel is mostly based on complaints from patients.

The supervision is based on the requirements laid down in the Health Personnel Act from 1999. If infringements are found, this may result in disciplinary measures. The Board can either give a letter of formal notice in which they point out what needs to be improved or they may also give a formal warning. In cases of severe infringements, the Board can decide to withdraw the authorisation.

A dentist may appeal a formal warning or withdrawal of authorisation to a designated board. If the decision is upheld by the designated board the dentist can try the decision in court.

In some cases the infringement includes violations of the penal code. Such cases, which are handled by the police, may result in fines, or in very serious cases imprisonment.

Data Protection

In accordance to national laws all dentists have an obligation to secure all patient records, including confidential patient data. Norway has adopted and embraced the EU Directive.

Advertising

Dentists are allowed to advertise and may use websites. They may not give information which is misleading or incorrect, and may not give information about special treatments etc. in a way that may mislead patients. Such rules are included in the ethical code and also apply to advertising on websites.

Corporate Dentistry

Dentists are allowed to form companies and the boards are not limited to dentists

Indemnity Insurance

Liability insurance is compulsory for dentists. Since January 2000 the cost has been included in the annual membership fee of the NDA, to ensure compliance. The insurance itself is with a private company and provides cover for damages related to dental treatment. Non-members must organise insurance themselves.

For members the insurance costs approximately 1,500 NOK (€190). (A higher insurance cost for dentists working with implants). Under Norwegian law they may have their registration suspended if they do not have insurance.

Tooth whitening

Tooth whitening products under 0.1% concentration of hydrogen peroxide can be sold to without restriction.

Products between 0.1 to 6% may only be sold if advised by dental/medical personnel.

Products of a greater concentration of hydrogen peroxide than 6% are regulated as Medical products and can only be applied by health personnel including dentists and dental hygienists

Health and Safety at Work

There are a number of regulations concerning Health and Safety at work, for instance concerning radiation protection, handling of toxic substances etc. However, inoculations such as for Hepatitis B are not compulsory.

Ionising Radiation

The Norwegian Radiation Protection Authority (NRPA) is responsible for supervision in the field of radiation protection. The supervision is based on the Act on Radiation Protection and Use of Radiation from 2000 and supplementary regulations. Dentists have to give the NRPA notice before dental x-ray equipment is installed for use. There are general criteria concerning education and training. Both dentists and dental hygienists may use x-ray equipment, but there are no requirements concerning supplementary training.

Hazardous waste

Amalgam separators are required by law – since 1996 (with a revision to the law in 2003). The waste amalgam must be collected by a registered carrier.

Regulations for Health and Safety

for	*administered by*
Ionising radiation	Norwegian Radiation Protection Authority
Electrical installations	Directorate for Fire and Electrical Safety
Waste disposal	Norwegian Pollution Control Authority/local government
Amalgam	Directorate for Health and Social Affairs
Medical Devices	Directorate for Health and Social Affairs
Infection control	Institute for Public Health

Financial Matters

Retirement pensions and Healthcare

General health care is mostly paid for by the National Health Insurance Scheme. This covers hospital services which are free at the point of delivery, and partially subsidises other services such as general practitioner visits. Contributions for national health insurance are deducted from salary and paid to the RTV by the tax authorities. Employees pay 7.8% of income, owners of companies or practitioners pay 10.1% and employers pay 14.1% of employees' salaries.

Retirement pensions are paid by the RTV on the basis of a dentist's income. The retirement age is 67 for RTV purposes. Dentists who work in the private sector receive the basic RTV pension of NOK 66,800 per year (2008) (€8,350) and in addition a supplement based on the individual earnings from those years in which they have been member in the RTV. In addition the dentists may have private pension schemes. Dentists employed by the Public Dental Health Service receive a pension of 66% of their final salary. This is based on 30 years of work in the PDHS.

Dentists may work beyond 67 if they wish. In public service they may work until they are 70. Private practitioners can actually work until they lose their licence. Few work beyond 70.

Taxes

National income tax:

There is a national income tax (dependent on salary). The lowest rate is 28% and the maximum is 54.3% .The rate of taxation is based on the income level. The rate increases in a step by step system depending on the income level.

VAT/sales tax

VAT is also payable on certain goods and services, in general 25% (a lower percentage for some goods and services). Dental treatment is excluded from VAT. However, costs related to purchase of dental equipment, instruments and materials are subject to VAT and will be reflected in prices.

Various Financial Comparators

Zurich = 100	Oslo 2003	Oslo 2008
Prices (excluding rent)	117.8	120.0
Prices (including rent)	111.3	114.9
Wage levels (net)	87.0	93.9
Domestic Purchasing Power	68.6	81.6

Source: UBS August 2003 & January 2008

Other Useful Information

Main national association and Information Centre:	*Competent Authority:*
Norwegian Dental Association POB 3063 Elisenberg N-0207 Oslo Tel: +47 22 54 74 00 Fax: +47 22 55 11 09 Email: tannlegeforeningen@tannlegeforeningen.no Website: www.tannlegeforeningen.no	Norwegian Directorate for Health POB 7000 St. Olavs plass 0130 Oslo Tel: + 47 810 200 50 Fax: + 47 22 16 30 01 Email: postmottak@shdir.no Website: www.shdir.no

Publications:

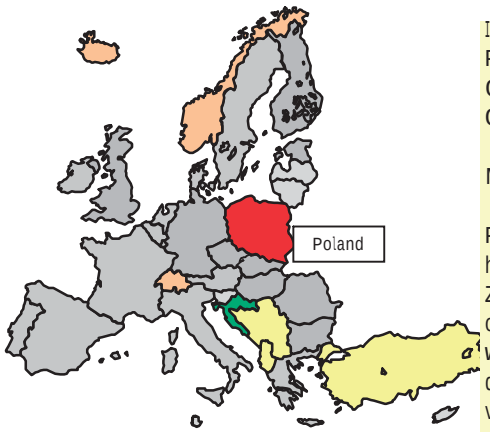
The Norwegian Dental Journal is NDA's main journal. The web address is www.tannlegetidende.no

The journal publishes articles on new developments in odontology as well as information concerning dental political issues, international developments, interviews and a variety of useful information for members concerning for example new laws and regulations.

Dental Schools:

Oslo	Bergen	Tromso
Det odontologiske fakultet Geitmyrsveien 69/71 POB 1142 Blindern 0317 Oslo Tel: +47 22 85 20 00 Fax: +47 22 85 23 32 E-mail: infoskranke@odont.uio.no Website: http://www.odont.uio.no Dentists graduating each year: 65 Number of students: 325	Det medisinsk-odontologiske fakultet Institutt for klinisk odontologi POB 7804 5020 Bergen Tel: +47 55 58 65 60 Fax: +47 55 58 65 77 E-mail: post@iko.uib.no Website: http://iko.uib.no Dentists graduating each year: 48 Number of students: 240	Det medisinske fakultet Institutt for klinisk odontologi Universitetet i Tromsø 9037 Tromsø Tel: +47 77 64 91 02 Fax: E-mail: Keth.Wohni@fagmed.uit.no Website: http://uit.no/odontologi Dentists graduating each year: 0 * Number of students: 100 * * in May 2008

Poland



Date of last revision: 1st October 2008

In the EU/EEA since	2004
Population (2008)	38,115,641
GDP PPP per capita (2006)	€13,995
Currency	Zloty (PLN)
	3.51 PLN = €1.00 (2008)
Main language	Polish

Poland has a system of healthcare financed by means of a common health insurance within the National Health Fund (Narodowy Fundusz Zdrowia, NFZ), with16 divisions. The fund's budget is financed by an obligatory premium, an 9% tax charged on the income of each citizen who is employed or conducts commercial activity. Availability of NFZ dental care is limited due to the Fund's insufficient financial means and very low budgetary expenditure on dentistry. Private care is freely available, however.

Number of dentists:	29,947
Population to (active) dentist ratio:	1,752
Membership of Dental Chamber:	100%

Specialists are widely used, but the clinical (operating) auxiliaries are limited to hygienists.
Continuing education for dentists is mandatory and is administered by the Polish (Main) Chamber of Physicians and Dentists and the Regional Chambers of Physicians and Dentists

Government and healthcare in Poland

Poland is a northern central European country, with the Baltic Sea to the north and 7adjacent neighbouring countries –Belarus, the Czech Republic, Germany, Lithuania, Russia (Kaliningrad Oblast), Slovakia and Ukraine. The land is mainly flat plains, but with mountains to the south. The capital is Warsaw.

Poland has a Parliamentary democracy, with a Bicameral Parliament – the Sejm and the Senate – as the legislative authority, the government – as the executive authority, and a judicial authority. The President of the State is elected in common election by the People. Authority is exercised in the State by the government administration down to the regional level (*voivodeships* of which there are 16) and self-government authorities – *gminas* and *poviats*, and the Voivodeship Parliament (*sejmik*) wherein the territorial self-government authorities are represented at the voivodeship level.

The government (state administration) representatives in the regions (voivodeships) are voivodes. At the voivodeship level, the representational authority is exercised by the President of the voivodeship.

Until 1998, the national healthcare system was financed solely by the state's budgetary means (taxes). From 1998 to 2003, it was financed by common health insurance institutions – the 17 sick funds.

Since 2003, the system has been financed by means of the common health insurance within the National Health Fund (Narodowy Fundusz Zdrowia, NFZ), with its 16 voivodeship divisions. The fund's budget is financed by an obligatory premium.

Regardless of how a citizen earns income, including old age pensioners, they are obliged to pay the premium of 9% of income from each source. However, those who pay the said amount entitled to a 7.75% deduction from income tax, while 1.25% is not. Farmers are charged according to a different rule, conditioned by the price – they are exempt from tax, so do not have to pay for health insurance. The unemployed and the homeless have their premium paid by the state with its budgetary means. A part of medical services are also financed by the state's budgetary means, for example the comprehensive treatment of developmental clefts.

		Year	Source
% GDP spent on health	6.2%	2004	OECD
% of this spent by government	68.6%	2004	OECD

There is no private or state additional insurance, although attempts are being made aiming to introduce such forms of insurance.

Oral healthcare

Public compulsory health insurance

The act on universal health insurance determines the scope and principles of providing dental medical services financed by means of the NFZ. Subject to the act, the persons insured are entitled to the basic dental services, normally performed by a dental surgeon, as well as dental materials specified by the Minister of Health, subsequent to the opinions of the President of the Fund and the Polish Chamber of Physicians and Dentists.

Children and young people under 18 years, as well as women who are pregnant and in the post-natal period (up to 42 days after childbirth) are entitled to additional services by a dental surgeon, taking into account the specific dental needs of this section of population. These services are provided by various entities: health care establishments owned by gminas, or individuals, including dental surgeons (but not necessarily dental surgeons), and dental surgeons in private practice, individually or in a group.

Starting work for NFZ is decided in a tender announced by NFZ. One of the conditions is the lowest price. The availability of the services is limited by the budget for dental health care. Persons insured within NFZ are not entitled to services other than those mentioned in the list of the Minister of Health and so have to pay for them from their own means.

Availability is limited due to the Fund's insufficient financial means and very low budgetary expenditure on dental care. An insured person is entitled to a dental examination, or periodical examination, once a year. Children and young people are entitled to an additional periodical examination and a wider range of services.

The NFZ budget is established on the amounts deducted from income tax and its size may vary - amongst other criteria it is conditioned by the level of citizens' incomes. Besides these, within the state's budgetary means, the Minister of Health sometimes finances additional highly-specialist medical procedures and health care programmes. Relating to dental care, the programme for comprehensive treatment of developmental defects (cleft palate) is one such initiative.

If a dental surgeon is employed, it is the employer's duty to provide a salary. If he works on his own account, and provides services for insured patients under a contract with a sick fund, the fund provides the financial means for the services contracted. In such a case it is the fund which exercises supervision.

All private practitioners are under the supervision of the physicians' chamber. If they work exclusively on their own account, their remuneration is included in the service price. The price is agreed with the patient.

Not all practitioners can work in the state system, since its financial means are limited. About a third of all dental practitioners work for the NFZ. Others work exclusively outside NHF, practising in their own private practice, as owners of establishments, who employ their colleagues or co-owners in partnerships or exclusively in their own private practice.

So, some dentists have contracts directly with NFZ but work in their own (private) offices and other dentists work in health centres and clinics which have contracts with NFZ. Specialist treatment is paid at a higher rate of points. There is a difference between private practices under the NFZ and clinics because in private practices the patient pays all costs of treatment, whilst in NFZ clinics the patient does not pay for some treatments which are under the insurance, although some procedures are also payable.

The remaining dentists operate in the free market. Private fees are fully free market in nature. They are determined in agreements between dentists and their patients. The majority of dental surgeons see private patients in their own surgeries, regardless of whether they are in employment contract with some other employer.

A dentist under contract to provide full time NFZ services would look after 3,500 – 4,000 insured persons, including children and young people under 18 years.

Patients would normally attend their dentist for an oral re-examination 6 monthly.

Availability of NFZ care is limited everywhere in the country but there are no difficulties in obtaining dental services within private dental practice.

Home services are provided if there is a need to give an aid to a sick person. The service is performed by a dentist asked to do so. In the event such a service is not possible at home, the sick person is referred to hospital in order to undergo the appropriate procedure.

		Year	Source
% GDP spent on oral health	0.20%	2004	Chamber
% of OH expenditure private	No data		

Working time

Working time is determined in a contract with an insurance institution. In the case of employment, the working time is regulated under the labour code. "Full-time employment" before 2004 amounted to 2,040 hours a year, (40 hours per week). Since 2004, this has been adjusted to 5 days a week, 5 hours a day, for a contract.

Private Fees

Private fees are fully free market in nature. They are determined in agreements between dentists and their patients. Attempts have been made at founding private insurance systems. However, they are still only attempts and thus cannot be considered an organised system.

The Quality of Care

There are regular inspections, as well as ones following a complaint. In most cases they are from a complaint made by a patient.

Health data

		Year	Source
DMFT at age 12	3.10	2007	NOHM
DMFT zero at age 12	19.3%	2007	NOHM
Edentulous at age 65	42%	2005	OECD

NOHM is the National Oral Health Monitoring

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no fluoridation schemes in Poland, although there is natural fluoridation of the water to optimal levels in some areas.

Education, Training and Registration

Undergraduate Training

To enter a dental school a student has to have graduated from high school, passed a maturity exam and an entrance exam for the university with a very good result, because each year there are 4 to 5 candidates for every place. The entrance exam is in the form of a test in physics, chemistry, biology and one foreign language from English, German or Russian. The number of students is regulated by the Minister of Health.

Year of data:	2008
Number of schools	10
Student intake	855
Number of graduates	809
Percentage female	80%

The universities educating dental students across Poland are: Medical Universities in Warsaw, Poznan, Lodz, Bialystok, Lublin and Zabrze/Katowice, Collegium Medicum of the Jagiellonian University in Kracow and Medical Academies in Gdansk, Wroclaw and Szczecin. The Dental schools are known as Wydzial Lekarski (Faculty of Medicine), Oddzial Stomatologiczny (Division of Stomatology) or Wydzial Stomatologii (Faculty of Dentistry). All are publicly funded, although a small number of places are reserved for fee paying private individuals. Also, places are allocated for non-Polish dentists who are taught in English.

The Dental Practitioners' Committee of the Polish Chamber of Physicians and Dentists was of the opinion in 2008 that the number of graduates is too large for future oral healthcare requirements in Poland and was consistently calling for limitation of the student intake.

In 2002, the undergraduate training curriculum was changed to bring it into line with the requirements of the EU. The length of the dental training at the University is now 5 years (10 semesters). The overall number of class hours is 5,000 hours among these 4,540 stated in educational standards. Subjects are divided into 3 groups:

- Basic subjects - 505 hours;
- General medical subjects – 1,575 hours
- Dental subjects – 2,460 hours, including 1,450 hours of practical clinical training.

The first graduates under the new syllabus qualified in the Summer of 2008.

The responsibility for quality assurance in the faculties is by the Ministry of Education, the Chancellor of the University and the Dean of the Faculty.

Qualification and Vocational Training

Primary dental qualification

The titles awarded on qualification are:

- Dental doctor (lekarz dentysta) - until 1996
- Stomatologist (lekarz stomatolog) - 1996 to 2004
- Dental Doctor (lekarz dentysta) – since 2004

Vocational Training (VT)

In order to be awarded the *"Right to practice the profession"* a graduate has to complete vocational training.

Each graduate of dentistry may apply for a "Limited right to practice the profession" (a licence). This licence is awarded in order to undergo vocational training - the obligatory one-year post-graduate internship (staz podyplomowy) aimed at improving practical skills, while being supervised by experienced dental practitioners. The internship is a requirement for obtaining the full licence (the right to practise the profession). Interns are remunerated from the state budget.

Since October 2004 there is also an additional requirement to pass the State Dental Exam (Lekarsko-Dentystyczny Egzamin Panstwowy). This exam can be taken during or after the internship.

Polish internship is not applicable to dentists from other EU/EEA Member States who hold the evidence of formal qualifications subject to automatic recognition under the EU Directive.

Registration

In Poland, a dental diploma awarded upon graduation does not entitle a graduate to commence the practice of the profession. To practise, it is necessary to obtain a *"Right to practise the profession"*. All graduates who want to practice the profession, are obliged to register according to the place of residence, with the Regional Chamber of Physicians and

Dentists (*Okregowa Izba Lekarska*). The Chamber is the competent authority, given by the state, and maintains the registers of dentists and of dental specialists.

EU/EEA citizens who hold professional qualifications obtained in another EU/EEA Member State apply for recognition of their qualifications on the basis of the system of automatic recognition of qualifications under the Directive 2005/36/EC. When their qualifications are recognised they are awarded the *"Right to practice the profession"* and have the same right as the dentists qualified in Poland.

There are no registration fees.

Language requirements

Sufficient command of Polish is one of the requirements to be awarded the *"Right to practice the profession"*. EU/EEA citizens however are not required to pass any language tests. They just make a written statement that their command of Polish is sufficient to practice as a dentist.

Non EU/EEA dentists have to pass a language test organised by the Polish Chamber of Physicians and Dentists.

Further Postgraduate and Specialist Training

There are 3 elements to postgraduate education and training:

- Continuing education for all dentists
- Specialist Training
- Academic Training

Continuing education

Dental practitioners have an ethical and legal obligation to permanent education and are under a statutory obligation to take part in continuing education. This is determined by the Law on the Professions of Physician and Dental Practitioner. The tasks specified therein are fulfilled by the Chambers in accordance with the regulation of the Minister of Health. A credit-point system is applied, 200 credit points have to be collected in a 4-year period. Continuing education is conducted in various forms and in accordance with a grading scale.

Many kinds of courses and training sessions, as well as routine monthly training are organised by the Polish Dental Association (PDA).

Specialist Training

Dental practitioners may also commence specialist training. To commence specialist training a dentist has to hold the "Right to practice the profession" and to undergo a qualification procedure in the form of an interview. The result of the State Dental Exam is also taken into account. Education is conducted in the form of the so-called Residence – after qualification a dentist obtains remuneration from the state and is employed at an eligible entity entitled (accredited) to conduct specialist training in a given field. The employment of the dentist may also be in other forms, whereby he obtains no remuneration but is still employed at the eligible entity. The list of eligible entities is drawn up by the Minister of Health. The vast majority of them are universities educating dental surgeons.

Specialist training is conducted according to a given specialisation programme, determined by the Minister of Health, at the request of Centrum Medyczne Ksztalcenia Podyplomowego (Medical Centre for Postgraduate Training). The education is supervised by the Medical Centre for Postgraduate Training in Warsaw, as well as regional centres managed by voivodes, through the so-called national and voivodeship consultants in a given field, appointed by the Minister of Health and the voivodes. The co-ordinating role in continuing education is played by the Regional Chambers.

Registration of specialists is by State entities - the Medical Centre for Postgraduate Training and voivodeship centres for postgraduate training.

Poland has 7 main specialties:

- oral surgery
- orthodontics
- paediatric dentistry
- dental prosthetics
- periodontology with oral medicine
- conservative dentistry and endodontics
- oral maxillofacial surgery

Besides, dentists may take up the following fields of specialisation:

- hygiene and epidemiology
- organisation of health care

There is also the specialty of Oral Maxillo-facial surgery.

Titles follow the specialty, eg dental doctor specialist in the field of periodontology (or periodontologist).

Academic training

Academic training is usually connected with obtaining a PhD or publishing a work. There are a number of degrees and diplomas associated with specialist qualifications, and these may be awarded by the universities (such as PhD, Doctorates, university professorships).

Workforce

Dentists

Year of data:	2008
Total Registered	29,947
In active practice	21,750
Dentist to population ratio*	1,752
Percentage female	78%
Qualified overseas	600

* active dentists only

In 2008 there were over 34,000 dentists but just less than 90% held the right to practise. Many of these were not actually "active" for various reasons:

Year of data:	2008
Retired with right to practise	4,200
Emigrated but with right to practise	1,200
Physicians with dentist qualifications	570
Maternity leave	1,200
Limited practice through internship	970

The Polish Chamber reports that in 2008 about one third of all dentists are over 50 years old, and it is presumed that most of these dentists will retire in within the next 20 years (dentists normally retire at 70 or younger). Just under 5,000 registered dentists are over 65 years old.

It is reported that there are no permanently unemployed dentists. However, as young dentists cannot establish their own practice for at least two years after graduation, they may have short periods of unemployment.

Nevertheless, the Chamber believes that there are too many active dentists in Poland. To counter this problem they have concluded that admission to dental studies should be restricted, as they suggest that during recent years the quota of students was too high.

Movement of dentists across borders

Since the accession of Poland to the EU approximately 1,500 dentists had considered the possibility of practising the profession abroad, by 2008. As far as the Chamber was aware the most popular destination for Polish dentists was the UK. They reported that the outflow of dentists did not influence dental care in Poland.

Specialists

Orthodontic and other specialists work in both private and NZF practices. In the NZF, as specialists, their "points" are higher, but it is not known how many still practise in the clinics and how many in fully liberal practice. Patients do not have to be seen on referral from primary dentists.

Most oral surgeons work in private practices or practices with contract with NFZ, also, apart from oral maxillo-facial surgeons who work mainly in hospitals.

Year of data:	2008
Orthodontics	1,078
Endodontics & Conservation	1,622
Paedodontics	478
Periodontics	369
Prosthodontics	1,441
Oral Radiologists	
Oral Surgery	713
OMFS	260
Dental Public Health	71
Hygiene & epidemiology	122

Auxiliaries

There are two kinds of clinical auxiliaries in Poland – Dental Hygienists and Dental Technicians. Additionally, there are dental nurses and receptionists.

Year of data:	2000
Hygienists	2,500
Technicians	7,000
Denturists	0
Assistants	9,725
Therapists	0
Other	0

These are estimated numbers from the year 2000. In 2008, there were no more up to date numbers, although it was reported that discussions regarding a national register for auxiliaries were taking place.

If auxiliaries are employed at public establishments they are full-time employees; in private establishments and in the case of private practice it may either be a full-time or other forms of employment provided for by the law. The provisions of the labour code are binding.

Dental Hygienists

The training for dental hygienists is conducted at medical schools and universities, for 2 years, after a high school diploma has been obtained. Dental hygienist is a professional title conferred upon the completion of the training, when a diploma is granted by the Minister of Education, acting in agreement with the Minister of Health.

In 2008 there was no register. A draft law on certain medical professions was elaborated and was being formulated to introduce a national register run by the Minister of Health.

Hygienists' duties include preparation, registration, prophylactic care and promotion of health. They may not diagnose or give local anaesthesia and cannot work without the presence of a dentist. They cannot accept fees from patients, except on behalf of the dentist.

Dental Technicians

The training for dental technicians is conducted at medical schools and universities (technical colleges), and lasts 2 years. Dental technician is a professional title conferred upon the completion of the training, when a diploma is granted.

Again, in 2008 there was no register but the same law planned for hygienists would embrace dental technicians also.

Technicians normally work in commercial laboratories, only a few are employees of dentists or of clinics. They may work in clinics on salaried contract or by tender for fees.

There is no reported problem in the Poland with illegal denturists/clinical dental technicians.

Dental Nurses (Assistants)

Dental nurses are assistants, with training by the dentist. There is no formal education available, except for a one-month course, BHP in Public Service. Besides assisting the dentist they are not permitted to undertake other duties.

Practice in Poland

Year of data:	2008
General (private) practice	20,240
Public dental service	500
University	400
Hospital	150
Armed Forces	400
General Practice as a proportion is	93%

Year of data:	2008
Retired with right to practise	4,200
Emigrated but with right to practise	1,200
Physicians with dentist qualifications	570
Maternity leave	1,200
Limited practise through internship	970

Working in Liberal (General) Practice

Not all the physicians willing to work within the NFZ system can be employed, due to the limited amounts of financial means allocated to medical care. Only about a third of dental surgeons worked for Sick Funds in 2008. Others work exclusively outside NFZ, practising in their own private practice, as owners of establishments, who employ their colleagues or co-owners in partnerships or exclusively in their own private practice. The state has not set the legal framework for the principles of practising, which would allow only one of the aforementioned forms of practice.

Fee scales

The Minister of Health determines the kind of services and their point value according to the ICD-9-CM, which is a catalogue of dental work in points (*klasyfikacja procedur medycznych i dodatkowych badan laboratoryjnych*).

Joining or establishing a practice

The rules of entering into the list of physician and dental practice are specified by an Act, as well as by the regulation of the Minister of Health. One has to fulfil specific requirements concerning the premises, the sanitary and epidemiological arrangements, ionising radiation, sterilization, storage and disposal of waste materials.

There are no limitations as to the building type. There is also no limitation as to the area size, or the number of partners (employees) or the number of patients.

They must register their practices with the Regional Chamber of Physicians and Dentists. They have to possess premises which meet the requirements of the law, have the right to practise the profession and be registered members of the regional chamber. They may join a company or register their own establishment (clinic).

Remuneration is decided by a given establishment's remuneration regulations. In private practice, it is the profit gained after payment of liabilities. Supervision of individual and group private practice is exercised by a regional chamber through dental surgeons. The quality of services provided by NFZ is controlled by NFZ through its consultants, i.e. dental surgeons.

Working in Public Clinics

There are public clinics in Poland. Everyone insured to the extent of the services provided by NFZ may benefit from them. Besides, services paid directly by the patient are also available. They do not bear any costs of services to which they are entitled free of charge if they are insured.

The quality of services provided at health care establishments is supervised by a voivode, through the voivodeship consultants, who are dental surgeons, although most often academic workers.

Persons employed at public establishments receive fixed remuneration (salary), very often divided into several components such as seniority, specialisation, premium etc.

Working in Hospitals

Hospitals are public property. There are a small number of private hospitals run, for example by the Church or individuals. Procedures tend to be oral maxillofacial surgery, undertaken by oral maxillofacial surgical specialists.

Dentists are employed at clinics and university hospitals and at certain hospitals in larger cities.

Working in Universities and Dental Faculties

There are 10 dental schools, in which about 400 dentists work. Whilst they are normally full-time employees of the University, in practice many of them work part-time in private practice also.

The titles of university teachers are: dental doctor or professor. They may need to have a further degree such as PhD.

Working in the Armed Forces

Dentists serve full-time in the Armed Forces – the gender mix is not available.

Professional Matters

Professional associations

	Number	Year	Source
Polish Dental Association	5,217	2008	Chamber
Chamber of Physicians and Dentists	21,800	2008	Chamber

The Polish Chamber of Physicians and Dentists includes, with equal status, both physicians and dental practitioners. It is divided into 23 regional chambers, with a separate chamber of military physicians and dentists, which has legal status of a regional chamber, although it is active in entire country. Chambers deal with all kinds of problems of practising medicine and dentistry in Poland.

The jurisdiction of individual regional chambers of physicians and dentists and their headquarters are determined by the Polish Chamber of Physicians and Dentists, in consideration of the basic territorial division of the state.

Democratically elected representatives (delegates) meet at the Regional Medical Assembly. The Assembly, in a secret ballot, elects the president of the regional medical council and members of some statutory offices (the medical court, the screener for professional liability), members of the regional medical council and representatives to the General Medical Assembly.

The General Medical Assembly ballots for the President of the Supreme Medical Council, the Supreme Screener and Deputy Screeners for Professional Liability, members of the Supreme Medical Court and the Supreme Audit Committee. One Vice President will usually be a dentist. The term of office for authorities of medical chambers is 4 years. The Polish Chamber of Physicians and Dentists (consisting of elected representatives) and regional chambers (encompassing representatives and all members in the region) are self governing, autonomous bodies of physicians and dentists, subject only to regulations of the legal act and possessing legal status.

The highest authority of the Polish Chamber of Physicians and Dentists is the General Medical Assembly, and, in regional chambers - regional medical assemblies. In the period between assemblies - the Supreme Medical Council and regional medical councils respectively carry out day to day business. The Supreme Medical Council represents the medical profession at the state level, and regional councils at regional levels.

Membership in the Chamber is mandatory. All the physicians and dental practitioners who intend to practice medicine or dentistry in Poland have to belong to the Chamber, as these are the chambers that award the right to practice medicine or dentistry.

The Polish Dental Association - the Polish Stomatological Association- or PDA, is the main scientific dental association to which practising dental practitioners generally belong. This Association takes part in helping dental practitioners undertake their obligation to take part in continuing education. It strives to advance the science of dentistry. Membership of this association is not mandatory.

The PDA is currently divided into regional divisions which are co-terminous with governmental administrative divisions at a regional level. Each division organises area meetings in which papers, lectures and scientific research are delivered. The functions are carried out in cooperation with the regional Polish Chambers. There are many other scientific dental associations in Poland, but the Polish Dental Association is the biggest. All dental practitioners with specialisations must belong to one of them.

Other registered and acting scientific and specialist societies are: the Polish Orthodontic Society, the Polish Society of Oral Cavity and Maxillo-Facial Surgery, and the Polish Society of Stomatological Implantology.

Ethics and Regulation

Ethical Code

Dental surgeons are bound by the ethical code. The ethical code was adopted in 1993. The sanctions against a dentist found guilty of breaching the ethical code by a Medical Court include an admonishment, suspension of the licence (for up to 3 years) or full deprivation of the licence. Any appeal is to the Supreme Medical Court.

Fitness to Practise/Disciplinary Matters

The rules are determined from the Act on the Profession of Physician and Dental Practitioner. The Medical and Supreme Medical Courts comprise dentists (dental doctors/stomatologists) and physicians. However, cases rigidly connected with dental practice would be conducted by dentists only. Other problems about the ethical code may be undertaken by physicians. Screeners for Professional Liability and for the Regional Courts, at each of the 24 regional chambers, and one Supreme Court screener, supervise compliance with the rules of the ethical code. Dental practitioners are active in the work of the Supreme and Regional Screeners, for Professional Liability and the Medical Courts, as they deal with all the matters of dental practitioners, but they may also be involved with work in cases about physicians. The Polish Chamber also employs lay people for advice and assistance to dentists and physicians.

A complaint by a patient is taken over by a Screener. He may abandon the proceedings or bring the case to a regional medical court. An appeal can be made to the Supreme Screener. A complaint may also be brought by a complainant to common courts and if error is suspected, the case may be taken over by the prosecutor and, subsequently, decided by the common court under criminal proceedings.

In the event of a case being in the common court, the rules of appeal are determined under a separate act.

Data Protection

Poland has adopted the EU Directive on Data Protection. By general statute, the dentist is bound to observe patient confidentiality. Information acquired by the dentist in the course of his/her professional duties, concerning the patient and his/her background is confidential. The death of the patient does not release the dentist from the duty of confidentiality. Whilst information may be stored in electronic form, dentists must also carry paper records.

Advertising

According to the Act on Healthcare Establishments, public announcements have to be exempt from commercial advertisement features. According to the Act on the Professions of Physician and Dental Surgeon, dental surgeons may inform the public of the medical service they provide and the content and form of such information must also be exempt from the features typical of commercial advertising. The rules according to which physicians and dentists announce their services are determined by the Chamber of Physicians and Dentists. The following adjectives are banned from the information: "cheapest, best, painless etc".

According to the ethical code, a dental surgeon must not impose a service, or gain patients, in a manner inconsistent with ethical and deontological principles, and the rules of loyalty to fellow practitioners. Information, such as address, practice hours and specialisation may be placed in the press, but adverts are not permissible.

Dentists may run their own websites, but the information contained therein must comply with the general rules on advertising of dentists as described above.

Indemnity Insurance

A patient is entitled to lodge a complaint and demand compensation before a medical court or a common court. Every dentist has to be insured against civil liability for the practice of the profession.

Insurance is provided by commercial insurance companies. Chambers hold collective contracts of insurance covering members of the chambers. Very often the insurance packages include other types of insurance also (surgery, flat, house, car, etc.). The insurance rate is not conditioned by the form of practice, whether it is salaried or private. Dentists combine both forms and work both under employment contract and pursue private practice. If there are claims on the part of the patient and a public establishment is involved, the establishment is liable. Nevertheless, if a dentist's fault is proven, the establishment may claim return of the costs.

Corporate Dentistry

Dentists in Poland may form companies - Grupowa Praktyka Lekarska, Spólka Partnerska, Niepubliczny Zaklad Opieki Zdrowotnej. A non-dentist can be a shareholder, on the board, or the owner of the company, but he should register a company in the City's Office (*Urzad Miasta*) and Public Health (*Zdrowie Publiczne*) but not at the Chamber.

Only general company rules apply so there are no limitations as to the numbers of non-dentist members.

Tooth whitening

Generally tooth whitening products are considered as medicinal products that can be used and prescribed only by dental practitioners. The Chamber has no information about illegal bleaching (eg by hygienists), with no media reports on such practices.

However, products with low percentage of peroxide are also available in pharmacies without the need for prescriptions for individual use.

Health and Safety at Work

The types of obligatory vaccination are determined by the state and supervised by the State Sanitary Inspector. Each employee must undergo periodic medical examination (Health Book). There is no obligation for Hepatitis B vaccination. However this vaccination is recommended and may be required by the employers. Students undertaking dental studies are usually inoculated against Hepatitis B, as are all Public Health dentists.

Regulations for Health and Safety:

For	*Administered by*
Ionising radiation	SANEPID (Sanitary Inspection, the state)
Electrical installations	Inspekcja Pracy – BHP (The state)
Waste disposal	Incineration only
Medical devices	The Medical Chamber
Infection control	SANEPID (Sanitary Inspection, the state)

Ionising Radiation

Radiation equipment has to be registered with the SANEPID.

Training in ionising radiation is part of the new undergraduate course. Previously radiology was restricted to qualified radiologists only. Radiation protection training is followed by a test, which is repeated every 5 years for certification.

Only the dentist (in a practice) is the competent person ("radiology inspector") to direct ionising radiation – or radiation technicians under a dentist's directions.

Courses are currently organised in the medical faculties for those who did not receive training as part of the (old) undergraduate course.

Hazardous waste

The EU Hazardous Waste Directive has been transposed into Polish law. However, amalgam separators are not mandatory in dental practices. Regulations restrict the collection of waste dental amalgam to registered carriers.

Financial Matters

Retirement pensions and Healthcare

Women of 60 years and men of 65 years are entitled to retirement at those ages (this had previously been that dental surgeons could retire at the age of 55 and 60 years, respectively). However, in private practice there is no age limit. In fact, dental surgeons normally end their practice before they are 70 years old.

The profession was included among professions who practised under special conditions, with pensions of €250 - €400 a month received by dental surgeons who retired under the old system. But, currently the reception of retirement pensions is conditioned by income. In the new pension system young dentists will retire under the new scheme, whereby they have to make their own personal contributions to their pension funds. A minimum of 60% of average income in the country is the basis of retirement schemes.

Taxes

n 2008, the first 3,090 PLN (€964) earned in the year are free of tax, with income exceeding this figure but lower than 44,490 PLN (€13,900) taxed at 19%. Yearly earnings in the bracket from 44,490 PLN to 85,528 PLN (€27,000) incur 30% tax. The top personal income-tax rate of 40% was levied on earnings above 85,528 PLN per year.

VAT

In Poland there are three VAT rates: 0% on dental services, 7% on materials and drugs, 22% on instruments and equipment

Various Financial Comparators

Zurich = 100	Warsaw 2003	Warsaw 2008
Prices (excluding rent)	50.7	68.0
Prices (including rent)	51.8	65.0
Wage levels (net)	11.4	17.7
Domestic Purchasing Power	23.2	27.2

Source: UBS August 2003 & January 2008

Other Useful Information

Details of information centres:	
Misterstwo Zdrowia (Ministry of Health) Tel: Fax: E-mail: Website: www.mz.gov.pl	Narodowy Fundusz Zdrowia (National Health Fund) Tel: Fax: E-mail: Website: www.nfz.gov.pl
Main national association and the competent authority	*Other national association*
Polish Chamber of Physicians and Dentists Sobiesko,110 00-764 Warsaw Poland Tel: +48 22 559 13 09 Fax: +48 22 559 13 10 Email: stomatologia@hipokrates.org Website: www.nil.org.pl	Polish Dental Association 50-138 Wroclaw, ul. Kuznicza 43/45 Poland Tel: +48 71 342 42 16 Fax: +48 71 342 42 16 Email: paradont@stom.am.wroc.pl Website: www.pts.net.pl
Other useful contacts:	
Centrum Medyczne Ksztalcenia Podyplomowego (Medical Centre for Postgraduate Training) Tel: Fax: E-mail: Website: www.cmkp.edu.pl	Główny Inspektorat Sanitarny SANEPID (The Main Sanitary Control / Inspection) Tel: Fax: E-mail: inspektorat@gis.mz.gov.pl Website: www.gis.mz.gov.pl

There are two scientific periodicals: "Journal of Dentistry" and the "Journal of Prosthodontics", which are issued by the Polish Dental Association. These journals are for scientific research articles and advertisements about courses and other assemblies of dental practitioners in Poland.

There are also other magazines/scientific periodicals:

Dental Magazine (Magazyn Stomatologiczny), Your Review Stomatologic (Twój Przeglad Stomatologiczny), New Dentistry (Nowa Stomatologia), Modern Dentistry (Stomatologia Współczesna), Guide for Dentistry (Poradnik Stomatologiczny), Ace of Dentistry (As Stomatologii) and many others.

Dental Schools:

	Number of Undergrads 2008		Annual Graduates 2007		Places for overseas
Bialystok	433		82		14
Gdansk	354		61		12
Kraków	408		67		15
Lublin	485		78		20
Lódz	545		94		20
Zabrze (Katow ice)	484		94		16
Warszaw a	500		87		15
Szczecin	487		69		16
Wroclaw	453		91		15
Poznan	457		86		15
Overall total	4,606		809		158
About 5% of places for Polish students are priv ate (fees pay able)					

City: *Bialystok*
The Dean
Oddzial Stomatologiczny
Wydzial Lekarski z Oddzialem Stomatologii i Oddzialem
Nauczania w Jezyku Angielskim
Uniwersytet Medyczny
ul. Kilinskiego 1
15-230 Bialystok
POLAND
Tel: +48 85 748 54 79
Website: www.amb.edu.pl
Dentists graduating each year: 82
Number of students: 433

City: *Gdansk*
Academia Medica Gadanesis
The Dean
Oddzial Stomatologiczny
Wydzial Lekarski z Oddzialem Stomatologicznym
Akademii Medycznej w Gdansku
Al. Zwyciestwa 41/42
80-210 Gdansk
POLAND
Tel: +48 58 349 1064
Website: www.old.amg.gda.pl
Dentists graduating each year: 61
Number of students: 354

City: *Krakow*
The Dean
Oddizial Stomatologiczny
Uniwersytet Jagiellonski Collegium Medicum
Wydzial Lekarski
ul.Sw. Anny 12 31-008 Krakow
POLAND
Tel: +48 12 422 54 44
Website: www.wl.cm-uj.krakow.p
Dentists graduating each year: 67
Number of students: 408

City: *Lublin*
The Dean
Oddizial Stomatologii
I Wydzial Lekarski z Oddzialem Stomatologicznym
Uniwersytet Medyczny
Aleje Raclawickie 1
20-059 Lublin
POLAND
Tel: +48 81 528 88 19
Website: www.am.lublin.pl
Dentists graduating each year: 78
Number of students: 485

City: *Lodz*
The Associate Dean
(Faculty of Medecine and Dentistry
Medical University of Lodz)

Wydzial Lekarsko-Dentystyczny
ul. Pomorska 251
92-213 Lodz
POLAND
Tel: +48 42 675 74 46
Fax: +48 42 675 74 56
Website: www.umed.lodz.pl
Dentists graduating each year: 94
Number of students: 545

City: *Zabrze / Katowice*/
Medical University of Silesia (Katowice)
The Dean

Wydzial Lekarski z Oddzialem Lekarsko - Dentystycznym
Slaski Uniwersytet Medyczny w Zabrzu
Pl. Traugutta 2
41-800 Zabrze
POLAND
Tel: +48 32 271-72-19 w 252
Website: www.slam.katowice.pl
Dentists graduating each year: 94
Number of students: 484

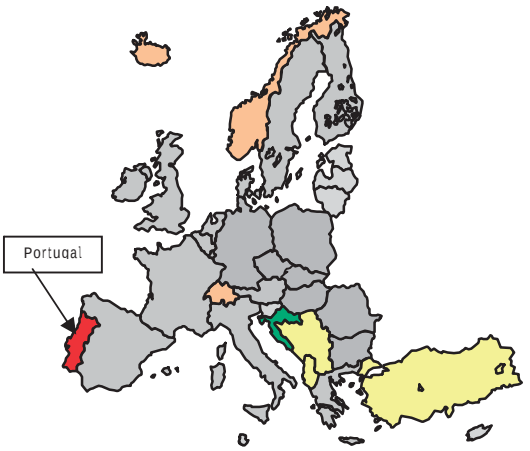
City: *Warsaw*
The Dean
Oddzial Stomatologii
I Wydzialu Lekarskiego Akademii Medycznej
ul. Zwirki i Wigury 61 pok. 213
02-091 Warszawa
POLAND
Tel.: +48 022 572 02 08
Fax: +48 022 572 02 66
Website: www.wum.edu.pl
Dentists graduating each year: 87
Number of students: 500

City: *Szczecin*
The Dean
Katedra Stomatologii Zachowawczej i Periodontologii
Wydzial Lekarsko-Stomatologiczny
Pomorska Akademia Medyczna
ul. Rybacka 1
70-204 Szczecin
POLAND
Tel: +48 91 48 00 812
Website: www.pam.szczecin.pl
Dentists graduating each year: 69
Number of students: 487

City: *Wroclaw*
The Dean
Wydzial Lekarsko - Stomatologiczny
Akademii Medycznej we Wroclawiu
ul. Krakowska 26
50-425 Wroclaw
POLAND
Tel: +48 71 209 761
Fax: +48 71 215 729
Website: www.stom.am.wroc.pl
Dentists graduating each year: 91
Number of students: 453

City: *Poznan*
Wydzial Lekarski II
Collegium Stomatologicum
Uniwersytetu Medycznego im. Karola Marcinkowskiego
w Poznaniu
ul. Bukowska 70
60-812 Poznan
Tel. +48 61 854 71 31
Fax. +48 61 854 71 33
Website : www.amp.edu.pl
Dentists graduating each year: 86
Number of students:457

Portugal



In the EU/EC since	1986
Population (2008)	10,617,575
GDP PPP per capita (2007)	€17,885
Currency	Euro
Main language	Portuguese

The publicly funded oral health care system is complex & financed by taxes, under the National Health Service. Dentists may contract to one or more Private or Public Insurance schemes. Each scheme has its own list of eligible treatments and scale of fees and most include emergency care. Few provide cover for advanced prosthodontics.

Dentists, stomatologists & odontologists:	7,514
Population ratio (active workers):	1,503
Membership of the OMD by dentists:	100%

The specialties of Oral Surgery and Orthodontics were implemented only in 1999, so are small in numbers. There are also Oral Hygienists. Continuing education for dentists is mandatory from January 2009. It is supervised and regulated by the Ordem dos Médicos Dentistas (OMD), the Portuguese Dental Association, to which all dentists must belong.

Date of last revision: 1st October 2008

Government and healthcare in Portugal

Portugal is a democracy. There is a centralist government elected by proportional representation. The Portuguese Parliament (called the Republic Assembly) is the representative assembly of all Portuguese citizens, with 230 deputies, as stipulated in the electoral law. The deputies are elected by electoral circles geographically determined in the law, so that the proportional representation system is assured. The legislature has an electoral period of four years. The Portuguese Parliament has the legislative competence, as well as political and fiscal power above the government. The capital is Lisbon.

There is currently no regional tier and major functions such as health and education are managed nationally through ministerial departments. A local government network also exists, which collects some taxes, but only limited authority is given to this system, for example, motor vehicles and commerce.

Healthcare is controlled by a Minister of Health who delegates powers to Districts (cities and towns). Each District has a politically appointed President who is often a Public Health Doctor. There is no committee or board at this level; instead there is a Regional Administration that is responsible for large Hospitals and Health Centres, which provide primary and secondary care, and Clinics which only have primary care facilities. The National Health Service employs doctors, nurses, other health professionals, and supporting staff - only a small number of stomatologists and a very few dentists (médicos dentistas).

Portugal has a Public National Health Service which should be free for all the Portuguese population. However, all dental practices demand the payment of a special fee, although some parts of the population do not have to pay these fees - such as those over 65 years old, the unemployed, blood donors, pregnant women, firemen and low income earners. All the working population pay a Public social security tax (employees pay premiums of 11% of earnings, with employers contributing 23.75% of earnings).

There are a large number of other funds which provide additional cover for individual professions, for example for, lawyers, banks, industry, the military and civil servants. Each fund has its own administrative structure and each one pays a different level of benefit as a contribution towards the cost of care. Payments to each fund vary and the system is progressive with higher paid personnel contributing more than those with lower salaries. Payments are collected by employers from salaried personnel and the self-employed pay a quarterly amount based on the previous year's income. The level of contributions is calculated annually according to expenditure and deficits are not allowed.

Entitlement to care is not affected by the differential payments from individuals and any additional benefits are provided through private insurance or/and additional funds. The public funds cover employees and their dependants.

		Year	Source
% GDP spent on health	10.2%	2006	OECD
% of this spent by governm't	70.6%	2006	OECD

The Parliament decides the level of health expenditure each year.

Oral healthcare

Publicly funded oral healthcare

		Year	Source
% GDP spent on oral health	0.36%	2004	OMD
% of OH expenditure private	40%	2004	OMD

For the first time in the political health strategy a part of the public budget for 2008 was consigned to oral health. Through the then recently created National Oral Health Promotion Programme "Cheque-dentista", two specific targets of the population – pregnant women and aged people with lower incomes - benefit from some public expenditure on oral treatments, with the possibility to choose freely from a list of private adherent dentists. This low income elderly people (registered in a special aid programme called Solidarity Complement for Seniors (*Complemento Solidário para Idosos*), also would benefit from a contribution up to €250 in a three-year period regarding prosthetic procedures.

Since 1986, there have been programmes of promotion and prevention in Oral Health. But only in 1999 was a curative perspective introduced that has received the contribution of dentists (médicos dentistas) and stomatologists enrolled in their respective professional associations.

The National Programme for Oral Health Promotion (PNPSO), that was introduced in 2005, has as primary strategy an intervention based on oral health promotion and on oral illness prevention that develop throughout the cycle of life and in environments where children and teenagers live and study. It contemplates, also, a curative perspective to a small part of school population reached by the programme.

The PNPSO reaches children and teenagers from 3 till 16 years and is constituted by three sub programmes, promotion of the oral health in families and schools, prevention of the oral illnesses and precocious diagnostic and dental treatment.

It is the competence of the General Directorate of Health, through its structure, to guarantee the health promotion, the prevention of oral illnesses and afford assistance of oral health, capable of being performed in the National Health Service (SNS). This intervention is assured by the professionals of the Local Medical Centres (Centros de Saúde), through actions directed to the individual, the family and the school community.

For admission to the PNPSO regarding dental intervention, only dentists (médicos dentistas) and stomatologists enrolled in the respective professional associations can apply.

According to data from the General Directorate of Health, from a cohort of 1,200,000, about 50,000 children per year have benefited from dental care, with significant profits on oral health.

In 2008, the PNPSO (regarding dental intervention) was widened to include pregnant women enrolled in the National Health Service and to aged people who are beneficiaries of the Solidarity Complement for Seniors (SCI).

SCI is an integrated monetary installment in the Subsystem of Solidarity of the Public System of Social Security, destined for national and foreign citizens with low resources. It is a distinguishing installment, that is, it is an additional support to the resources that the addressees already possess. It was given €21 million for both programmes.

The rest of the publicly funded oral health care system in Portugal is complex and not very comprehensive for dental medicine. Dentists may contract to one or more Sick Fund schemes. Each scheme has its own list of eligible treatments and scale of fees and most include emergency care. Few provide cover for advanced prosthodontics and those that do, usually have a prior approval system. The Social Security system is controlled by a national law and each Fund is self regulating within its own rules.

Most oral healthcare is provided in private (liberal) practices although a few hospitals and Health Centres from the National Health Service have dentists.

Domiciliary care is not offered in the Public System.

Private insurance for dental care

The Private Healthcare insurance market in Portugal is growing quickly. Some companies are starting to include dental medicine care and dental medicine care plans. Such plans are often expensive and can have two options: reimbursement and convention. In the first system, the patient pays the total cost of treatment to the dentist and then reclaims, as appropriate from the company. Prior approval applies through reports from the dentist and sometimes, contributions may be made to advanced prosthodontics. In the second system, the cheaper and the most common, the dentist earns a certain amount for each treatment defined by the insurance company. A part of this amount is paid by depending upon the company and the patient has to make directly to the dentist a co-payment that varies in function of the contract established between the company and the patient.

Dental care is excluded from the Public Health System, mainly for financial reasons, except as described above.

The Quality of Care

The quantity or the quality of the care provided is monitored by the OMD and in most of the cases fraud is identified and pursued. Complaints from patients are dealt with in two different ways (see below).

Health data

		Year	Source
DMFT at age 12	1.50	2004	OECD
DMFT zero at age 12	47%	2004	OECD
Edentulous at age 65	39%	2001	ONSA

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no water fluoridation schemes. The PNPSO provides fluoride toothpaste to some children who are under the scope of the programme.

Education, Training and Registration

Undergraduate Training

To enter dental school a student must finish secondary school, and then undertake national exams, to apply to the university, according to the *Numerous Clausus* that are defined per University. Then the candidates are selected after consideration of the average classification obtained on the school and on the national exams.

Three of the dental schools are publicly owned and run, and four are private. The three state dental schools are located in university faculties of Medicine (*Coimbra*) or in faculties of Dental Medicine (*Porto* and *Lisbon*). The private schools are in Institutes of Health (North - CESPO and South - Egas Moniz), in the Fernando Pessoa University and in the Catholic University. Some students in private schools receive help towards their tuition fees, but not all.

Year of data:	2007
Number of schools	7
Student intake	591
Number of graduates	425
Percentage female (2006)	59%

In 2007 there were an abnormally high number who did not graduate, for various reasons. Some students changed to medicine and some failed to conclude their graduation successfully. However more importantly, the numerus clausus increased every year. So, the number of graduates in 2007 referred to the numerus clausus defined in 2001.

Until the entry into the EU in 1986, many dentists qualified as "Stomatologists" who are medical practitioners with additional dental training. They are trained in public hospitals of the National Health Service. EU membership has caused a growth of the number of dentists whose education meets the requirements of the Dental Directives (Médicos Dentistas) and a reduction of the education of stomatologists. Few stomatologists are still being trained per year (one only in 2008).

The students who entered university in 2005 or after have planned study of 5 years duration, which includes theoretical education and practical training. Before 2005 the education had a duration of 6 years.

Qualification and Vocational Training

Primary dental qualification

The main degree which may be included in the register is the *Carta de curso de licenciatura em medicina dentaria* (diploma conferring official recognition of completion of studies in dentistry).

Vocational Training (VT)

There is no requirement for post-qualification vocational training in Portugal although its implementation was being analysed by the *Ordem dos Médicos Dentistas* (OMD) in 2008.

Registration

To obtain registration an applicant must hold a degree or Diploma in Dental Medicine or meet the requirements for European Union freedom of movement.

Applications are to the OMD, which also holds the register. The Statute of the OMD defines the acts that a dentist may perform as "the study, prevention, diagnosis and treatment of dental and oral diseases, jaws and annexed structures".

Cost of registration (2008)	€250+

Registration costs from €250 to €1000, depending on the administrative procedures for the analysis of each request.

Language requirements

Migrants have to have knowledge of the language necessary for practising the profession in Portugal. The rules conform to the 2005 Directive on the recognition of professional qualifications. Nevertheless, the disposition of this had not been not completely transposed into an official control of entry by 2008.

Further Postgraduate and Specialist Training

Continuing education

Continuing education is regulated by the OMD and is expected to be mandatory by January 2009. However its implementation was not yet completed in 2008. The draft law which regulates continuing education already foresees its conditions and the terms.

The OMD arranges an annual continuing education programme; there is one annual multidisciplinary scientific congress (3 days) and another scientific congress each two years. There are also several courses such as: thematic courses, usually one-day in length; mini-courses (half-a-day courses) and practical courses. Dentists who attend pay a registration fee and receive a Certificate of Attendance.

Specialist Training

Specialist training in Portugal, in the recognised specialties of orthodontics and oral surgery, is at least 3 years in length, and takes place in the universities, and is followed by a clinical cases presentation exam evaluated by a jury nominated by the OMD. Students receive no particular remuneration during training.

The titles awarded for specialist qualification (provided by OMD) are:

- especialista em ortodontia (orthodontics)
- especialista em cirurgia oral (oral surgery).

Specialists must register as such in a register administered by the OMD.

Workforce

The Structure of the Dental Profession

As in several other EU countries, dentists did not exist as an identifiable independent profession until Portugal became a member of the European Community (in 1986). Before then, oral health care was provided by *Stomatologists*, who undertook 3 years of dental training after obtaining their medical degree. Stomatologists work in hospitals and in private practice. Portuguese Stomatologists, as well as dentists (Médicos Dentistas), can work in other countries of the EU under "acquired rights" legislation.

To complement the two groups identified there are also Odontologists, a professional category introduced by the government many years ago to meet the problem of their illegal practice. None are being trained now, but there is still pressure on the government from these unrecognised practitioners, to recognise them individually within the Laws which govern the dental discipline. It is reported by the OMD, that some of them are practising illegally in Portugal. They certainly do not have "Acquired Rights" to enable them to work elsewhere in the EU.

The European Commission, following pressure from the Portuguese Dental Association (OMD), decided in early 2003 to take a recommendation before the European Court of Justice, in connection with Portuguese legislation on the profession of "odontologista", which regularises, with this professional title, certain groups that practice dentistry in Portugal with no legal basis. The Commission considered this legislation to be contrary to Directives 78/686/EEC and 78/687/EEC on the mutual recognition of qualifications of practitioners of dentistry and the coordination of training for that profession respectively, since the profession of "odontologista" as defined in the legislation in question, operates in virtually the same area as that of dentists holding the Portuguese qualification referred to in Directive 78/686/EEC, which respects the training conditions laid down in Directive 78/687/EEC.

The Commission deemed that the profession of "odontologista" would therefore seem to be alternative to and to compete with that of dentist. "Odontologistas" do not, however, have the qualifications provided for in Directive 78/686/EEC and so they stated that that their training is in no way comparable to that laid down in Directive 78/687/EEC. The Commission consequently considered that the legislation in question conflicts with the purposes of the Directives as regards both freedom of movement for members of the professions and public health, and in fact circumvents these Directives.

Dentists

Year of data:	2008
Medicos Dentistas registered	6,150
Medicos Dentistas in active practice	5,700
Population to dental worker ratio*	1,503
Percentage female	53%
Qualified overseas	892
Stomatologists	698

Odontologists	666

* active dentists, stomatologists & odontologists

Movement of dentists across borders

There is a significant cross border movement, which the OMD report was increasing (also) significantly in 2008.

Until the late 1990s Brazilian-trained dentists were allowed to practice in Portugal under a bi-lateral agreement with Brazil. However, since the implementation of the EU Directives immigrants from Brazil are recognised no differently to those who enter from other non-EU/EEA countries. This means that they need to gain recognition of their diplomas through the public universities.

Specialists

Year of data:	2007
Orthodontics	38
Oral Surgery	4
OMFS	90

The specialties of Orthodontics and Oral Surgery were introduced in 1999. Oral Maxillo-facial surgery is a medical specialty.

Most of the specialists work in private practice, only.

Auxiliaries

Other than Dental Assistants, for whom there is no organised formal education, or training requirements, there are two other recognised grades in Portugal. They are:

- Dental hygienists
- Dental technicians

Year of data:	2008
Hygienists	500
Technicians	546
Denturists	0
Assistants (2004 data)	3,400
Therapists	0
Other	0

Dental Hygienists

Dental hygienists must train in dental schools or Health Institutes and gain the recognisable qualification before they can work. Their training course has a 3-year duration, and at the end they have a bachelor certificate.

To work they have to be registered. The registration is administered by the Ministry of Health. Hygienists must work under the direction of a dentist, who must be present at the office when they are working. The permitted acts for hygienists are oral hygiene education and screening, examination, history taking and prophylaxis (scaling), the application of topical medicaments and sealants, clinical assistance to the dentist and care of dental equipment. They are not permitted to give local anaesthetics.

They can be paid either by a percentage of the dental fees established by the dentist or by a salary.

Dental Technicians

Training for dental technicians is at dental schools and Health Institutes and lasts 3 years, at the end of which the student has a certificate (a registerable qualification) for dental technicians. Legally, they can only prepare prostheses. Students may study for one more year and obtain a degree (4 years). However, most of them do not have academic qualifications.

They must register with the Ministry of Health. They may also register with the Dental Technicians' Association, but this is not compulsory. Those who are medical devices fabricants have to be registered at the Competent National Authority for Medical Devices (INFARMED)

Technicians work in dental laboratories and earn fees from dentists for their work.

Dental Assistants

There is no available information about dental assistants in Portugal. There is no register for them.

Dental Assistants in Portugal are mandatory in each dental team working under a valid clinical direction. There is no compulsory formal training for dental assistants. However they can obtain technical training in some universities or institutes that provide professional courses. The OMD also allows them to attend specific seminars and workshops organised during the annual OMD congress.

Practice in Portugal

Year of data:	2008
General (private) practice	6,974
Public dental service	43
University (2004 data)	200
Hospital	90
Armed Forces	31
General Practice as a proportion is	95%

These figures for hospitals refer to stomatologists who practise only in hospitals. The remainder are in general (private) practice. Note: approximately 50% of the population is not provided with dental care, due to financial reasons, amongst others.

Working in General Practice

If a dentist is contracted to a Private Sick Fund, he claims his fees directly from the scheme and there is in most cases no patient charge, except for care that is not covered. A co-payment from patient in some Private Sick Funds does happen. Dentists who are not contracted may still accept patients from Sick Funds but the patient pays the fee and reclaims a part of it from the scheme.

Stomatologists work within a similar system, but Odontologists do not (they are limited to a certain number of types of treatment, as they do not have appropriate training).

Fee scales

In Portugal most of the dentists work in private practice, where patients pay 100% of fees, and also work with patients included in sick fund schemes. Each sick fund is self regulating in the setting of fees and the OMD have no part in the process.

Specialists receive the same fees as the generalists, when they are paid by the sick fund system.

There are no formal controls on the quality and quantity of care provided in private practice, other than those described in the ethical code.

In 1998 a law was introduced which allows patients who receive private or general oral health care from a doctor or a dentist to produce receipts and gain income tax relief. The tax relief may be up to 100% depending upon the person's income.

Joining or establishing a practice

There are no restrictions on the establishment of dental practices. However, the law regulates the operation of dental clinics and consulting rooms as health units which, regardless of their name and legal structure, carry out activities related to the prevention, diagnosis and treatment of disorders and diseases of the teeth, mouth, jaws and adjacent tissues.

In order to promote quality and safety, by adopting a similar system to that established regarding already regulated health centres, this law defines the requirements which concern facilities and equipment, as well as the rules regarding organisation and operation, regulates the licensing process and establishes the supervising bodies, and the tools for the practice of dentistry at national and regional levels.

Most dentists work in single-handed practice but occasionally mixed practices are established, with a dentist, a stomatologist or even an odontologist (the premises may be shops, special buildings, or converted houses).

Dentists can be employed as assistants, with legal responsibility for their own work, and are then usually paid a percentage of their gross income. Only rarely do assistants progress to partnerships. No government funding is available for the purchase of practices.

Working in the Public Clinics (Centros de Saúde)

There are about 400 Public Health Centres: in 2008 only few dentists were working in health centres or clinics, although there were dental surgeries in some. OMD negotiated with the State (Direcção Geral de Saúde) some salaried posts to provide care for children and other priority groups – progress had already been made with the National Programme for Oral Health Promotion (PNSOP) on children and teenagers and then with pregnant and aged people. This programme is being executed in some health establishments of the Health Ministry and it relates to a whole range of activities of primary and secondary tooth decay prevention.

The PNPSO has a primary strategy for intervention, based on oral health promotion and on oral illness prevention.

Working in Hospitals

Only Stomatologists are allowed to work in the approximately 80 Public hospitals in Portugal, and there are very few dental posts. The number of private hospitals is growing and some dentists work in them, but no information is available about the dental access to these premises.

Working in Universities and Dental Faculties

The dentists who work in the dental schools are salaried, although most of them maintain commitments in private practice. Their duties are mainly teaching. The quality of this function is monitored by the Ministry of Higher Education. The number of dentists working in Universities is growing due to an increase in the number of private dental schools.

To teach in universities, in general a dentist would not only need the degree of a licentiate (6 years of study) but also hold a Master's degree, or Doctorate (the highest degree of a faculty or university).

Working in the Armed Forces

There are dentists working in the Armed Forces. In 2008 this included 13 in the Army, 11 in the Navy (8 females) and 7 in the Air Force (3 females).

Professional Matters

Professional associations

The national dental association in Portugal is the *Ordem dos Médicos Dentistas* (OMD), which also administers the dental register. All dentists are members - it is obligatory to be a member to practice. (Stomatologists are regulated by their own Ethical Code and association).

OMD is a national association (for now) without regional branches, but only with the possibility of being represented at a regional level. The OMD is a Public Entity, autonomous, independent from the Portuguese State, which regulates dental practice in Portugal. There is a full time working office structured by a national headquarter in Porto (north of the country) and 3 local delegations - one in Lisbon and two more in each one of the two political and administrative autonomous regions (Açores and Madeira). The OMD has a General Assembly, a Board of Directors a Fiscal Board and also a Disciplinary Board. The President (Bastonário) of the OMD, as well as the Board of Directors and the Fiscal Board, are directly elected by all members. The Disciplinary Board is also directly elected but within an autonomous election.

The OMD provides the relevant, professional information to its members. This includes international and national legislation and also transnational recommendations such as CED information, that are able to clarify (as much as possible) the path that must be taken.

	Number	Year	Source
Ordem dos Médicos Dentistas	5,700	2008	OMD

Stomatologists are members of a college of the Portuguese Medical Association and odontologists have their own association.

There is no specific body to register odontologists, although they do need to register with the Ministry of Health. There is also a disciplinary body working to regulate and produce an ethical code for them.

Ethics and Regulation

Ethical Code

In Portugal, there are laws and codes which control professional conduct and ethical behaviour. They include fitness to practise, advertising and continuing education.

Fitness to Practise/Disciplinary Matters

Complaints from patients are dealt with in two different ways. If the issue involved is solely one of contract then it is considered by a legal assessor. If the quality of care is challenged then the patient is examined by the Clinical Director in a Sick Fund and/or by an independent dentist, if the patient has been treated by private contract. If *prima facia* evidence is found to support any complaint, it may be referred to the Ethical Council of OMD for investigation. Only dentists serve on the Council.

The Council has the power to reprimand, suspend for up to five years or remove from the register. Any appeal against a decision of the Council is made to the administrative courts.

None of the above prevents civil action by patients in the courts. All in all, the procedure is very slow and each case may take two to three years to conclude. Dentists may also appeal to the courts. Criminal offences are included in the court process.

Data Protection

There is an internal Portuguese Law that transposed the EU Directive on Data Protection. Dentists must comply with this legislation by legalising their clinical database and also by preventing clinic files from any privacy violation.

Advertising

The OMD is responsible for the regulation about advertising in Portugal. There is an internal national rule according to the general law and also according to the Ethical Code for Dentists. Websites may be used, but only according to the Ethical Code of the OMD.

Indemnity Insurance

Liability insurance is not compulsory for dentists. However, professional insurance is provided by private general insurance companies. Cover depends on the dentist's individual requirements and premiums will vary to reflect this. There is no minimum mandatory rate.

Corporate dentistry

According to the 26th Article of the Deontological Code of the OMD, dentists may form into companies. The number of them is unknown.

Non-dentists can own a company, but according to the Deontological Code, companies must have a clinical director, who must be a dentist.

Tooth whitening

Portugal implements the legislation that restricts the free sale of products that contain hydrogen peroxide with greater than 0.1% concentration, whilst no specific national legislation exists on tooth whitening products. The regulating national authority is the *INFARMED*, which follows the legislation of the European Union on this matter.

In 2008, the OMD shared the then opinion of the Scientific Commission in Consumers Products (SCCP) that the tooth-whitening products with hydrogen peroxide content between 0.1 and 6% should not be on free sale and can only be used after the approval and under the supervision of a dentist.

Health and Safety at Work

Inoculations, such as Hepatitis B are not compulsory for the workforce. A co-payment of 40% for the cost of them is guaranteed by the National Health Service.

Ionising Radiation

There is an internal law that transposes the EURATOM Directive. There is formal training in radiation protection for the one responsible for the radiation practise in each dental office. For dentists the law assumes that their general qualification in dentistry already allows them to work with radiation practices.

There is no mandatory continuing education requirement.

Hazardous waste

Portugal has specific legislation on hazardous waste, concerning the general question of waste management. The law has even created a new electronic integrated System (SIRER), in order to register the relevant information on the level of produced and imported waste by the responsible units. Nevertheless, this legislation does not refer specifically to amalgam, because as it was said, it is a generic law.

All those responsible for each unit related to hazardous waste have to comply with the law, by assuming some specific legal obligations towards the Health Ministry, such as sending regular and periodic information about the individual waste management.

At a national level, there is some regulation that recommends the use of the amalgam separators. But this is not legally mandatory. The spirit of the law points out the importance of its use, in order to improve the achievement of complete equipment by the dental professionals.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Departamento de Protecção e Segurança Radiológica, and Laboratório Nacional de Energia e Tecnologia Industrial
Electrical installations	Local city authorities, and (forthcoming) regulation by the Ministry of Health
Waste disposal	Ministry of Health
Medical devices	Ministry of Health
Infection control	Ministry of Health

Financial Matters

Retirement pensions and Healthcare

Employees pay premiums of about 11% of earnings (with employers contributing 23.75% of earnings), which, in addition to the retirement pension also provides social security protection against unemployment, and includes the sick fund contribution.

The scheme for self-employed people is different - they pay a quarterly amount based on the previous year's income. Retirement pensions in Portugal are typically 80% of a person's salary on retirement (for 36 years' work). Normal retirement age is 65 years. Dentists can practice beyond the normal retirement, as there is no age limitation.

Taxes

Income Tax

There is a national income tax (dependent on salary) with rates up to 40% of gross salary (at incomes above €52,300).

VAT/sales tax

VAT is payable at various rates (20% normally and 5% for anaesthetics). It is payable on all dental equipment and consumables.

Various Financial Comparators

Zurich = 100	Lisbon 2003	Lisbon 2008
Prices (excluding rent)	65.1	72.3
Prices (including rent)	68.5	76.4
Wage levels (net)	25.1	32.9
Domestic Purchasing Power	37.7	43.0

Source: UBS August 2003 & January 2008

Other Useful Information

Competent Authority:

Ministério da Saúde
Departamento de Recursos
Humanos da Saúde
Avenida Miguel Bombarda, 6
1000-208 Lisboa
Tel: + 351 21 7984200
Fax: + 351 21 7984220
E-mail: drhs@drhs.min-saude.pt
Website: http://www.min-saude.pt

Publications:

Boletim Informativo
Av. Dr Antunes Guimarães, 463
4100 - 080 Porto
Portugal
Tel.: + 3
Fax: + 3
Email: ordem@omd.pt
Website: www.omd.pt

Main National Association and Information Centre:

Ordem dos Médicos Dentistas (OMD)
Av. Dr Antunes Guimarães, 463
4100 -080 Porto
Portugal
Tel: + 351 22 619 7690
Fax: + 351 22 619 7699
Email: ordem@omd.pt
Website: www.omd.pt

Lisbon Delegation
Campo Grande, 30-5º-C
1700-093 Lisboa
Portugal
Tel: + 351 21 794 1344
Fax + 351 21 799 3551
Email: delegacao@omd.pt
Website: www.omd.pt

Madeira Delegation
Vereda da Vargem, Bloco A – Conjunto Habitacional do Amparo S. Martinho
9000-276 Funchal
Tel.: +351 291 761 178
Fax: +351 291 768 252
Email: delegacao.madeira@omd.pt
Website: www.omd.pt

Dental Schools:

Public Faculties:

Faculdade de Medicina Dentária do Porto
Rua Dr Manuel Pereira da Silva
4200 Porto
Tel: + 351 22 5093938
Fax: + 351 22 5507375
Email: fmdup@fmd.up.pt
Website: www.fmd.up.pt

Dentists graduating each year 2005/2006 = 60
Number of students 2006/2007 = 404

Faculdade de Medicina Dentária de Lisboa
Cidade Universitária
1600 Lisboa
Tel: + 351 21 7922600
Fax: + 351 21 7957905
Email: correio@fmd.ul.pt
Website: www.fmd.ul.pt

Dentists graduating each year: 2006/2007 = 63
Number of students: 2007/08 = 378

Faculdade de Medicina da Universidade de Coimbra
Licenciatura de Medicina Dentária
Av. Bissaya Barreto
3049 Coimbra Codex
Tel: + 351 23 9400 578
Fax: + 351 23 9402 910
Email: dmduc@iol.pt
Website: www.fmed.uc.pt

Dentists graduating each year: 2006/2007 = 37
Number of students: 2006/2007 = 193

Private Faculties:	
Instituto Superior de Ciências da Saúde do Norte Rua Central da Gandra 1317 4580 Paredes Tel: + 351 22 4157142 Fax: + 351 22 4155954 Website: http://www.cespu.pt/cespu/universitario/iscsn/meddent.asp Dentists graduating each year 2006/2007 = 66 Number of students 2006/2007 = 500	Instituto Superior de Ciências da Saúde Egas Moniz Quinta da Granja Travessa da Granja 2825 Monte da Caparica Tel: + 351 21 2946700 Fax: + 351 21 2946768 Email: iscsem@egasmoniz.edu.pt Website: www.egasmoniz.edu.pt/iscsem/index.html Dentists graduating each year: 2006/2007 = 78 Number of students: 2007/2008 = 419
Universidade Fernando Pessoa Rua Carlos da Maia, 296 4200-150 Porto Tel: + 351 22 5074630 Fax: + 351 22 5074637 Email: geral.asaude@ufp.pt Website: http://www.ufp.pt Dentists graduating each year: 2006/2007 = 70 Number of students: 2007/2008 = 586	Universidade Católica Portuguesa Centro Regional das Beiras Estrada da Circunvalação, 3504-505 Viseu Tel: + 351 23 2430200 Fax: + 351 23 2428344 Website: www.ucp.pt or www.crb.ucp.pt Dentists graduating each year: 2006/2007 = 50 Number of students: 2007/2008 = 229

Romania

In the EU/EEA since	2007
Population (2008)	21,528,627
GDP PPP per capita (2006)	€17,885
Currency	Romanian New Lei (RON)
	3.70 RON = €1.00 (2008)
Main languages	Romanian

Romania has a healthcare system which depends on the compulsory membership of each insured citizen in the Social Health Insurance System. It provides a legally prescribed standard package of general and oral healthcare. Most dental care is provided under private arrangements.

Number of dentists:	14,000
Population to (active) dentist ratio:	1,573
Membership of the Dental Association::	25%

Specialists are widely used, but there are no clinical auxiliaries. Continuing education for dentists is mandatory, and is administered by the Romanian Collegiums of Dental Physicians (RCP), to which all dentists must belong.

Government and healthcare in Romania

Romania is situated on the Black Sea, between Ukraine and Bulgaria – with a land area of 237,500 sq km.

It is governed as a constitutional republic with an elected parliament with two chambers. The country is administered as 40 counties and 1 municipality, the capital Bucharest.

The statutory health insurance system was established in 1998. General and oral health care depends on the compulsory membership of each insured citizen in the Social Health Insurance System. The National Social Health Insurance House (NSHIH) at national level and County Social Health Insurance House (CSHIH) at county and capital level administrate the system. The whole population is insured and pays monthly a fixed amount of their salaries to the CSHIH, situated in the county where they live. The system of social health insurance provides a legally prescribed standard package of general and oral healthcare.

Financial sources from general taxation (from the national Budget) are only for the general prevention programmes, managed by the Ministry of Health and Family. The budget for NSHIH is directly proportional to the level of the salaries of the population. In every year the budget of NSHIH is estimated according to the previous year's budget, adjusted for inflation.

The administration of the NSHIH establishes at every year-end, by negotiating with the Romanian Collegiums of Dental Physicians (RCDP), the expenditure for the different medical specialties (hospitals, family medicine, specialties, emergencies, drugs, and dentistry). At the end of 2002 the Government ended the right of the RCDP to be a negotiating organisation, and established that the Ministry of Health and Family together with NSHIH undertook all the activities of social health insurance system.

The funds for NSHIH are met by a 12.5% levy on salaries (employers contribute 7% of salaries and employees 5.5%). The different level of contribution to NSHIH generated by the different levels of salaries does not affect the level of quantity or quality of the health care. The allocation of monies and resources is managed by the NSHIH and CSHIH, which are the legal financing institutions. The main functions of NSHIH and CSHIH are to pay the providers of medical and dental services and to control the quantity and quality of the services.

They represent the interests of the general community of the insured persons. In the original text of the law the Board of the NSHIH and CSHIH must be democratically elected by a general assembly of the insured persons but in practice this does not happen, because they are under Government control and designated by the Government. The legal framework of NSHIH and CSHIH restrict their activities only to social health care.

From the beginning of the social health insurance system, the Romanian Dental Association of Private Practitioners (RDAPP) had many proposals to improve the laws and regulations and to introduce more rights for dentists who work in the NSHIH. A number of proposals for the improvement of the law of NSHI were made by RDAPP to the Senate and the Deputies' Chambers, when the law was being reviewed by the Parliament. In a new Law in 2002, about Social Health Insurance, many of the proposals of the RDAPP were accepted.

The followings groups are exempt from paying monthly contributions for NSHIH:

- children and young people until 18 years old,
- unemployed persons, pregnant (retired) women and after-pregnancy (retired) women,

- persons who undertake military service, war veterans and seriously war-wounded,
- political prisoners and1989 revolutionaries,
- disabled persons.

The special institutions of the Government (Treasury, Ministry of Work and Social Solidarity, the Secretariat of Government for Disabilities Persons, etc.) are responsible for these special groups.

		Year	Source
% GDP spent on health	5.1%	2004	OECD
% of this spent by governm't	66.1%	2004	OECD

There is no more up to date available information

Oral healthcare

	Year	Source
% GDP spent on oral health	No data	
% OH expenditure private	No data	

There is no more up to date available information

Almost 90% of dentists are private; they have fiscal code and all kinds of legal authorisations for free practice, with full responsibilities. 60% of dentists are owners of their dental offices. 30% of dentists are not owners, but work in old buildings offered temporarily, free of rent, by the government, which is the real owner. Since 1994, when healthcare reform began, there have been many proposals by the government to sell their medical and dental offices to their occupants, but these have never been finalised - maybe for political and social reasons. 10% of dentists work as employees in primary schools and dental faculties.

Almost half of Romanian dentists, owners or non-owners of their dental offices, work within the CSHIH. The other half of the dentists work in a completely liberal (private) system, with direct payments from patients only. The number of CSHIH dentists is limited by the Social Health Insurance Houses at county level.

Only 1% of the medical funds of the CSHIH are spent on dental treatments - the greatest part of the funds is spent in hospitals (75%), or for family medicine (10%), etc. It is estimated that patients directly pay at least 90% of the costs of dental treatments.

They are major differences between access to medical and dental care in the population: at rural level only 25% of the population access dental treatment; at urban level, 75% of population access it. However, there are some shortages of dentists working in inner city areas and some specific social groups (children, farmers, retired persons) are having trouble accessing dental care at rural level.

In some parts of Romania, it is reported that some dentists use old types of dental treatment and prosthetic restorations, due to the level of dental education of different generations of dentists.

Insured patients would normally receive annual prevention control.

Public Compulsory Health Insurance

The social health insurance provides cover for all prevention and treatments for children and young people, until they are 18 years old. For adults, the NSHIH initially covers 10% of the costs of the list of dental treatments. Patients directly pay the difference of 90%

The RDAPP created and proposed to the NSHIH and RCDP the concepts of basic (social) dental care for adults and optional (free) dental care for adults. In the first years (1998-2000) the concepts were respected, the NSHIH covered only 25% of the entire list of dental treatments and 75% of treatments were optional. Then, from 2001 to 2004 the package of social dental care increased to over 55% and the optional treatments were only 45%. In the same last period the proportion allocated to dentistry was decreased from 3.5% to a nominal 2% (but actually to 1%). This was not enough for all dental treatments, and the NSHIH covered children's prevention and adult's emergency care only.

Following proposals of RDAPP to improve the dental social health insurances, which had been invited by the Ministry of Health to a "Partnership for Health", since the beginning of 2004 in *Norms of Application* of the Frame Contract between dentists and NSHIH, the following treatments are supported by the social health insurance:

- Preventive care for children and adolescents – 100%
- Dental treatments of children and adolescents (up to 18 years) – 100%
- Pain relief and emergency treatments – 60%
- Basic surgical care (with emergency treatments) – 60%
- Risk-diagnostics and preventive consultation – 100%
- Mobile social acrylic dentures for adults – 100%

The quantity of dental treatments provided by dentists is monitored only in social health insurance, at county level, by the CSHIH. The quality of work claimed by dentists from the remuneration bodies is monitored in the social health insurance system, at county level, by the Romanian Collegiums of Dental Physicians.

Private dental care

A large number of dentists have completely private patients, who pay the total cost of care. Private fees are regulated by the internal rules of every dental office and generally they are established after a direct negotiation between the dentist and his patient. A real free dental market was established between 1990 to 1998, with prices regulated by the principles of the market economy.

Approximately 38% of dentists have private patients only.

Private health insurance companies are not yet functioning in Romania.

The Quality of Care

A mixed commission (CSHIH and the Romanian Collegiums of Dental Physicians), only following a complaint of a patient, can judge the quality of work in the NSHIH system. Outside the NSHIH, in the liberal system, the quality of dental work can be judged only by the RCDP. From the quality point of view, the County Social Health Insurance House has the right to control regularly the activities of dentists who have a contract with them, through an inspection commission composed of employees of the CSHIH, which may or may not have dentist members. For further information see *Ethical Code*

A full-time dentist working either in the NSHIH or in a private system would have about 2,500 patients who he would count as his "list".

There is no form of domiciliary dental care.

Health data

		Year	Source
DMFT at age 12	4.10	2004	CECDO
DMFT zero at age 12	No data		
Edentulous at age 65	No data		

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There are no water or other fluoridation schemes in Romania.

Education and Training

Undergraduate Training

To enter dental school a student needs to be a high school graduate and pass an entry examination. There is no need for vocational entry.

Dental schools were known as Faculties of Stomatology, as a part of a University of Medicine and Pharmacy, until 2003. From the 2003-04 academic year they became Faculties of Dental Medicine.

Year of data:	2008
Number of schools	11
Student intake	1,500
Number of graduates	1,000
Percentage female	60%

Three of the dental schools are privately funded.

Students have to pay no contribution for the state-funded faculties and the full costs for the privately funded faculties. Every state funded faculty also has the right to manage a limited number of private places for students each year for study, for both budgeted and fee-paying students.

The RCDP disagrees with this as they believe this affects the basic quality of undergraduate dental training and would prefer a Romanian "numerus clausus". The competent authorities act on a general basis of free market principles.

Undergraduate training was for 6 years from 1991 to 2002. It was modified to 5 years in 2003, by the Ministries of Health and Education, to bring this training into line with EU requirements.

The Ministry of Education monitors the quality of the training and the Council of the Faculty is directly responsible.

Qualification and Vocational Training

Primary dental qualification

Upon qualification, the graduates received the title "Physician stomatologist" until the 2002-03 graduate year. The title "dentist" was substituted from the start of the 2003-4 dental school year.

Vocational Training (VT)

For the licence examination, the graduate has to undertake a written test with 200 questions, a practical test and to defend his or her diploma project. A previous "probationary" scheme was abandoned following the curriculum change in 2003.

The RCDP consider the lack of any vocational training a great danger both for the safety of the patients and for the quality of dental treatments and have been pressing for the introduction of one- year of minimal vocational training.

Diplomas from other EU countries are recognised without the need for any vocational training.

Registration

The Romanian Collegiums of Dental Physicians registers all Dental Physicians and all specialists.

Language requirements

It is absolutely necessary to know the Romanian language, to be registered with the RCDP. EU citizens must follow some study of Romanian language, followed by a written and oral test.

Cost of registration (2008)	€ 13.50

Further Postgraduate and Specialist Training

Continuing education

Continuing education is compulsory for all dentists. The Romanian Dental Association and the specialist dental associations organise continuing education (courses, seminars, symposiums, Congresses), under the supervision of Romanian Collegiums of Dental Physicians, in collaboration with the Ministry of Education, Research and Youth.

Every physician and dentist must undergo 200 hours of continuing education in every 5 year period. If they do not achieve this the RCDP has the legal obligation to end the right of the dentist to practise.

Specialist Training

For entering into specialist training dentists must have only their licensing diploma, as there is no vocational training. The specialist training is undertaken in the Dental Faculties and the Board of the Faculties monitors and are responsible for the quality assurance of the training.

There is training in 3 specialties:

- Orthodontics: 3 years training,
- Oral-maxillofacial surgery: 5 years training,
- Dento-alveolar surgery: 3 years training.

Any dentist can undertake specialist training, but the Ministry of Health limits the number of specialists. The trainees are paid during their training by a fixed budgetary salary supported by the Ministry of Health. In this period it is forbidden to work in private dental practice. At the end they receive a specialist degree and the diploma:

- physician specialist orthodontist;
- physician specialist maxillo-facial surgery;
- physician specialist dento-alveolar surgery.

From the former (communist system), Romania has an inheritance of two professional degrees: "specialist physicians" and "primary physicians", obtained after a period of home training followed by a final examination. These two professional degrees were held by a large number of generations of dentists. The first of these "specialist physicians" is at the origin of the "general stomatology" specialisation. The second one is a matter of higher fees in the NSHIH system.

Workforce

Dentists

Year of data:	2008
Total Registered	14,000
In active practice	13,687
Dentist to population ratio*	1,573
Percentage female	68%
Qualified overseas	450

** active dentists*

There is no information about whether there are unemployed dentists.

The active dental work force is thought by the RDAPP to be increasing. More then 40% of dentists are younger than 40 years.

Movement of dentists across borders

There are an unknown number of emigrant young dentists in the EU, the USA and Canada.

Specialists

Year of data:	2008
Orthodontics	412
Endodontics	
Paedodontics	
Periodontics	
Prosthodontics	
Oral Radiologists	
Dento-alveolar surgery	157
OMFS	234
Dental Public Health	

General Stomatology	4,938

Specialists practice in dental faculties, hospitals, private dental offices, and they receive higher fees regularly from the CSHIH or optionally directly from the patients.

Patients being seen by a specialist within the social health system must be referred by a generalist. However, in liberal practice they may access a specialist directly, without the need for a referral.

Arising from the former (communist system), Romania has an inheritance of two professional degrees: 'specialist physicians' and 'primary physicians', obtained after a period of home training, followed by a final examination. These two professional degrees were held by a large number of dentists. The first of these 'specialist physicians' is the origin of the general stomatology'. The second one involves higher tariffs within the NSHIH system.

The RCDP is the body in charge with the registration of all specialists.

Auxiliaries

There are limited numbers of clinical dental auxiliaries in Romania.

Year of data:	2008
Hygienists	100
Technicians	6,000
Denturists	8
Assistants	6,000
Therapists	0
Other	0

Dental Hygienists

The RCDP have provided data which shows that there are 100 dental hygienists in Romania, but there is no further information about these.

Dental Technicians

Dental technicians are trained in dental technician colleges, organised in frame of the dental faculties. The training is for 3 years, with a final examination and a diploma. Since 2007 they have had to register with the Order of Romanian Dental Technicians.

Dental technicians normally work in separate dental laboratories and invoice the dentist (or directly the patient) for completed prosthetic work. A small number of technicians are employees of dental offices and they are paid with a percentage of the fees for the prosthetics work.

There is some illegal dental practice practicing by non-specialised technicians, without a higher degree qualification, but the RCDP and RDAPP fight against these and the number of cases is decreasing every year.

Denturists

The RCDP have provided data which shows that there are 8 denturists in Romania, but there is no further information about these.

Dental Assistants (Nurses)

Dental assistants train in secondary medical schools, with 3 years of study and a final examination and diploma. They must be registered in the Order of Romanian Medical Assistants.

The duties of dental assistants are: assisting dentists, maintaining records, sterilisation, infection control, and office work. Dental assistants are paid a salary.

Practice in Romania

Year of data:	2008
General practice (private)	6,603
General practice (CSHIH)	7,000
Public dental service	1,200
University	950
Hospital	234
Armed Forces	80
General Practice as a proportion is	97%

The figures above add up to more than the number of active dentists in Romania. This is because most dentists who work in the public sectors also undertake some general practice. Those recorded as "General practice (private)" represent practitioners who do not work in the NSHIH.

Working in Liberal (General) Practice

Patients pay dentists who work in the private sector directly and completely. Every dentist chooses whether to work only with CSHIH (County System Health Insurance House) or in an independent way, or both. Of course, the financial position of the patient also determines the choice. There are two systems of payment, one is Item of Treatment Fees, for NSHIH dentists and the other direct patient full payment.

There is no prior approval for treatment necessary - only the consent of the patient, established freely and directly together with the dentist.

Fee scales

The fees for dentists in the NSHIH system were negotiated annually to 2002, between NSHIH and RCDP. Since the end of 2002 the fees have not been amended, as the NSHIH that the contract is not mandatory but optional for dentists.

The NSHIH pays dental services for dentists who accept the terms offered to them. Some work is completely paid, whilst other work is paid at only 40-60% of the cost. For children and under special laws the work is completely paid for but only out of the value of what the RCDP considers an insufficient maximum price (about €400). The reporting operation has to be done in an integrated computerised system.

The Parity Commission made up of PHB (Public Health Board), CSHIH (County System Health Insurance House), CCDP (County Collegiums of Dental Physicians) establishes the number of physicians' offices in contact with the CSHIH (County System Health Insurance House).

Joining or establishing a practice

The only restrictions are for the dentists who work with the NSHIH on setting up dental practice in big cities, which are full of dental offices. Here, the CSHIH establishes the number of new dental offices which are able to work with the CSHIH. However the local RCDP councils often allow dentists to establish themselves in liberal dental offices.

There are no rules regarding the type of a dental practice, in terms of building: house, apartment, and clinic. There is no state assistance for establishing a new practice, so some dentists take out commercial loans from a bank. There are no limits regarding the maximum number of partners or associates or a maximum/minimum number of patients.

Any dentist can own a dental practice, and there is also provision for them to be run as limited companies (see Corporate Dentistry).

It is possible to sell the equipment, as well as the building. The patients of a dentist who stops his activities may choose freely another dentist, including of course, the new owner, of an old dental office. However, there is no list of patients in Romania so a newly opened dental office must create its own list of patients.

When starting new practice, private dentists have to inform the local health authorities, and to obtain all the necessary authorisations and visas.

Working in Public Clinics

The number of dentists who work only in the public service is not exactly known, because they also work in their own dental offices. The main sector is public schools, but the number is decreasing every year.

The service is not limited. The patients (children) do not pay for their treatment. General prevention programmes of Ministry of Health and Family support the costs. All the dentists from schools are salaried and paid for by the County Health Board. The dentists who work in the public service may only treat patients inside the public dental service (CSHIH system).

The quality of dentistry in the public dental service is assured through the controls of County Health Board.

Working in Hospitals

Hospital dentists work in maxillo-facial surgery in hospitals. All of these dentists are employees of the hospitals, which are owned and run by regional government. The can work part-time in private practices.

Working in Universities and Dental Faculties

Academic dentists are normally salaried employees of the Faculty of Stomatology. They are allowed a combination of part-time teaching employment and private practice (with the permission of the faculty).

The titles of university teachers are: professors. This involves a further degree (publication activities, a record of original researches and the study for a PhD is also required).

Working in the Armed Forces

About 4% of the (full-time) dentists in the Armed Forces are female.

Professional Matters

Professional associations

The Romanian Collegiums of Dental Physicians (RCDP) oversees and administers ethical issues. Since 2004 it has been a legally based, non-governmental organisation and serves the whole of Romania at national level. In each of 40 counties and in the capital, a regional body exists, which administrates ethical issues.

It is compulsory that all dental physicians in Romania - from hospitals, general dentistry, schools, army, etc. are members of the RCDP.

The Romanian Dental Association of Private Practitioners (RDAPP, established in 1990) represents and defends the liberal dental profession. The RDAPP obtained from the Ministry of Justice, the quality mark of a "national representative association legally certified", which is very important for negotiation with the NSHIH.

Before accession, the EU Commission recommended the establishment of a new Law relating to the dental profession, "the Law for establishing the Romanian Collegium of Dental Physicians". The RDAPP was consulted by the Parliament and 70% of the RDAPP's proposals were included in the Law about Romanian Collegium of Dental Physicians

	Number	Year	Source
Romanian Collegiums of Dental Physicians (RCDP)	14,000	2007	RCDP
Romanian Dental Association of Private Practitioners (RDAPP)	2,000	2007	FDI
Romanian Soc of Stomatology	200	2007	FDI

Specialists (orthodontists and oral-maxillo-facial surgeons), have their own professional associations.

Ethics

Ethical Code

Dentists work under a general physician ethical code, which covers relationships and behaviour between physicians, dentists, contracts with patients, consent, and confidentiality, continuing education and advertising. The ethical code is administered by the Romanian Collegiums of Dental Physicians.

Fitness to Practise/Disciplinary Matters

A complaint by a patient is first screened by the Local Board of RCDP and after is forwarded to a professional expertise commission of the RCDP

Complaints, which proceed, can be sent to a commission of dental experts, nominated from RCDP members with more than 10 years' experience.

The RCDP Commission of Dental Experts analyse the case and establish if the complaint is well founded. If this is confirmed, the consequences for the dentist are proportional to the gravity of the facts (medical problems and complaints, financial problems and complaints, or both). The RCDP has gradual sanctions, ultimately which can lead to the suspension of a dentist. A complaint may be referred to the justice system

The final sanctions are validated by the County Council of Romanian Collegiums of Dental Physicians at county level - justice decisions are very rare.

The dentist can appeal to the RCDP Commission at national level and after to the regular court in those instances. If the official commission of the RCDP establishes that the dentist is guilty he must repeat the treatment, supporting all the costs.

Data Protection

Law number 6772001 makes it mandatory that any information about a person's data should be protected and not disclosed.

Advertising

Usually, advertising is not permitted, except for the first announcement of the opening of the new dental or medical office. However, many physicians do not respect this rule and use different ways of advertising (newspapers, flyers, radio, TV and the internet).

Dentists may use websites to inform and advertise their services, subject to the usual rules of advertising and commerce. The RCDP Code of Ethics does not include specific regulations regarding electronic commerce and they have not adopted the CED rules on this

Indemnity Insurance

Indemnity insurance is compulsory in Romania for all dentists whether they work or not within the NSHIH. All dentists are free to choose the financial covering level of indemnity insurance starting with a minimum level established by NSHIH. There are many insurance companies, which advise and defend dentists against complaints and accusations of malpractice. The RDAPP studies and recommends to the members the best companies.

Corporate Dentistry

From 1990 a large number of new private dental offices organised as limited companies - by non-medical investors - with their tax advantages. But from the beginning of 1998 the Law of Medical Offices introduced the right of every investor to open dental practices as Limited Companies, but this is limited by the regulation that only 1/3 of the associates can be non-dentists.

Tooth whitening

Tooth whitening in Romania is counted as medicinal so its provision is restricted to being by dentists only.

Health and Safety at Work

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	CNCAN (National Council for the Control of the Nuclear Activities). At county level, the County Health Board.
Electrical installations	County Fire Brigade
Waste disposal	The County Inspectorate of Environmental Protection
Medical devices	The Ministry of Health and Family, at national level, through its specialized department SVIAM, administrate the rules relating to Medical Devices.
Infection control	The Ministry of Health and Family, at national level, and the County Health Board, at regional level, through the County Inspectorate for Transmissible Diseases.

All practising dentists and dental assistants must be inoculated against Hepatitis B - the County Health Board monitors these activities.

Ionising Radiation

There are specific and complex rules about ionising radiation. Training in radiation protection is given during undergraduate studies and the dentist is the only competent person in a practice to undertake radiography. However, there is no ongoing continuing education requirement.

Radiation equipment must be registered.

Hazardous waste

There are special orders of the Ministry of Health relating to the disposal of clinical waste. There is compulsory verifiable collection and incineration of biohazard contaminated medical and dental waste.

Amalgam separators are not required by law.

Financial Matters

Retirement pensions and Healthcare

The set age for retirement is the same for all citizens, 60 years old for females and 65 years old for males. Dentists and dental auxiliaries can work after the retirement only in the private liberal system.

There are both compulsory general social pensions and optional private pensions. In compulsory general social pensions the level of pensions is about €1,200 per year, but in optional private pensions the level depends upon the contributions made.

Taxes

The unique rate of tax is 16%, which is applied to salaries (for employed dentists), or to benefits (for self employed dentists).

VAT

For dental materials, instruments and equipment, VAT is the same as for general goods, 19%.

Various Financial Comparators

Zurich = 100	Bucharest 2003	Bucharest 2008
Prices (excluding rent)	33.2	53.2
Prices (including rent)	29.9	55.0
Wage levels (net)	11.9	11.3
Domestic Purchasing Power	31.4	20.6

Source: UBS August 2003 and January 2008

Other Useful Information

Competent and Legal Authority:	*Dental Associations:*
Romanian Collegiums of Dental Physicians Costache Marinescu street, 14, Sector 1, Bucharest Romania Tel: +40 21-222 5671 Fax: +40 21-222 5671 E-mail: secretariatcmdr@gmail.com Website:	Romanian Dental Association of Private Practitioners 3, Voronet street, Bl.D4, Sc. 1, Ap. 1 (Floor 1) Sector 3 031551 Bucharest Romania Tel: +40 21-327.41.19 Fax: +40 21-323.99.69 E-mail: amsppr@dental.ro Website: www.dental.ro
Main Specialist Associations:	
Romanian Society of Oral and Maxillo-Facial Surgery Mircea Vulcanescu street, 88, Sector 1, 010816 Bucharest Romania Tel: +40 21-212.63.65 Fax: +40 21-212.63.65 E-mail: Website:	Romanian National Association Of Orthodontists Tel: +40 232-211.683 Fax: E-mail: Website
Romanian Society of Stomatology (Academic Association) Ionel Perlea street, 12, Sector 1, 010209 Bucharest Romania Tel.: +40 21-614.10.62 Fax: +40 21-314.20.80 E-mail: Website:	
Main Professional Journals:	
Name: "Viata Stomatologica" (Dental Life) - RDAPP Tel: +40 21-327.41.19 Fax: +40 21-323.99.69 E-mail: amsppr@dental.ro Website: www.dental.ro	Name: "Stomatologia" (The Stomatology) - RSS Tel.: +40 21-614.10.62 Fax: +40 21-314.20.80 E-mail: Website

Dental Schools:

City: IASI UNIVERSITY OF MEDICINE AND PHARMACY "G.T. POPA"- FACULTY OF DENTAL MEDICINE Tel: +40 232-267686 Fax: +40 232-211820 Email: Dentists graduating each year: Number of students:	*City: TIMISOARA* UNIVERSITY OF MEDICINE AND PHARMACY « VICTOR BABES » FACULTY OF DENTAL MEDICINE Tel: +40 256-220480 Fax: +40 256-220480 Email : stoma@umft.ro Website: www.umft.ro Dentists graduating each year: Number of students:
City: TIRGU- MURES UNIVERSITY OF MEDICINE AND PHARMACY – FACULTY OF DENTAL MEDICINE Tel: +40 265-212813 Fax: Email: rectorat@umftgm.ro Dentists graduating each year: Number of students:	*City: CLUJ-NAPOCA* UNIVERSITY OF MEDICINE AND PHARMACY « I. HATIEGANU » FACULTY OF DENTAL MEDICINE Tel: +40 264 597256 Fax: +40 264 597257 Email: Dentists graduating each year: Number of students:
City: CONSTANTA UNIVERSITY "OVIDIUS" FACULTY OF DENTAL MEDICINE Tel: +40 241 545697 Fax: +40 241 545697 Email: amariei@stomato-univ.ro Dentists graduating each year: Number of students:	*City: CRAIOVA* UNIVERSITY OF MEDICINE AND PHARMACY – FACULTY OF DENTAL MEDICINE Tel: +40 251 124443 Fax: +40 251 593077 Email: dentistry@umfcv.ro Dentists graduating each year: Number of students:
City: BUCURESTI UNIVERSITY OF MEDICINE AND PHARMACY « CAROL DAVILA » FACULTY OF DENTAL MEDICINE Tel: +40 21 3155217 Fax: +40 21 3126765 Dentists graduating each year: 250 Number of students: 1500	*City: SIBIU* UNIVERSITY OF SIBIU FACULTY OF DENTAL MEDICINE Tel: +40 269 436777 Fax: +40 269 212320 Email: medicina@ulbsibiu.ro Dentists graduating each year: Number of students:
	City: ORADEA FACULTY OF MEDICINE AND PHARMACY Tel: +40 259-412834 Fax: +40 259-418266 Email: medas@rdsor.ro Dentists graduating each year: Number of students:

PRIVATE FACULTY *City: BUCURESTI* UNIVERSITY OF MEDICINE AND PHARMACY « TITU MAIORESCU » FACULTY OF DENTAL MEDICINE Tel: +40 21 3251416 Fax: +40 21 3251415 Email : Website: Dentists graduating each year: Number of students:	*PRIVATE FACULTY* *City :IASI* UNIVERSITY « APOLLONIA » FACULTY OF DENTAL MEDICINE Tel: +40 232 215922 Fax: +40 232 215900 Email : Website: Dentists graduating each year: Number of students:
PRIVATE FACULTY *City: ARAD* WESTERN UNIVERSITY « VASILE GOLDIS » FACULTY OF DENTAL MEDICINE Tel: +40 257 228081 Fax: +40 257 228081 Email: rectoratuvg@inext.ro Email : Website: Dentists graduating each year: Number of students:	

Slovakia

Date of last revision: 1st October 2008

In the EU/EEA since	2004
Population (2008)	5,400,998
GDP PPP per capita (2007)	€17,620
Currency	Koruny (SKK)
	32.7 SKK = €1.00 (2008)
Main languages	Slovakian

Slovakia has a system of compulsory health insurance and the constitution guarantees healthcare free of charge for all the citizens. However, in reality this has led to very low fees for oral healthcare. Private care whilst freely available is heavily regulated, however.

Number of dentists:	3,185
Population to (active) dentist ratio:	1,751
Membership of the Dental Chamber::	95%

Specialists are widely used, and the use of clinical auxiliaries is also widespread.
Continuing education for dentists is mandatory, and is administered by the Chamber of Dentists. Membership of the Chamber is voluntary.

Government and healthcare in Slovakia

Slovakia is a small republic, established on January 1st 1993, in the geographical centre of Europe.

The land area is 49,035 km². The capital is Bratislava (with a population of about 600,000).

The ethnicity of the population is Slovak (85.8%), Hungarian (9.7%), Romany (1.7%), Czech (0.8%), Rusyn, Ukrainian, Russian, German, Polish and others (2%). Two thirds of the population follows the catholic religion.

Slovakia has been independent – as part of the Republic of Czechoslovakia – since 1918, but separation into the current statehood occurred in 1993. Slovakia is a Parliamentary democracy with unicameral parliament, the National Council of the Slovak Republic (*Narodna Rada Slovenskej Republiky*) as a 150 seat legislative authority elected by proportional representation to serve for 4-year terms and the government as the executive authority. The President of the State is elected for 5 years, in a direct election by the people.

All citizens of the Slovak Republic are compulsorily insured. The insurance benefits do not depend on the level of income or salary. The state and the constitution guarantee healthcare free of charge for all the citizens, to a very wide extent, but the state may not have sufficient resources for this care.

There are 5 insurance companies. The premiums are 14% of income or salary (the self employed pay the whole amount, an employee pays only 4% and the remaining 10% is paid by the employer).The insurance is called "zdravotné poistenie".

		Year	Source
% GDP spent on health	7.1%	2005	OECD
% of this spent by governm't	74.4%	2005	OECD

Despite an increase in incomes over the period, Slovakia has seen a drop in spending on publicly funded healthcare (as a share of all healthcare spending) from over 91.7% in 1997.

Oral healthcare

Public compulsory health insurance

There is a principle of unlimited "solidarity" (compulsory insurance cover) for all persons. This means that the state insures non-insurable damages, which are paid by all, including by all patients whether they take care of their teeth or not.

The attempt by the Chamber to harmonise the catalogue of dental services in the compulsory healthcare system, with the requirements of the European Union, as defined by the European Law on Social Security is reported by them to have caused financial difficulties which have led to reductions in public expenditure. So, for example, from July 1st 2000, the share of payments for prosthetic dentures changed to 60% paid by the patient and 40% by the insurance company.

From 1st February 2000 an amendment of the Law (Medical order) came into effect. This amendment set the extent of the provision of dental care and the payments for dental care. The amendment also means that the patient must pay a part of the payment for dental services. The Law also set the basic group of dental services and prosthetic products ("Part A" of the Catalogue), in which the patient does not contribute to the payment.

The goal is to implement a model of multi-source financing, through the system of basic health insurance and complementary health insurance, with the contribution of the patient and direct payments. This is to develop the existing model of financing, which allows the utilisation of all sources of accessible finances. The regulation of prices is statutorily possible in the Slovak Republic.

		Year	Source
% GDP spent on oral health	0.19%	2004	Chamber
% of OH expenditure private	No data		

Private Practice

There is a relatively low percentage (about 10%) of private dentists without an agreement with an insurance company in the Slovak Republic. They rent the premises or work in private premises with their own equipment. They are paid directly by the patient (cash) according to their treatment tariffs. The insurance company does not pay for diagnosis or treatment.

Dentists in private practice, without an agreement with an insurance company take a free decision to work like this, but with authorisation from a state authority (see below). They are not assigned any levy, and are not bound by any agreement with an insurance company. They work on the basis of licence, as independent entrepreneurs, who take free decisions on the placement, way and extent of their work – as part of a liberal profession.

Nevertheless, this type of practice exists within Slovakia's economical and social environment – which includes relatively low average wages (€4,000 per annum), and 10.7% unemployment (December 2007).

This original situation was caused, according to the Chamber, by an obligation also to conclude this agreement with dentists who were in the "chain of institutions" assessed by the Ministry of Health. Some dentists remained in the private sector, without an agreement first, after the Ministry of Health assessed this chain.

Dentists without the agreement are able to take free decisions on the placement of their practice and the type of treatment they provide, as they are totally responsible for the costs of their practices and the level of their incomes.

The system of compulsory health insurance does not depend on the level of the salary and is said by the Slovak Chamber of Dentists to discriminate against patients of private dentists who have no agreement with an insurance company. Patients attending such dentists voluntarily repudiate the compulsory health insurance. Their motivation is said to be accessibility and increased quality of the treatment. Prices in private practices are different, dependent on the place and region of the provider and also on the overheads of the provider. Before treatment, an informed approval of the choice and way of treatment is obtained.

The Quality of Care

Patients expect a high-quality and long-lasting functional treatment, but this depends on the personal responsibility, skills and professional knowledge of the dentist.

Dental practitioners may be controlled by *revisory* dentists. These are dentists employed by an insurance company; they control, for example, the invoices that dentists send to the insurance company, from a professional (clinical) point of view.

However, in most cases quality is controlled by patient complaints. A patient can present a complaint to the *revisory* dentist, to the Municipality offices, to the Control Committee of each regional Chamber of Dentists, to the Section of state supervision and control of the Ministry of health or directly to a court. A control body had been established by 2008 (the Health Care Surveillance Authority) which is responsible for control of professional misconduct of provided health care. Patients who are not satisfied with provided oral care can contact the Authority with a written complain directly.

A Slovakian dentist will see on average 1,689 patients, who attend every one to two years for their oral examinations. According to the Law, one yearly oral examination for adults and two for children under 18 is permitted. Pregnant women are entitled to visit the dentist for examinations twice in pregnancy period.

Health data

		Year	Source
DMFT at age 12	2.80	2003	OECD
DMFT zero at age 12	50%	2004	OECD
Edentulous at age 65	No data		

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There is no water fluoridation, or fluoridation of milk. Only fluoridated salt is available. There are no free toothpaste for children schemes.

Education, Training and Registration

Undergraduate Training

To enter dental school students have to pass a state school-leaving examination (GCE) and pass a dental studies entrance examination. The undergraduate course lasts 6 years.

There are 3 medical faculties within Slovakian universities, all which are state owned and financed. Only two have dental schools, which are known as *lekárska fakulta*. These are at the universities of Bratislava and Košice.

Year of data:	2008
Number of schools	2
Student intake	101
Number of graduates	45
Percentage female	60%

In 2008 it was reported that there had been a previous increase in student intake, hence the big discrepancy between intake and the number of graduates..

The responsibility for quality assurance in the faculties is by an accreditation commission of the Ministry of Health.

Qualification and Vocational Training

Qualification

Upon qualification, until 2003, the title was MUDr – *Medicinae Universae Doctor*. A new title MDDr was introduced for undergraduates who entered dental school from 2004. The first graduates with the title MDDr. will be in the year 2009. After 2009 graduates with MDDr. will be entitled to open their own practice, they will not need to do the 3 years vocational training.

Vocational Training (VT) – known as "Stomatology" in Slovakia.

Following qualification, there is a programme of vocational postgraduate training for 36 months, under the guidance of skilled dentists, which is a prerequisite for obtaining a licence (the right to practise the profession of dental surgeon). After the training the dentist has to pass an interview in front of a Commission which has three members, to obtain a practice certificate. Only then may a dentist lead his own dental practice, as a fully licensed dentist. During this training the dentist is a salaried employee.

This post-qualification training has a medical part - the participant has to work in a hospital. The dentist works 2 months in anaesthesiology and intensive medicine, 2 months in surgery, 2 months in internal medicine, 1 month in hygiene and epidemiology and 1 month of optional specialisation. There is a theoretical part of training (compulsory attendance at recommended courses and lectures).

This VT will cease, with effect from the graduations in 2009.

Registration

All dentists in the private sector work under a licence issued by the state authority, after completing the "1st grade attestation", (3-years' preparation after graduation). The dentist has to be registered in the register of the Slovak Chamber of Dentists and he has to substantiate to the state authority the confirmation of his professional and ethical eligibility, issued by the Slovak Chamber of Dentists. For the graduates in 2009 the "1st grade attestation" will not be compulsory anymore.

The steps are as follows:

1. Recognition of the diploma – this must be done by sending a request, together with an authenticated copy of the diploma, an official translation and a copy of the syllabus studied, to the Ministry of Education, department for diploma recognition.

2. Pass a linguistic examination of knowledge of the Slovak language, controlled by the Ministry of Education. One of the conditions needed for registration in the Chamber for foreign dentists is confirmation on language test. The language tests are ensured by the Comenius University, department for foreign languages. The dentist must be able to communicate with the patient.

For the regulations related to practising please see the later section.

Language Testing

As stated above, a potential registrant must pass an examination of the ability to speak and understand the Slovak language. The Ministry of Education is responsible for issuing of the certificate on language tests for foreign dentists, which is one of the conditions needed for registration with the Chamber.

However, language knowledge is only a prerequisite for obtaining a licence which entitles independent practise of dentistry and is not necessary for employees or for registration. Language testing is not compulsory for every overseas applicant, but it may be ordered for those about whom there are serious doubts about the language knowledge. The dentist must be able to communicate with the patient.

Cost of registration (2008)	€ 15

Further Postgraduate and Specialist Training

Continuing education

Dental surgeons are under a statutory obligation to take part in continuing education. Control over continuing education is responsibility of the Chamber which supervises and provides the Quality Assurance.

The schemes are provided by universities, the Chamber and the employers. A dentist who does not complete the continuing education requirement breaks the rules and the duties of a member of the Chamber, which will be announced to the responsible authorities (the Health Care Surveillance Authority). In continuing education, credit is the basic unit set for evaluation of continuing education in Slovakia. Generally it is a time period of 45 minutes the medical employee has to spend in the process of continuing education.

All medical employees have to prove the continuing education to their Professional Association that is responsible for maintenance of the Register, update and maintenance of their competences on the level required by the law and this must be done in a written form to the employees responsible for Register of appropriate medical profession.

Continuing education in dentistry is evaluated by the Chamber in a five year period. The first evaluation is done after five years after registration of the dentist in the Chamber and every consecutive evaluation is done after five years from the last evaluation. The condition of continuing education is fulfilled, if the dentist can proof 250 credits for the evaluated period.

Specialist Training

Slovakia has 3 main specialties:

- Orthodontics
- Paediatric Dentistry
- Oral Maxillo-facial Surgery

Dental surgeons are also entitled to specialist education and training. Study is for 3 years in Orthodontics and Paedodontics. Maxillo-facial surgery lasts 4 years.

Specialist training is conducted according to a given specialisation programme, determined by the Medical University of the Ministry of Health. This institution also determines the form, length and course of the studies. The education is also supervised by this institution. The dentist's participation in study is recorded by the Medical University in the cooperation with the Chamber. The co-ordinating role in continuing education is undertaken by the Chamber together with the educational institutions and associations of specialists. Training takes place at dental clinics, or at the Slovak Medical University, or in dental practice under supervision of a specialist.

The titles upon completion of the courses are:

- Specialist in orthodontics (celustný ortopéd)
- Maxillofacial surgeon ("maxilofaciálny chirurg")
- Specialist in paedodontics ("pedostomatológ")

Since 2003 training for periodontics and prosthodontics has ceased (it was 3 years), but those who have already qualified in these specialties and those entering Slovakia from abroad are recognised as such.

Registration of specialists, like all dentists, is by the Slovak Chamber of Dentists.

Workforce

Dentists

Year of data:	2007
Total Registered	3,185
In active practice	3,085
Dentist to population ratio*	1,750
Percentage female	61%
Qualified overseas	0

Over 80% of active dentists work in private practice (90% with an agreement, and 10% with no agreement with insurance companies).

The Chamber expects that the active dental workforce will decrease. In 2008, more than half of all active dentists were over 50 years and it is presumed that during the early years of the century more dentists will leave their practices due to reaching retirement than will join the profession.

Movement of dentists across borders

The Chamber registered 73 requests for a "certificate of good standing" from dentists planning to leave Slovakia to work, during the period 2004 – 2008. This certificate is among the conditions to be registered abroad.

Specialists

There is a specialist register held by the Chamber.

Patients do not go directly to specialists and are always referred.

Year of data:	2007
Orthodontics	198
Endodontics	
Paedodontics	74
Periodontics	95
Prosthodontics	64
Oral Radiologists	
Oral Surgery	89
OMFS	26
Dental Public Health	
Stomatology	2,614

"Stomatology" is described in Slovakia as "specialisation", but in most countries it would be described as "mandatory vocational training", as the training does not follow the usual specialisation model in the EU. The training will cease from 2009.

Auxiliaries

There are two kinds of clinical auxiliaries in Slovakia – Dental Hygienists and Dental Technicians. Additionally, there are dental nurses and receptionists.

Every medical employee has a lawful obligation to undertake continuing education.

Year of data:	2007
Hygienists	148
Technicians	1,461
Denturists	0
Assistants (estimated)	4,000
Therapists	0
Other	0

If auxiliaries are employed at public establishments they are full-time employees; in private establishments and in the case of private practice they may either be a full-time or part-time or in other forms of employment provided for by the law. The provisions of the labour code are binding.

In non-public establishments various forms of employment envisaged by the law occur. This means that whether work is full-time or part-time, there must be prior agreement on the execution of a work and the working activity.

Dental Hygienists

The training for dental hygienists is conducted at state medical schools. There are two schools in Slovak Republic, in Bratislava and in Prešov. After high school (and obtaining of A level) they may study in a 2-year specialised course in dental hygiene at the supra-structural school in Bratislava or a 3-years study for dental hygienists in Prešov (see below) - graduation degree is Bc (bachelor). Then the dental hygienist obtains a professional title, Diploma of Dental Hygienist. They are registered at the Association of Dental Hygienists.

Dental hygienists cannot work alone – the must work only under the supervision of the dentist.They must be employed by a dentist. They can diagnose, but only to the extent of the nature of their work. So, they can diagnose periodontal diseases, by assessing PBI, CPITN, the status of loose teeth, the level of inflammation of the gingivae and so on, but they cannot assess whether the extraction of a tooth should be made (and other such cases) that only a dentist would assess.

They cannot give local anaesthetics, nor can they accept monies from patients, although they may sell oral healthcare products such as toothbrushes.

It is not possible to estimate how many registered hygienists are actively working.

Dental Technicians

Training for dental technicians is conducted at secondary schools. The length of the course is 4 years and the student gains the title Dental Technician. Without this title they cannot open their own laboratory.

For opening their own laboratory a technician has to pass 2 years' of specialised study after completion of general A-level study and obtain the title *Diploma Dental Technician*. He or she then has to register at the Slovak Chamber of Dental Technicians.

Technicians can work in commercial laboratories, or be an employee of a dentist or of a clinic. In 2007, it was reported that about three quarters of registered technicians were actively working – half in independent dental laboratories dental technicians, and a quarter employed by the public dental service.

The independent practice of denturists is illegal in Slovakia.

Dental Assistants (Nurses)

They are educated at secondary schools for 4 years, with a leaving examination - baccalaureat. They work at the chairside, as employees of dentists. A dentist may not undertake treatment without the presence of a dental assistant.

The training of dental nurses is formal and lasts for 4 years. The dental nurses (chair-side assistants) are registered in the section for Nurses working in Dentistry of the Chamber of Nurses and Midwifes. This section is very new – it was created in 2007.

Practice in Slovakia

Year of data:	2007
General (private) practice	2,563
Public dental service	622
University	93
Hospital	29
Armed Forces	24
General Practice as a proportion is	83%

Working in Liberal (General) Practice

About 90% of private dentists have an agreement with an insurance company. The insurance company and the district are assigned by a public dentist. These dentists work mostly in former public institutions, where they rent the premises, and sometimes also the dental equipment. They are paid from the health insurance according to their output, paid fully or partly by the insurance company (depending upon the patient's co-payment). The insurance company does not pay for treatment if there is no agreement between the dentist and the patient.

Payments from insurance companies are up to the limit of a budget. After depletion of the limit, the insurance company does not pay anything. In other words, the free choice of dentist is circumscribed by the agreement between the patient and the dentist. The patient has to have an agreement with a dentist. He can then change dentist after 6 months.

Fee scales

As fees paid by the insurance companies are low and these may not cover the expenses of the practice in providing the prosthesis. Treatments that are not in the Medical Order must be paid for in full by the patient. This (supplementary) payment is calculated in a free market, but according to the operating costs of the practice.

"Liberal" practitioners calculate their own prices (a price list must be displayed on the wall of the practice). Net profit can be a maximum of 30% (according to Law No. 18/1996 on prices). This is checked by the fiscal bureau/office. A dentist whose profit is more than 30% breaks the law on prices, which may lead to a fine or other sanctions.

Joining or establishing a practice

There are three steps towards estabiuishing general practice:

1. Registration at the Slovak Chamber of dentists. Documents needed by the registration: education (verified diplomas and certificates on education and specialisation), criminal record check, payment of the registration fee.
2. A Licence for individual execution of the dental profession is issued by the Chamber. Documents needed for the license: health fitness, education, respectability (criminal records), no disciplinary measures within the last 2 years, payment of the fee.
3. Permission issued by the municipality office according to the regional competence. For the permission following documents are needed: copy of the license from Chamber, copy of the premises rental or ownership confirmation, copy of the payment order of the administrative fee, hygiene institution report.

Employees – graduates of the Medical faculty, clinical employees, who work in this field also have to be registered in the register of the Slovak Chamber of Dentists, but they do not need the licence issued by the state authority.

There are no limitations as to the building type, but there is a limitation as to the minimum size of the floor area. There is no regulation relating to the number of partners (employees) or the number of patients. The minimum requirements (personnel, space, and equipment) are set by the Act 428/2006.

The state does not subsidise the costs of opening an individual practice or establishment.

Once established, the dentist must be registered in the Chamber. They may form a company or register their own establishment or clinic. They may not start their own practice until 3 years have passed from the moment of completion of their study and obtain the right to practice in the profession. After 2009, graduates with MDDr. will be entitled to open their own practice; they will not need to do the 3 years vocational training.

Patient lists must be kept - this means that the dentist has to have a *written* agreement with all patients and must retain the documentation for all the patients.

Working in Public Clinics

There are public polyclinics in the Slovak Republic. These are clinics which include a number of health professionals (including dentists) who supply health services in the same venue. They do not supply hospital-type services. They may be owned by the municipality or even private individuals. The number of these health care professionals is set by the government in the Act on minimum net.

Every insured person may benefit from attending them, but they may also provide services paid directly by the patient. All clinical controls are the same, but the responsibility for the facilities lie with the owner of it.

Persons employed at public establishments receive a fixed remuneration (salary).

Working in Hospitals

Hospitals are public property. They tend to be clinics and university hospitals and certain hospitals in larger cities. There are a number of private hospitals run, for example by the Church, municipality offices or individuals.

Procedures tend to be maxillofacial surgery, undertaken by maxillofacial surgical specialists.

Working in Universities and Dental Faculties

There are two medical faculties which include dentistry as part of their teaching. The dentists who work in these dental schools are normally full-time salaried employees of the university. They may be allowed the combination of part-time teaching employment and private practice (with the permission of university).

The titles of university teachers are:

- Academic (for teachers): Doc. (Docent), Prof. (Professor)
- Scientific: CSc. (Candidate of Science), DrSc. (Doctor of Science), PhD

This involves a further degree (publication activities and a record of original research).

Working in the Armed Forces

There are dentists working in the armed forces. Some are professional soldiers but the majority are employees in army institutions.

Professional Matters

Professional associations

The main dental association is the Slovak Chamber of Dentists. The endeavour of the Chamber is to reach an independent, equitable and serious evaluation of the work of dentists, and to create an environment and conditions for a high-quality provision of dental services for patients on an international level, in all the dental practices in Slovakia, and to move the development of Slovak dentistry towards a modern Europe. Membership of the Chamber is voluntary, except for the licensing referred to previously.

	Number	Year	Source
Slovak Chamber of Dentists	3,200	2008	FDI

The Slovak Chamber of Dentists has 8 Regional Chambers. The chambers are not self-governing organisations, they are one body with the Chamber. The important constituent parts are:

Statutory body: The President

Bodies of the Chamber:

- Assembly (highest body, meetings are held minimum once a year, usually twice a year)
- Council (meets 4 times a year)
- Presidium (once a month)
- Control Committee
- Honourable Council – name changes into Disciplinary committee

Ethics and Regulation

Ethical Code

Dental surgeons are bound by the ethical code. The ethical code is a part of the Act No. 578/2004. This act defines the duties regarding membership of the Chamber and the duties concerning the provision of services.

According to the ethical code, a dental surgeon must not impose his service, or gain patients, in a manner inconsistent with ethical and deontological principles, and the rules of loyalty to fellow practitioners.

Fitness to Practise/Disciplinary Matters

The sanctions against dentists who break the ethical code are defined in the Act. This may lead to an admonishment. If he repeatedly fails to respect the admonishment, then a fine of up to SK 10,000 (€300) or up to SK 50,000 (€1470) from breaking the obligations of a member of the Slovak Chamber of Dentists repeatedly may result.

The ultimate sanction is to be excluded from membership of the Slovak Chamber of Dentists. This fact will be announced to the responsible authorities (Health Care Surveillance Authority).

Data Protection

Act No. 428/2002 on the Protection of Personal Data regulates the use of information. This act is based on the EU Directive.

Advertising

Dentists may inform the public of the dental service they provide but the content and form of such information must also be exempt from the features typical of commercial advertising.

Information may be placed in the press. The dentist can present medical themes in front of the public, in TV, radio, or press but cannot act unworthily by using this to augment the number of patients.

Every dentist may run his own website. However, in 2008, the ethical code did not yet contain a chapter on the regulations following from the Electronic Commerce Directive.

Indemnity Insurance

It is compulsory for dentists to have malpractice insurance. Insurance is concluded with insurance companies active on the insurance market. The amount covered is for claims up to SKK 1,000,000 (€24,000). When the dentist provides surgical services also, it can be over SKK 1,000,000. A patient is entitled to lodge a complaint and demand compensation before a court. Every dentist has to be insured against civil liability for the practice of his profession.

Insurance is concluded with insurance companies active on the insurance market. The Chamber has a collective contract of insurance covering members and also the secretariat of the Chamber. Very often the insurance packages include other types of insurance as well (such as surgery, flat, house, car, etc.). The insurance rate is not conditioned by the form of practice, whether it is under employment contract or private. But it does depend on the value of the equipment. Slovak dentists combine both forms and work both under employment contract and pursue private practice. If there are claims on the part of the patient and a public establishment is involved, the establishment is liable. Nevertheless, if a dentist's fault is proven, the establishment may claim return of the incurred costs. The cost of cover up to SKK 1,000,000 for a non-specialist would be about SKK 6,000 (€140) for 1 year.

This does not cover a Slovak dentist's practise abroad.

Corporate Dentistry

Dentists in Slovakia may form companies. A non-dentist can be a shareholder, member of the board, or even the owner of the company, but when he is an owner he has to have a professional guarantor.

Tooth whitening

In Slovakia, tooth whitening is a medical procedure, under Medicinal rules. It can be undertaken by dentists only.

Health and Safety at Work

All employees have to be checked and examined regularly by the specialist in preventive and occupational medicine ("pracovná zdravotná služba").The risk-holder is the employer.

Ionising Radiation

The Public Health Authority of the Slovak Republic issues permission for the running and operating of ionising radiation equipment. For this permission the applicant must undergo a training course and pass an exam every 5 years.

Hazardous Waste

The EU Hazardous Waste Directive is incorporated into law and actively enforced. Amalgam separators are legally required.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Institut of public health (Urad verejného zdravotnictva)
Electrical installations and Electrical devices	Revisory technicians authorised by the State testing institution
Waste disposal	Ministry of environment
Medical devices	Institut of public health (Urad verejného zdravotnictva)
Infection control	Institut of public health (Urad verejného zdravotnictva)

Financial Matters

Retirement pensions and Healthcare

The normal retirement age is 62 for a man and variable (according to the following table) for a woman:

	man	woman				
Number of children	Always 62	0	1	2	3-4	5 - more
Retirement age		57	56	55	54	53

A dentist may work beyond normal retirement age. The pension depends on the number of years that the dentist has worked, and also on the salary or profit through his life.

Taxes

There is a flat rate of national income tax of 19%

VAT

The general rate of VAT in Slovakia is 19% and for drugs and medicines it is 10%.

Various Financial Comparators

Zurich = 100	Bratislava 2003	Bratislava 2008
Prices (excluding rent)	38.3	56.7
Prices (including rent)	38.9	54.8
Wage levels (net)	9.8	19.0
Domestic Purchasing Power	26.2	34.6

Source: UBS August 2003 & January 2008

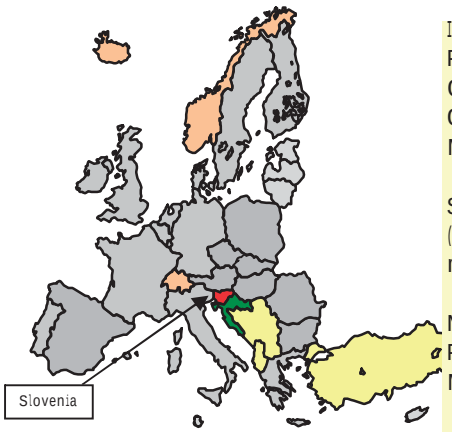
Other Useful Information

Competent authority:	
Registration and issuing licences: Slovenská komora zubných lekárov The Slovak Chamber of Dentists Fibichova 14 821 05 Bratislava 2 Slovakia Tel: +421 2 43 29 31 22 Fax: +421 2 43 41 31 98 Email: dent@skzl.sk Website: www.skzl.sk The Chamber is also the Professional Association	*For recognition of a diploma:* Ministerstvo školstva SR Ministry of Education of Slovak Republic Section for education diploma recognition Stromová 1 813 30 Bratislava Tel. +421 2 59 23 81 23 Fax. +421 2 59 23 81 24 E-mail: naric@minedu.sk
Details of indemnity organisations:	*Main information centre:*
Všeobecná zdravotná poistovna The General health insurance Tel: +421 2 67 27 71 11 Fax: +421 2 62 41 26 31 E-mail: Website: www.vszp.sk	Ministerstvo zdravotnictva SR Ministry of health Tel: +421 2 59 37 31 61 Fax: +421 2 54 77 76 59 E-mail: ozv@health.gov.sk Website: www.health.gov.sk
Major Specialist Associations:	*Main Professional Journals:*
Slovenská ortodontická spolocnost The Slovak Orthodontic society Tel: +421 2 65 42 23 05 Fax: none E-mail: alex1@netax.sk Website: none President/ contact person: Dr. Gabriela Alexandrová Name: Slovenská stomatologická spolocnost Sekcia Maxillo-faciálnej chirurgie Tel: Fax: E-mail:	Name: Zubný lekár The Dentist Tel: +421 2 48 20 40 73 Fax: +421 2 43 41 31 98 E-mail: zubnylekar@skzl.sk Website: www.skzl.sk Name: Stomatológ The Stomatologist Tel./Fax: +421 2 905 360 496 E-mail: durovic.eugen@netkosice.sk Website:

Dental Schools:

Medical Faculty with specialisation in dentistry:	Medical Faculty with specialisation in dentistry:
Bratislava Name of University: Univerzita Komenského Lekárska fakulta Univerzity Komenského Špitálska 24 813 72 Bratislava Tel: +421 25 9357 466 or 52 961 736 Fax: +421 25 9357 201 or 52 925 574 e-mail: sd@fmed.uniba.sk Website: www.fmed.uniba.sk Dentists graduating each year: 28 Number of students: 200	Košice Name of University: Univerzita Pavla Jozefa Šafárika Univerzita P. J. Šafárika v Košiciach Lekárska fakulta Trieda SNP c.1 040 11 Košice Tel: +421 55 6428 141 Fax: +421 55 6428 151 or 6420 253 e-mail: gdovin@central.medic.upjs.sk Website: www.medic.upjs.sk Dentists graduating each year: 17 Number of students: 250

Slovenia



Date of last revision: 1st October 2008

In the EU/EEA since	2004
Population (2008)	2,025,866
GDP PPP per capita (2007)	€23,079
Currency	Euros
Main languages	Slovene

Slovenia has a system of compulsory national social health insurance (HIIS). About half of dental care is provided in general practice and half municipal clinics, in the HIIS. There is some fully liberal private practice.

Number of dentists:	1,637
Population to (active) dentist ratio:	1,563
Membership of the Chamber::	100%

Specialists are widely used, but there were no clinical dental auxiliaries until 2005, when the first dental hygienists qualified.
Continuing education for dentists is mandatory, and is administered by the Slovenian Medical Chamber, to which all dentists must belong.

Government and healthcare in Slovenia

The Republic of Slovenia lies at the heart of Europe, bordering the Alps and the Adriatic Sea. There are four neighbouring adjacent countries: Austria, Italy, Croatia and Hungary. The country has a land area of 20,273 sq km.

Slovenia was formerly part of the Republic of Yugoslavia (until June 1991), and proclaimed its independent constitution in December 1991. The constitutional system is a parliamentary democracy. The population comprises 88% Slovenes, 0.2% Italian, 0.4% Hungarian and 11.4% others.

The capital city is Ljubljana.

The official Language of Slovenia is Slovene. The majority of Slovenes are Roman Catholic.

The President of the Republic is elected directly by the people, and the Prime Minister by the National Assembly. The unicameral National Assembly or *Drzavni Zbor* has 90 seats - 40 are directly elected and 50 are selected on a proportional basis (the numbers of directly elected and proportionally elected seats varies with each election; members are elected by popular vote to serve four-year terms). There are some selected seats based on minorities, so that there is one seat each for Italian and Hungarian minorities.

Healthcare is a constitutional right for all citizens. In Slovenia most healthcare is provided through a national social insurance system. There are three levels in the healthcare system. The first level is the responsibility of the local government. For secondary and third levels (hospitals and clinics), these are the responsibility of the state government.

There are three organisations providing health insurance. The first one, the Health Insurance Institute of Slovenia - ,*Zavod za zdravstveno zavarovanje Slovenij* - (HIIS), is for compulsory health insurance. Every resident in Slovenia must be registered in this health insurance institute and the majority outlay for healthcare is paid from this insurance. The members are democratically elected, but the executive director must have the agreement of parliament. The main function of the HIIS is to conclude agreements with public oral health institutes and private dentists.

There are also two more health insurances, for non-compulsory health insurance. Their titles are the Mutual Health Insurance (*Vzajemna zdravstvena zavarovalnica*) and the Adriatic Insurance Company (*Adriatic zavarovalna družba*). In 2003 another insurance company started: Triglav insurance company (Triglav zavarovalna družba).

Public health care is budgeted for by Parliament after proposals by Health Insurance Institute of Slovenia.

		Year	Source
% GDP spent on health	8.2%	2007	HIIS
% of this spent by governm't	75.6%	2007	HIIS

Oral healthcare

Public compulsory health insurance

The majority of the oral health services are organised in the same way as the general healthcare system. The dental services are delivered through the system of public clinics, municipal health centres or by private dentists.

		Year	Source
% GDP spent on oral health	0.14%	2007	HIIS
% of OH expenditure private	35%	2007	SDA

Public compulsory health insurance provides dental cover for all patients of 0 to 18 years of age, all removable and fixed appliances, and for adults, surgical items, some basic prosthodontic treatments, periodontal and conservative treatment such as fillings and endodontics. Some cover for this treatment is borne by the non-compulsory health insurance. Some treatments – such as for cosmetic treatments, porcelain crown and bridge and implants have to be paid for in full by the patient. There is no annual limit of treatment range for an individual patient.

A full-time working dentist would normally have a list of 1,800 patients attending regularly. Oral re-examinations would normally be carried out for most adult patients every 9 months.

It is estimated by the Chamber (see later) that about 40% of the whole population access dentistry in a 2-year period.

In Slovenia about 7.6% of the public healthcare budget is spent on dentistry, although it is estimated that about 1.9 % is paid directly by patients for non-obligatory insurance, for dentistry, in addition.

Dentists do not undertake domiciliary care in Slovenia.

Epidemiological surveys are carried out by the National Insttitute for Healthcare.

Private care

In fully liberal practice, patients must pay the full cost of their dental care, at a price directly negotiated with the dentist. There is no regulation of the fees.

Private health insurance does not exist in Slovenia.

The Quality of Care

For dentists who have agreements with the HIIS, the quantity of work is monitored by the HIIS. They have an annual contract with a maximum that they can fulfil.

For private dentists, work is monitored by The Medical Chamber of Slovenia for minimal price and government market inspection (see below, Working in General Practice).

For all dentists, the quality of work is monitored by the Chamber. There are routine checks and also if someone has made a complaint (patient, other colleagues, insurance companies or the Ministry of Health), the Professional Medical Committee of the Chamber carries out the investigations (see Ethics).

Health data

		Year	Source
DMFT at age 12	1.70	2003	CECDO
DMFT zero at age 12	40%	2003	OECD
Edentulous at age 65	20%	2003	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth.

Fluoridation

There is no water or other fluoridation in Slovenia but there is some natural fluoridation at an optimal level.

Some dentists provide topical fluoride treatments for children.

Education, Training and Registration

Undergraduate Training

To enter the dental school a student needs to be a secondary school graduate - including a school leaving examination, known as matura exam, with a good score. There is no entry examination and no vocational entry, such as from being a qualified dental auxiliary.

There is one dental school, which is state-funded. The school is known as *Medicinska fakulteta, Odsek za stomatologijo*, (Faculty of Medicine, Department of Oral Medicine) of the university.

Year of data:	2008
Number of schools	1
Student intake	70
Number of graduates	49
Percentage female	70%

Dental undergraduate training is for 6 years.

Quality control

The dental school is inspected for course curriculum quality by the registration authority.

Qualification and Vocational Training

Primary dental qualifications

- "Doctor dentalne medicine"*(dr.dent.med.)*;
- Diploma , s katero se podjeljuje strokovni naslov "doktor dentalne medicine/doktorica dentalne medicine"

Vocational Training (VT)

There is a 12-months' period of vocational training necessary following graduation. The Ministry of Education is responsible for the supervision of this. The trainees are paid a salary of €1,276 per month (gross income in 2008), from the Ministry.

This post-qualification training has a practical part (the participant has to fulfil a list of prophylactic, diagnostic and treatment items) and a theoretical part (compulsory attendance on recommended courses and lectures). There is a final examination, which must be passed to work as a dentist. A Slovenian graduate cannot work in Slovenia or abroad until the examination has been passed.

Registration

The Medical Chamber of Slovenia registers all physicians and dentists.

Diplomas from other EU countries have been recognised without the need for vocational training since May 2004.

Cost of registration (2008)	€ 70

Language Requirements

It is necessary to know the Slovenian language to be able to practise in Slovenia.

Further Postgraduate and Specialist Training

Continuing education

Continuing education is compulsory for all dentists. Every physician and dentist must undergo 75 points (about 10 courses) of continuing education in every 7 year period, provided by the Chamber. The responsibility for the supervision of this lies with the Chamber.

If the dentist does not fulfil this 75 points obligation, then he must undertake an examination. Failure to pass the examination leads to a loss of licence to practice. Courses taken overseas are estimated by the Medical Chamber and are allowable.

Specialist Training

Before entering into specialist training dentists must have completed their 1 year post-qualification training. The specialist training is undertaken in Stomatology clinics, private and public health institutes which are licensed to provide this.

- Oral Surgery
- Oral Maxillo-facial Surgery
- Orthodontics
- Conservative Dentistry & Endodontics
- Prosthetic Dentistry
- Preventive and Paediatric Dentistry
- Oral Medicine and Periodontology

There are limited numbers who may undertake training, all of which is for 3 years, except Oral Surgery, which is for 4 years and Oral Maxillo-facial Surgery for 6 years. A specialists' degree is received on completion of training.

The title given is:

- Specialist in orthodontics

Potrdilo o opravljenem specialisticnem izpitu iz celjustne in zobne ortopedije,

- Specialist in Oral Surgery

Potrdilo o opravljenem specialisticnem izpitu iz oralne kirurgije

The Medical Chamber of Slovenia is responsible for the registration of specialists.

Workforce

Dentists

Year of data:	2008
Total Registered	1,637
In active practice	1,296
Dentist to population ratio*	1,563
Percentage female	63%
Qualified overseas	63

The dental workforce is said by the Chamber to be decreasing as a high proportion of practising dentists are over 50 years of age.

Movement of dentists across borders

Most of the foreign dentists working in Slovenia are from the countries which previously formed Yugoslavia

Specialists

There are 6 classes of specialists in Slovenia. All specialists see patients on referral from a primary dentist, only.

- Orthodontics
- Conservative Dentistry & Endodontics
- Preventive and Paediatric Dentistry
- Oral Medicine and Periodontology
- Prosthetic Dentistry
- Oral Surgery

There is also Oral Maxillo-facial Surgery, which is a medical and dental specialty.

Year of data:	2008
Orthodontics	106
Endodontics	20
Paedodontics	50
Periodontics	33
Prosthodontics	47
Oral Radiologists	
Oral Surgery	28
OMFS	28
Dental Public Health	

Auxiliaries

There were no legal clinical dental auxiliaries in Slovenia until 2005, two years after the first special training school for dental hygienists started in 2003. There are Dental Technicians and additionally, dental assistants.

Year of data:	2008
Hygienists	15
Technicians	759
Denturists	0
Assistants	1,275
Therapists	0
Other	0

The figure for dental assistants is estimated. Normally, there is at least one assistant per dentist but there is no special register for them.

Dental Hygienists

The dental hygiene school is privately financed, and training is for 2 years. They receive the diploma of Dental Hygienist, which is not centrally registerable.

They are registered by individual dentist employers and they cannot work without this control. They can administer only topical anaesthesia. They are salaried.

Dental Technicians

Dental technicians are trained in dental technician secondary schools, for 4 years and then may go to colleges. To work, they must register with the Economy Chamber.

Dental technicians normally work in separate dental laboratories and invoice the dentist for the work done. A small number of technicians are employees of dental offices and they are paid by taking a percentage of the fees for the prosthetics work.

Dental Nurses (Assistants)

Dental nurses assist the dentist.

There are no special schools for dental assistants and it is not necessary to be a trained nurse to be a dental assistant. However, they are often first medical nurses after which they are trained by the dentists where they work. Indeed, the majority of dental assistants are nurses, but several are dental technicians and from other professions.

They are always salaried and have their own representative organisation, but membership is not obligatory.

Practice in Slovenia

Year of data:	2008
General (private) practice	772
Public dental service	514
University	21
Hospital	21
Armed Forces	0
General Practice as a proportion is	60%

Just over half of active dentists in Slovenia work in general practice, in which the practice is not owned by the state. Over 25% of these dentists are self-employed in fully private practice, and they employ a small number of salaried dentists. They may also be in partnership with other dentists.

The remaining GDPs are in salaried positions or are self-employed practice owners in contract with the HIIS.

Almost an equal number of dentists work in public municipal health centres, as salaried practitioners.

Working in General Practice

In Slovenia general practitioners may work in the HIIS and in fully liberal practice, or as has been stated above may be in fully liberal private practice only. There is only one system of payment, which is Item of Treatment Fees, for HIIS work, and direct patient payments for other (fully private) work.

For payment, the contracted dentist sends an invoice with the list of patients and the provided dental care, to the health insurance company, monthly (by e-mail). The payment by the insurance company is also monthly (by lump sum) and at the end of the year, a final payment.

There is no prior approval for treatment necessary - only the consent of the patient, established freely and directly together with the dentist.

Fee scales

Each year new prices are scheduled as a result of negotiations between the HIIS, delegates of the Chamber and the Ministry of Health. The prices of items fully covered by the insurance system are the same across the country. For dentists working within the system of the HIIS (contractual) these prices are obligatory.

For fully private dentists, the contract is between the dentist and the patient, who must pay the full cost of the dental care, directly negotiated with the dentist.

Minimum prices are regulated by The Medical Chamber.

Joining or establishing a practice

There are no stated regulations which specifically aim to control the location of dental practices. There are also no other factors which effectively restrict where dentists may locate. Any type of building may be used if this fulfils the legislative claims to be a dental practice. But rules do exist which define, for example, the minimum size of rooms, the equipment for a dental practice, and the standards of hygiene.

Normally dentists practice on their own, without another dentist in the practice. Rarely, they practice as two dentists together. There are a few large practices, with joint owners. Anyone may own a dental practice, but non-dentists need a dentist present during working hours.

Working in Public Clinics

Dentists who work in the Public Service are salaried and work in public clinics. As stated above, nearly half of Slovenia's dentists work there. These municipal ambulatory dental departments offer common dental care for any citizen, also paid by HIIS care. All other conditions are the same - the difference is only of the ownership and that all the dentists are salaried.

They may treat patients outside the public dental service, for example after normal work in an afternoon, if they have the permission of the Director of the Clinic. This might be in the clinic or at a private practice.

The quality of dentistry in the public dental service is assured through the Medical Chamber.

Working in Hospitals

In Slovenia, all dentists who work in hospitals are employees of the hospitals, which are owned and run by the state government. All of them are dental specialists.

Working in Universities and Dental Faculties

The dentists who work in the dental school are normally full-time employees of the University. However, they are allowed a combination of part-time teaching employment and private practice (with permission of university).

The titles of university teachers are:
Asist.... ... ...dr.dent.med.
Asist.mag. ... .. dr.dent.med.
Doc.dr. ... ...dr.dent.med.
Prof.dr. ... . dr.dent.med.
Prof.dr ... ... dr.dent.med., višji svetnik

Study for a PhD is also required for the positions of docent and professor; it also necessary to pass an "habilitation" - this involves the further degree and a record of original research, and a public lecture in front of the Scientific Council of University.

Working in the Armed Forces

No dentists serve in the Armed Forces.

Professional Matters

Professional associations

The Slovenian Medical Chamber is the national professional association. All the physicians and dental practitioners who intend to practice medicine or dentistry in Slovenia have to belong to the chamber, as these are the chambers that award the right to practice medicine or dentistry.

	Number	Year	Source
Slovenian Dental Association	1,637	2007	SDA

The Slovenian Medical Association is an independent, professional, democratic, public body of all physicians and dentists working in Slovenia. Its aims, objectives and activities are determined by statute. There is equal status for both physicians and dental practitioners.

The Assembly of the Chamber is where democratically elected representatives meet as delegates. The President of the Medical Chamber is directly elected by all physicians and dentists. One of the two Vice Presidents of the Chamber has to be a dentist. The term of office for officers is 4 years.

Dental practitioners are represented at all organisational levels of the Medical Chamber. The representation of dental practitioners is secured in the Executive board of the Medical Chamber of Slovenia. A Dental Committee is one of seven committees in the Chamber.

The tasks of the Slovenian Medical Chamber are:

- exercising care over conscientious practice, protecting the prestige of physicians and dentists
- preparing, performing, controlling and updating of decisions concerning the quality and conditions of medical practice, expressing its opinion on matters concerning public health and health policy of the state with its national and provincial local bodies, in cooperation with other associations and institutions in Slovenia and in foreign countries: Communication of the standpoints of the medical profession on matters of health policy and medicine
- setting the principles of professional ethics. Ethical Code: regulate ethical and professional obligations of physicians and dentists among themselves and vis-à-vis patients
- defending individual and collective interests of members, offering mutual aid and other forms of assistance to members
- expressing its opinion on matters concerning postgraduate education of physicians and dentists, taking part in its realisation
- Promotion of quality assurance

The Slovenian Medical Chamber performs the tasks by means of

- keeping the register of physicians and dentists
- cooperation in working out the general conditions of contracts between physicians/dentists and the National Health Insurance Fund
- delivery of opinions on draft legislation concerning the protection of health and practising as a physician or dentist
- making decisions with respect of inability to practice as a physician or a dentist
- professional and ethical supervision of members
- negotiating conditions of work and remuneration
- defending individual and collective interests of the members

Ethics and Regulation

Ethical Code

There is a written ethical code in Slovenia. Whilst the Medical Chamber has an ethical code, the CED Ethical Code has also been adopted – but as a subordinate to the main code.

Fitness to Practise/Disciplinary Matters

The Chamber has a Professional Medical Committee which investigates complaints against and the quality of care given by Slovenian dentists. There are also Medical courts, which are part of the Chamber. This executive body has the responsibility to censure dentists, or ultimately to remove their licence to work, for life.

There is a self-standing dental committee which looks at dental matters. The Professional Dental Committee is composed of three dental specialists of different specialities. They cannot award compensation to aggrieved patients.

Advertising

Advertising is permitted, under the framework of the ethical code, but this is very limited. It is restricted to information on name, title, telephone number, address, specialisation and consultation hours – and is only permitted when a dentist opens a new practice or changes location of an existing practice, but only three times in the first three months from the opening. The dentist cannot use TV/radio but can advertise in Yellow Pages.

Slovenian dentists may use websites, within the ethical considerations - although the ethical code does not include a specific section on the issue. The CED Code on Electronic Commerce has been incorporated into the code.

Data Protection

The EU Data Protection Directive has been incorporated into Slovenian law.

Indemnity Insurance

Indemnity insurance is taken out with commercial companies, at a cost of about €250 per year (2008) (it is possible to choose the level of cover). It is not compulsory by law, but is strongly recommended by The Medical Chamber.

This indemnity may cover the dentist for work overseas, depending upon the insurance policy.

Corporate Dentistry

Anyone may own or invest in a dental practice. The person undertaking the dentistry must be a dentist but there is no requirement for the investors to be dentists.

Tooth whitening

Tooth whitening in Slovenia is regulated as medicinal and application is limited to dentists.

Health and Safety at Work

Dentists, and those who work for them, must be inoculated against Hepatitis B. The employer usually pays for inoculation of the dental staff.

Ionising Radiation

There are specific regulations about radiation protection. Training in radiation protection is mandatory for the competent person in each practice – the dentist or the DSA. Dentists must undergo continuing training, within any general requirements for continuing education.

Hazardous Waste

The EU Hazardous Waste Directive is incorporated into law and actively enforced. There is compulsory contracting with special companies who transport and dispose of waste.

Amalgam separators are legally required in all practice units.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Institute of Occupational Safety
Electrical installations	Institute of Occupational Safety
Waste disposal	Ministry of Health
Medical devices	Ministry of Health
Infection control	Ministry of Health

Financial Matters

Retirement pensions and Healthcare

The set age for retirement is 58 years, for males after at least 40 years of work, and for females after 38 years of work. Dentists may practice until they are 75 years of age.

The contribution rate for state pensions is €700 per year, and this gives a state pension of about €1,000 year on retirement. But for optional additional private pensions the level depends upon the contributions made.

Taxes

The top rate of tax is 41 % and is charged on net incomes above € 14,375 per year.

VAT

For dental materials, instruments and equipment, VAT is the same as for general goods, 20%.

Various Financial Comparators

Zurich = 100	Ljubljana 2003	Ljubljana 2008
Prices (excluding rent)	55.0	66.2
Prices (including rent)	59.1	61.6
Wage levels (net)	17.6	25.9
Domestic Purchasing Power	31.4	42.0

Source: UBS August 2003 & January 2008

Other Useful Information

Competent and Legal Authority:	*Dental Association:*
Name: Ministry of Education, Science & Sport Tel: +386 1 478 4600 Fax: +386 1 478 4719 E-mail: Website: http://www.mszs.si	The Medical Chamber of Slovenia Dalmatinova 10 1000 Ljubljana Slovenia Tel: +386 1 307 2100 Fax: +386 1 307 2107 E-mail: zdravniska.zbornica@zzs-mcs.si Website: http://www.zdravniskazbornica.si/

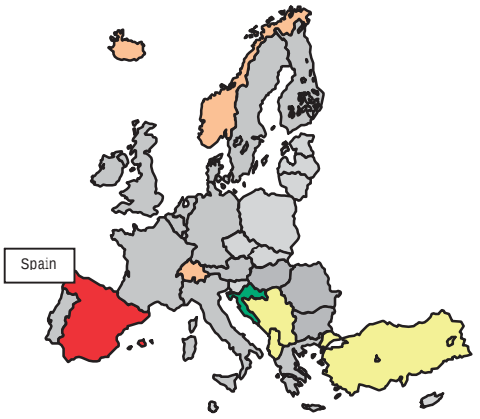
Dental School:

City: Ljubljana

The Dean
Faculty of Medicine
Department of Stomatology
Hrvatski Tr g 6
1000 Ljubljana
SLOVENIA
Tel: +386 1 543 7700
Fax:
E-mail: stoma@mf.uni-lj.si
Website: http://animus.mf.uni-lj.si/~stoma/

Number of students: 397

Spain



Date of last revision: 1st October 2008

In the EU/EEA since	1986
Population (2008)	45,283,259
GDP PPP per capita (2007)	€24,612
Currency	Euros
Main languages	Spanish Also, Catalan, Basque, Valencian & Galician

Comprehensive health care is available to all by law. However, Dentistry, Psychiatry and Cosmetic services (for example, Plastic Surgery) are excluded. Hospital and Primary Medical care is free at the point of delivery. There is a small Public Dental Service which operates in Primary Health Care Units (Ambulatorios) managed by the regions. This only provides emergency care. Private care is freely available, however.

Number of dentists:	24,515
Population to (active) dentist ratio:	1,887
Membership of the Dental Association:	100%

Specialist care is very limited and clinical auxiliaries are limited to hygienists.
Continuing education for dentists is not mandatory, and is administered mainly by the dental association – the Consejo General de Colegios Oficiales de odontólogos y estomatólogos de España.

Government and healthcare in Spain

Spain is a democratic country with a history of centralist government supported by a regional structure. The capital is Madrid. Currently, all the regions have autonomous powers. Autonomy operates through a system of 'delegated competencies' eg health, education, police etc., and the central government retains authority for foreign policy and defence.

There are 17 Regions (*Autonomias*), and two autonomous cities, governed by elected local politicians. Some of these already have delegated 'health competencies' which largely operate through programmes which complement national laws. To manage these programmes, each region has established a health care institution, for example, the Catalan Institute of Health, Andalusian Health Service etc.

Comprehensive health care is available to all by law. However, dentistry, psychiatry and cosmetic services (for example, plastic surgery) are excluded. Hospital and primary medical care is free at the point of delivery but there is a charge for medicines unless the medicaments are provided directly. The charge varies according to the drugs prescribed but an average is 70% of the total cost. Access to elective surgery is controlled by waiting lists.

Medical staff who are employed by each regional healthcare institution *Insalud* are said to be not well-paid and usually supplement their income through private practice. When competencies are introduced, better pay and conditions for more committed hours are often negotiated and waiting lists are usually reduced. In some regions, social security funds buy private services rather than creating public systems.

Generally, healthcare provided by the government or the regions is funded by deductions from earnings, supplemented by employers for their employees. These payments are aggregated into a national social security pool from which pensions and unemployment and sickness benefit are also funded. There is therefore an annual budget for health, although the social security fund is often in deficit, which is met from national taxation.

Individual contributions are progressive and depend on income, with an annual collective agreement which sets the national minimum wage and the minimum social security payment. This system ensures equity and applies to all citizens except government employees who have a special agency for pensions and health. The agency operates a compulsory insurance scheme which allows civil servants to choose between private or state care. The scheme for government employees includes limited dental care.

		Year	Source
% GDP spent on health	8.4%	2006	OECD
% of this spent by governm't	71.2%	2006	OECD

Oral healthcare

Almost all oral healthcare in Spain is provided by private practitioners and patients usually pay the total cost.

		Year	Source
% GDP spent on oral health	No data	2008	
% of OH expenditure private	No data	2008	

Public Healthcare

There is a small Public Dental Service which operates in Primary Health Care Units (*Ambulatorios*) managed by each regional healthcare institution. This only provides emergency care such as extractions or the prescription of antibiotics, although patients may be referred to an oral surgeon if necessary. This provision is a legal requirement. Regions which are delegated health competencies may supplement this service through specific programmes. At present, these programmes are largely confined to prevention and paediatric dentistry.

Some capitation-based 'incremental programmes' have existed since 1989, In the Basque country and Navarre the schemes have been extended for children but at present they only care for children aged 6 to 15-years-old. In 2003 a programme was introduced in Andalucia and Murcia, starting at 6-7 years and is now being implemented throughout Spain.

Private Practice

Apart from the scheme for government employees referred to earlier, which only covers examinations, extractions and prophylaxis, there are a number of private health insurance plans which include these items and X-ray diagnosis. Several companies such as *Asisa*, *Caja Salud*, *Adeslas*, *Previasa* and *Sanitas* offer more comprehensive dental care for an additional premium. However, only 18% of the population (2007) use these private insurance schemes to cover their dental care costs.

All such schemes are personal plans, where individuals insure themselves by paying premiums directly to the insurance companies. The companies then pay fixed fees to the dentists for treatments which are covered by the companies. Private insurance companies are self-regulating (Insurance Law and the General Insurance Office) and act as intermediaries for the dentists, who in turn bear all the financial risks of treatment. The level of the premiums depends on the procedures covered and takes no account of the risk of poor health.

Patients who subscribe to these schemes are given a 'chequebook' for each procedure covered. After treatment, the dentist submits the cheques to the company and is paid. Cheques may be used as a part payment for advanced treatments, for example crowns and bridges. The schemes are not very popular with dentists because the fees per item are very low.

Patients in Spain do not attend for dental care on a regular (periodical) basis, but tend to go when they have dental problems, only. There is no form of domiciliary (home) care.

The Quality of Care

There is no formal monitoring of the quantity or quality of dental care.

Health data

		Year	Source
DMFT at age 12	1.33	2005	OECD
DMFT zero at age 12	53%	2005	OECD
Edentulous at age 65	23%	2005	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

Some of the main cities in Spain have artificially fluoridated water. These are Sevilla, Aljarafe, Badajoz, Murcia, Lorca, the Basque country, Girona and Linares.

The Canary Islands have naturally fluoridated water.

Education, Training and Registration

Undergraduate Training

Year of data:	2007
Number of schools	17
Student intake	2,900
Number of graduates	2,842
Percentage female	70%

To enter dental school students have first to pass a state school-leaving examination.

Dental schools are part of the universities, and not necessarily part of medical faculties. In 2008 there were 12 publicly funded dental schools, 5 private dental schools. In all the schools the course lasts 5 years.

Standards of care are not controlled in the private sector and the clinical facilities are limited. Dental schools have no health service responsibilities and students gain clinical practice within *Docente University Clinics*.

The responsibility for quality assurance of the courses in the schools is undertaken by the Ministry of Education.

Qualification and Vocational Training

The qualifications on graduation are as follows:

- *Licenciado en Odontologia* (1986 onwards)
- *Médico Especialista en Estomatologia* (1948 to 2001)
- and other historical categories: *Odontólogo* (1901 to 1948)

Until 2001, it was possible to train as a stomatologist, in Spain; this involved a period of dental training by qualified medical practitioners, followed by further training as a dentist.

Vocational Training (VT)

There is no post-qualification vocational training in Spain.

Registration

The law defines the specific acts a dentist may perform as: 'The treatment of diseases of the whole mouth' (law 10/86, RD 1594/1994).

To practise as a dentist a dentist must hold a degree awarded by a recognised Spanish University, or a diploma from a European Union country which is recognised by the *Ministerio de Educacion y Cultura*.

There is a register of dentists held by the *Consejo General* in Madrid. The list is revised every day and there is a fee for inclusion which varies because each regional Colegio charges its own fee according to local expenses. It varies, under a liberal system between €18 and €50 monthly. An incoming dentist must register regionally.

Language requirements

Dentists from other member states of the EU are not subject to any linguistic tests.

Further Postgraduate and Specialist Training

Continuing education

An extended system of evaluation of the continuing education systems is being developed, after encouragement by the government but it is not compulsory in 2008.

The current system of continuing education is organized by the Consejo General and local *Colegios de Odontólogos y Estomatólogos*. Some companies and particular initiatives offer programmes on continuing education, of different degrees of quality and control.

Specialist Training

There is no specialist training in Spain (but see Working in Hospitals).

Workforce

Dentists

Until 1986, to be a dentist a qualification in medicine was first required – with dental training following, producing a "stomatologist". Since then dentists could qualify with an EU recognised degree, and since 2001 no more stomatologists have been trained. In 2008 less than half the dentists practising in Spain are stomatologists.

Year of data:	2008
Total Registered	24,515
In active practice	24,000
Dentist to population ratio*	1,886
Percentage female	53%
Qualified overseas	5,400

* active dentists.

Many dentists in private practice also work part-time in other spheres.

The "dental association" believes that as numbers are growing (nearly 1,700 graduate each year) Spain has an excess of supply over need.

Movement of dentists across borders

There is also a tradition of accepting dentists trained in "third world" countries, usually South America, but the numbers entering Spain are reducing. The entry examinations for these dentists have become progressively more difficult. These dentists may not be able to work freely in other countries in the EU.

There are no figures for the movement of dentists out of Spain.

Specialists

No specialties as defined in the 1978 EU Dental Directives are formally recognised. There are a number of Stomatologists and Maxillo-Facial Surgeons who are specialists in Maxillo-facial surgery according to the EU Medical Directives.

There are an increasing number of practitioners who are limiting their practice to a given speciality, mainly orthodontics, periodontics, endodontics and oral surgery. Some Spanish universities offer postgraduate courses in different specialist areas, however they lack official professional validity.

Auxiliaries

Other than dental chairside nurses or receptionists, who are trained by dental practitioners directly, there are two main types of dental auxiliary. They are:

- Dental hygienists
- Dental technicians

Year of data:	2004
Hygienists	9,000
Technicians	7,500
Denturists	0
Assistants	25,000
Therapists	0
Other	0

Dental Hygienists

In Spain hygienists must hold a registerable qualification. Their education and training is provided over 2 years by private or public schools of *Formacion Professional* and certificates of proficiency are granted by the Ministry of Education and Culture.

Hygienists are allowed to carry out prophylaxis and oral health education, but only under the prescription of a dentist who must be present in the building while they are working. The employing dentist is responsible for their work. Until 1998 there was an unknown number of non-titled dental hygienists. However, in 1996 the Government started a validation process which finished in 1998 for dental hygienists who had accredited a minimum number of years of experience in dental practices, and then passed an examination process. This has resulted in a rapid increase in the number of "recorded" hygienists (there is no registration) from 1,000 to over 9,000.

Hygienists are almost exclusively employed in private practice. The public dental service has created positions for this group, although some are employed on preventive programmes, on temporary contracts.

Dental Technicians

There is a qualification for Dental Technicians which is obtained after training and education at schools of *Formacion Professional*, over a 2-year period. Voluntary registers are kept by the regional associations for the craft, but there is no national mandatory requirement and some regional 'colegios' are being established. However, in some regions it is compulsory and the numbers of such are growing.

In Spain dental technicians may only work in commercial laboratories.

Dental Assistants (Nurses)

Dental assistants work at the chairside. There is no formal training or qualification.

Practice in Spain

Year of data:	2008
General (private) practice	22,063
Public dental service	1,251
University	800
Hospital	340
Armed Forces	340
General Practice as a proportion is	92%

Many dentists in private practice also work part-time in other spheres.

Working in Private (General) Practice

Dentists who practise outside hospitals, universities or the public dental service are referred to as private practitioners. Approximately 92% of the profession work in this way and are largely in single-handed practice.

Most dentists in private practice are self-employed and earn their living through charging fees for treatments. Generally such private practitioners accept only private fee-paying patients.

Fee scales

There is no prescribed fee scale and the laws controlling free competition restrict the possibility of set fees, but regional dental associations provide recommended fees for different treatments. Local "Colegios" (regional dental organisations) set recommended fees but they cannot be enforced as mandation is against Spanish law.

Joining or establishing a practice

Newly qualified practitioners normally work as assistants and are paid a proportion (30-50%) of their gross earnings. A few of these eventually become partners but more usually they open their own practices. Although there are no workforce restrictions, there are agreed minimum conditions for a new clinic. These include sterilisation and prevention of cross infection, radiological protection, adequate waiting rooms and toilets, fire precautions and emergency lighting and insurance. Existing practices may also be purchased together with goodwill and it is acceptable to inform patients when this occurs. No state assistance is available for practice purchase, or establishing a new practice, but some banks have special agreements with the Colegios, for loans.

Premises may be rented or owned. They would usually be sited in houses or offices only.

There is no information available relating how many patients a dentist would normally look after on a regular basis.

Working in Public Clinics

A public dental service exists as described above and limited care is available to all sections of the population. Less than 5% of registered dentists work in the service but although the number employed by *Insalud* is stable, the number of those working in the regions is rising, for example in *Andalusia*. The titles used are *Odontólogo de área and Odontólogo de cupo*. No formal postgraduate training is required for these posts but attendance for continuing education is assessed on a points basis, when evaluating applicants. As in the hospital dental service there are no grades but every third year, a dentist receives a 'Trienio' which raises his salary.

The regional authorities have introduced a capitation system for children of 6 to 14 years old. Private practitioners are eligible to accept patients from these schemes.

Patients attending the public dental service pay nothing for their care. The number of procedures undertaken is recorded for statistical purposes and complaints are investigated through a medical system. Where these are upheld a warning may be recorded on the dentists file, but he may only be prevented from practising in the service by judicial sentence following malpractice.

Working in Hospitals

Most hospitals are owned by the state, but a few have been established by the large insurance companies. In the latter private practitioners may rent facilities and charge patients on a fee per item basis. Normally however, dentists are employed as Odontologists who provide routine dentistry and minor oral surgery, or medically qualified Stomatologists, who supplement the work of Odontologists with Temporo-Mandibular Joint therapy, and Oral Medicine or Maxillo-Facial Surgeons. In each case these are titles and not definitive grades.

There is no formal postgraduate training requirement for Odontologists and Stomatologists, but if applicants hold an oral surgery qualification they are evaluated preferentially. Maxillo-Facial Surgeons must have completed a formal five year training programme in an accredited hospital as set out in the EU medical Directives. No career structure exists for these appointments but pay, which is revised every three years, reflects experience. Posts are filled by national competition but autonomous regions can apply their own rules.

Working in Universities and Dental Faculties

Both full-time and part-time staff are employed and the latter also routinely work in private practice. Full-time staff may also practise outside their school when they have completed their university schedule if they have full 'dedication'. However this group can also opt for exclusive 'dedication' which denies them outside work but allows intra-mural practice.

The following grades have been established for faculty staff:-

- *Associate Professor (Profesor Asociado)*
- part-time faculty member
- *Assistant Professor (Profesor Ayudante)*
- contracted full-time and pursuing an academic career
- *Profesor Titular*
- full-time professor
- *Chairman (Catedratico)* - highest academic rank, with the same obligations and duties as a full-time professor

To be eligible for a full professorship, a faculty member must obtain a doctorate after a five year training programme in research methodology, a research project and the production of a thesis which must be defended. Professors are usually appointed to a predetermined subject by a panel of their peers after national competition. Appointees must also have had at least three years of teaching experience.

Teaching standards are not formally monitored but some universities have their own evaluation systems using student questionnaires. The quantity and quality of an individual's research is voluntarily monitored by a National Agency for Evaluation which also awards research grants. The agency reviews publications and if a candidate passes this process, a salary increment is awarded.

Working in the Armed Forces

Many dentists serve full-time in the Armed Forces - 17% of these are females.

Professional Matters

Professional association

There is a single federal organisation, the *Consejo General de Colegios Oficiales de odontólogos y estomatólogos de España* which has a Council (*Consejo General*) of which the Presidents of each of the 19 regional *Colegios* are members.

	Number	Year	Source
Consejo General de Colegios de Odontólogos y Estomatólogos de España	24,515	2008	FDI

The membership figure represents over 90% of dentists in Spain. The central organisation has a full-time office based in Madrid. The regional organisations are best contacted through this office (see later).

Ethics and Regulation

Ethical Code

There is an ethical code that is agreed and administered by a committee of the *Consejo General*. The code covers partnership agreements, disputes with other dentists, advertising where standards have been set for signs, plaques and newspapers and confidentiality. Written consent and patient contracts are not currently included.

There are no specific contractual requirements between practitioners working in the same practice other than private contracts agreed by individual dentists. A dentist's employees however are protected by the national and European laws on maternity benefits, occupational health, the payment of social security benefits and health and safety.

Fitness to Practise/Disciplinary Matters

If a patient wishes to complain about a dentist in general practice, this may be to either the Regional *Colegio* or Municipal Consumer Offices in the Town Halls or directly to the courts. Complaints to the former are considered by a *Deontologic* committee, which has only dental members. These committees may arbitrate, issue a private or public warning, suspend a dentist or, in severe cases, refer to the courts for removal from the Register.

Dentists have a right of appeal to the *Consejo General* and patients to the legal system. All criminal acts against patients are considered by the courts.

Data Protection

There is a strict compulsory protocol of clinical data collection and storage, for patient protection and all dental offices had to be adapted to conform by 2007.

Advertising

Since 2003, there has been a *Codigo de publicidad* about advertising in dentistry, accepted by the Tribunal of Competence Defence, which has applicability to all dentists.

Electronic commerce is not extensively implanted among dentists but some companies of dental supplies operate in this mode. However, dentists may have their own websites under the Codigo and the ethical code. Spain has adopted the CED ethical code on these matters.

Indemnity Insurance

Liability insurance is compulsory for dentists and is provided by private general insurance companies. It provides cover for financial liabilities of not less than €300k, up to €600k and premiums do not vary for different types of dentists (nb. a general dental practitioner pays between €150 and €240 annually).

The premiums do cover a Spanish dentist who is working overseas.

Corporate Dentistry

Dentists are permitted to form companies, in which to practise. Non-dentists can own or be on the board of such companies.

Tooth whitening

Tooth whitening products are considered cosmetic with less than 6% carbamide peroxide. This means that the provision of tooth whitening is not limited to dentists.

Health and Safety at Work

Inoculations, such as Hepatitis B are not compulsory for the workforce, although they are recommended.

Ionising Radiation

There are many regulations relating to the facilities, dosage, sanitary controls. To direct a radiograph formal training must have been undertaken, with a licence at the end of this.

However, continuing training is not mandatory.

Hazardous waste

Since 1986 it has been mandatory to fit amalgam separators to all newly equipped premises or newly installed units. This requirement extends to putting in older units in new premises. However, there may be differences in the autonomous regions towards compliance.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	State Government
Electrical installations	Regional Government
Waste disposal	Regional Government
Medical devices	Regional Government
Infection control	Regional Government

Financial Matters

Retirement pensions and Healthcare

Public pensions are paid as a percentage of up to 85% of average salary, up to a maximum of €1,502 a month, and assume a minimum of 15 working years. Many supplement their public pension with private pension plans. The compulsory retirement age in Spain is 70 (65 for some professions), but it can be done on a voluntary base from 65 years onwards. Dentists may continue to work in private practice beyond normal retirement age.

For the majority of the Spanish population general health care is free, paid for out of a General State Budget - from taxation 92%, and 8% from the Social Security contributions of employers and employees. Social security payments (autónomos) for a dentist in private practice are approximately €300 a month. Many dentists will also take out private health insurance plans.

Taxes

There is a national income tax: the highest rate is 43%, which is charged on net incomes above €53,000.

VAT

No medical procedures, including laboratory prostheses attract VAT. The VAT rates are 7% on dental equipment and 16% on materials.

Various Financial Comparators

Zurich = 100	Madrid 2003	Madrid 2008
Prices (excluding rent)	68.4	81.1
Prices (including rent)	67.5	82.6
Wage levels (net)	39.2	56.0
Domestic Purchasing Power	55.4	67.8

Source: UBS August 2003 & January 2008

Other Useful Information

Details of competent authority:	*Main Professional Journals:*
Direccion General de Recursos Humanos y Servicios Económicos Presupuestarios. Ministerio de Sanidad y Consumo. Paseo del Prado 18- 20. ES 28014 Madrid. Tel: +34 91 596 44 26 Fax: +34 91 596 40 36 Email : dgresep@msc.es Website: www.msc.es	RCOE (Revista del Ilustre Consejo General de Colegios de Odontólogos y Estomatólogos de España) BOCGOE (Boletin Oficial del Consejo General de Colegios Oficiales de Odontólogos y Estomatólogos de España) Calle Alcala 79-2 28009 Madrid SPAIN Tel: +34 91 426 44 13 Fax: +34 91 577 06 39 Email: rcoe@infomed.es Website: www.consejodentistas.org/rcoe.html
Professional Association:	*Main information centre:*
Consejo General de Colegios de Odontologos y Estomatologos de España Calle Alcala 79-2 28009 Madrid SPAIN Tel: +34 91 426 44 10/1 Fax: +34 91 577 06 39 Email: consejo@infomed.es Website: www.consejodentistas.org	Ministerio de Educación y Cultura Secretaria General Tecnica Subdireccion General de Cooperacion Internacional Paseo del Prado 28 (planta 2) E-28014 Madrid SPAIN Tel: +34 91 506 56 00 Fax: +34 91 701 86 48 Email Website: www.mec.es/sgci/index.htm

Private Dental Schools:

Universidad Alfonso X El Sabio Facultad Ciencias de la Salud Avda. de la Universidad, 1 Villanueva de la Cañada 28691 Madrid Tel: +34 91.810 92 00 Fax: +34 91.810 91 02 Email: info@uax.es Website: www.uax.es Dentists graduating each year: 270 Number of students: 1,350	Universidad Europea de Madrid Facultad Ciencias de la Salud C/ Tajo s/n Urb. El Bosque - 28670 Villaviciosa de Odón (Madrid) Tel: +34 91.616 82 56 Fax: +34 91.616 82 65 Email: uem@uem.es Website: www.uem.es Dentists graduating each year: 183 Number of students: 915
Universidad Internacional de Catalunya Facultad Ciencias de la Salud Campus de Sant Cugat. Hospital General de Catalunya Gomera s/n – 08190 San Cugat del Vallés Tel: +34 935 042 000 Fax: +34 935 042 001 Email: info@unica.edu Website: http://www.unica.edu/ Dentists graduating each year: 80 Number of students: 400	Universidad Cardenal Herrera CEU Facultad Ciencias Experimentales y de la Salud C/ Luis Vives, 2 46115 – Alfara del Patriarca (Valencia) Tel: +34 961 369 000 Fax: +34 961 395 270 Website: http://www.uch.ceu.es/principal/inicio.asp Dentists graduating each year: 80 Number of students: 400
San Pablo CEU Madrid. C/ Julián Romea 18. 28003 Madrid Tel.: +34 915 36 27 27 Fax: +34 915 36 06 60 Email: info.usp@ceu.es Website: www.medicina.uspceu.es Dentists graduating each year: 157 Number of students: 785	

Public Dental Schools:

Madrid
Facultad de Odontologia
Ciudad Universitaria
Universidad Compultense - 28040 Madrid
Tel: +34 91.394 19 15
Fax: +34 91.394.19.10
Email: infocom@ucm.es
Website: www.ucm.es/info/odonto/
Dentists graduating each year: 100
Number of students: 500

Barcelona
Facultad de Barcelona
Ciudad Sanitaria de Bellvitge "Principe de España"
Feixa Llarga, s/n
08907 - Hospitalet de Llobregat, Barcelona
Tel: +34 93 335 88 99
Fax: +34 93 403 59 27
Email: sec-odon@bell.ub.es
Website: http://www.ub.es/fodont/
Dentists graduating each year: 120
Number of students: 600

Valencia
Facultad de Valencia
C/Gascó Oliag
1 - 46010 Valencia
Tel: +34 96 386 41 75
Fax: +34 96 386 41 44
Email: dise@uv.es
Website: www.uv.es
Dentists graduating each year: 75
Number of students: 375

Granada
Facultad de Odontologia de Granada
Campo Universitario de Cartuja s/n
18071 Granada
Tel: +34 958 24 38 12
Fax: +34 958 24 37 95
Email odonto@ugr.es
Website: http://www.ugr.es/~odonto/
Dentists graduating each year: 89
Number of students: 445

Vizcaya
Facultad de Vizcaya
Universidad del Pais Vasco
Facultad de Medicina y Odontologia
Sarriena s/n
48940 Lejona (Vizcaya)
Tel: +34 94 464 77 00
Fax:
Email: rgzadmin@lg.ehu.es
Website: www.lg.ehu.es
Dentists graduating each year: 50
Number of students: 250

Santiago de Compostela
Facultad de Medicina de Santiago de Compostela
Entrerios, s/n1
15705 Santiago de Compostela (La Coruña)
Tel: +34 981 562 026
Fax: +34 981.582.642
Email coleinf1@usc.es
Website: http://www.usc.es/coies/
Dentists graduating each year: 50
Number of students: 250

Sevilla
Facultad de Sevilla
Facutad de Odontologia
C/ Avicena s/n, 41009 Sevilla
Tel: +34 95 448.11.03
Fax: +34 95 448.11.04
Email: fodonjsec@us.es
Website: www.us.es
Dentists graduating each year: 100
Number of students: 500

Murcia
Facultad de Medicina
Campus de Espinardo.
Hospital General Universitario Morales Meseguer
Avda. Marqués de los Vélez, s/n – 30008 Murcia
Tel: +34 968 36 43 12
Fax: +34 968.36 41 50
Email: www@um.es
Website: http://www.um.es/~medicina/
Dentists graduating each year: 40
Number of students: 200

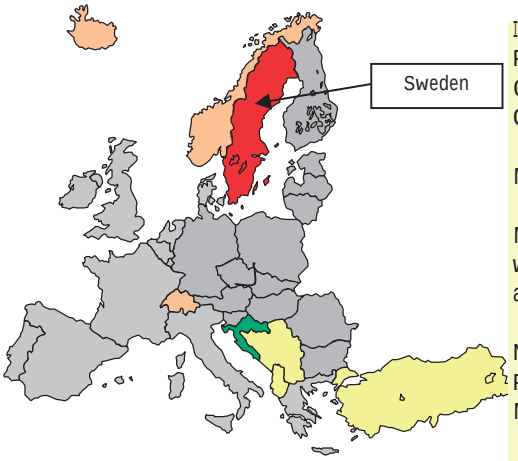
Oviedo
Facultad de Medicina.
Clínica Universitaria de Odontologia.
C/ Catedrático José Serrano, s/n , 33006 Oviedo
Tel: +34 98 510 36 47
Fax: +34 98.510.35.33
Email:
Website: www.uniovi.es
Dentists graduating each year: 48
Number of students: 240

Salamanca
Facultad de Medicina
Campus Miguel de Unamuno
C/ Alfonso X El Sa bio, s/n. 37007 Salamanca
Tel: +34 923.29.45.41
Fax: +34 923.29.45.10
Email: medicina@usal.es
Website: www.usal.es
Dentists graduating each year: 30
Number of students: 150

Madrid	Huesca
Universidad Rey Juan Carlos C/ Tulipán s/n 28933 (Móstoles) Madrid Tel: +34 91.665.50.60 Fax: +34 91.614.71.20 Email: info@urjc.es Website: www.urjc.es Dentists graduating each year: 75 Number of students: 375	Facultad de Ciencias de la Salud y del Deporte C/ Plaza Universidad, 3. 22002-Huesca Tel: +34 97 4239393 Fax: +34 97 4239392 Email: secrefsd@unizar.es Website: www.unizar.es/facuhu/ Dentists graduating each year: 25 Number of students: 125

	Number of Undergrads	Annual Graduates
Private		
Madrid: El Sabio	1,350	270
Madrid: Europea	915	183
Catalunya	400	80
Valencia	400	80
San Pablo CEU, Madrid	785	157
	3,850	770
Public		
Madrid	500	100
Barcelona	600	120
Valencia	375	75
Granada	445	89
Vizcaya	250	50
La Coruna	250	50
Sevilla	500	100
Murcia	200	40
Oviedo	240	48
Salamanca	150	30
Madrid Rey Juan Carlos	375	75
Huesca	125	25
	10,360	2,072
Overall total	14,210	2,842

Sweden



Date of last revision: 1st October 2008

In the EU/EEA since	1995
Population (2008)	9,182,927
GDP PPP per capita (2006)	€30,210
Currency	Kronor (SEK)
	9.44 = €1 (2008)
Main language	Swedish

Most healthcare is provided through a national social insurance system, which also provides sick pay, child benefits, disability allowances and pensions.

Number of dentists:	14,355
Population to (active) dentist ratio:	1,239
Membership of the Dental Association:	95%

The use of dental specialists is widespread and the development of dental auxiliaries is well advanced.
Continuing education for dentists is not mandatory.

Government and healthcare in Sweden

Sweden is a Nordic country and has a population with about 85% of inhabitants living in the southern half of the country. The capital is Stockholm.

It has a constitutional monarchy with a parliamentary system of government but, as Head of State, the King only has a ceremonial function. The Swedish Parliament, the Riksdag, consists of 349 members. These members are chosen in 29 different constituencies and therefore represent the entire country. At present (2008) seven political parties are represented in the Riksdag. Together, members belonging to the same party form a party group.

Many aspects of government, including healthcare, are delegated to the county or municipality level (290 municipalities in 2008). Both the counties and municipalities have elected councils which may levy taxes. Liberal immigration policies have given Sweden a multicultural population, with immigration accounting for 48 % of the gross population growth.

Social expenditure accounts for some 30 % of Sweden's Gross Domestic Product (2005).

		Year	Source
% GDP spent on health	9.1%	2006	OECD
% of this spent by governm't	84.6%	2006	OECD

Most healthcare is provided through a national social insurance system, which also provides sick pay, child benefits, disability allowances and pensions. The national insurance system operates as a government agency (the National Social Insurance Board or *Riksförsäkringsverket*), through local Social Insurance Offices (*Försäkringskassan*). Everyone who is resident in Sweden is registered with a social insurance office when they reach the age of 16. The expansion of healthcare in the 1950s and 1960s concentrated especially on secondary care, so that Sweden now has a high proportion of specialist and hospital-based services. Public expectations of health services are high. In total, around 85 % (2005) of healthcare costs including dentistry, are funded by government.

For the majority of the Swedish population general health care is paid for through general taxation, plus a small fee (€15 in 2008) for each visit to a doctor.

Oral healthcare

Oral healthcare is the responsibility of county government, although counties are not required to provide the services themselves.

		Year	Source
% GDP spent on oral health	0.68%	2006	SCB**
% OH expenditure private	78%	2005	NBHW*

**Källa SCB Nationalräkenskaperna
* The National Board of Health and Welfare

Public Healthcare

Almost all oral healthcare is provided in one of two ways. Firstly, there is a Public Dental Service (NDS) which provides free dental care to children up to the age of 19. These dental services are mainly delivered in local clinics which are managed by the counties. Children and their parents can choose to attend either the NDS or private practitioners. Secondly, adults and elderly people who are not entitled to free care from the Public Dental Service can get subsidised dental care from the NDS or dentists in private practice.

The framework changed in 2008 with a new national insurance scheme introduced on July 1st 2008.

A dental care voucher was introduced – the value of the dental care voucher is €32 every other year for everyone aged 30 to 74, €64 every second year for those aged 20 to 29 and 75 and over. The voucher can be used as a part-payment for a dental care check-up at any dentist's or dental hygienist's practice, or as a part-payment for subscription dental care.

A high-cost protection scheme that will provide compensation equal to 50% of a patient's dental care costs between €321 - €1590 and 85% of costs exceeding €1590. The first €320 is always paid by the patient.

"Reference prices" are introduced - compensation levels will be based on "reference prices". These should have a price-steering effect on prices and enables patients to compare dental prices more easily. There is free pricing with a subsidy.

Dentists in private practice settle their prices themselves. The counties settle the prices for all the clinics within the county.

Reimbursement – Not all kinds of dental care are reimbursable. Preventive measures and disease treatment are prioritised. Reimbursable dental care is both cost-effective and socioeconomically efficient.

For those with long-term illness, certain diseases or special need, get a subsidy for dental care.

In 2004 (latest figures available) the total cost for dental care was approximately €2.1 billion. Patients' co-payments were €1.3 billion of this sum, so the taxpayers' share was €0.8 billion. Of this, €0.33 billion was provided through the national insurance scheme.

It is easier to access NDS-care in the big cities than in the country. During a one-year period (2004) 68% of the population aged from 16 to 84, accessed dentistry. In any 2-year period, approximately 85% of the adult population access dentistry.

Private Insurance

Private insurance is available for oral healthcare but is very rare.

The Quality of Care

There is a Dental Act which states that all Swedish citizens are entitled to good quality dental care. The standards are monitored by the Regional Departments of the National Board of Health and Welfare (*Socialstyrelsen*). The authority has issued a regulation imposing the dental services to work with quality questions. The dental service also works using a system called Lex Maria, where all incidents that have caused or could have caused serious injury, are to be reported.

Health data

		Year	Source
DMFT at age 12	1.00	2005	WHO
DMFT zero at age 12	58%	2005	OECD
Edentulous at age 65	No data		

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth.

Fluoridation

In Sweden there is no fluoridation scheme although dentists work continuously with preventive information to all children. Children often get a toothbrush or a package of toothpaste on their first visit to the dentist.

Education, Training and Registration

Undergraduate Training

Primary dental qualification

All the dental schools are state owned and financed. They are all part of the Faculties of Medicine of the respective universities. To enter dental school, students must have completed secondary education. There is no entrance examination. The dental undergraduate course lasts 5 years.

Year of data:	2008
Number of schools	4
Student intake	247
Number of graduates	166
Percentage female	67%

Quality assurance for the dental schools is provided by the National Agency for Higher Education.

Qualification and Vocational Training

Primary dental qualification

On completion of studies students are awarded a degree, known as "Tandläkarexamen".

Vocational Training (VT)

There is no post-qualification vocational training in Sweden.

Registration

In order to practise as a dentist in Sweden, a qualified dentist must have a licence awarded by the National Board of Health and Welfare unit for Qualification and Education. This body keeps a register of dentists.

The main degrees which may be included in the register are: the *licence*, and a *diploma* of specialisation.

Cost of registration (2008)	€64.00

Dentists do not need to re-register annually.

The Social Insurance Office (*Försäkringskassan*) also keeps a register of practitioners who are affiliated to the national social insurance scheme, and dentists must be on this register before they can claim social insurance subsidies. Registering for affiliation with the national social insurance scheme only requires the production of a recognised degree certificate or diploma.

Language requirements

There are no formal linguistic tests in order to register, although dentists are expected to speak and understand Swedish. However, an employer has the right to demand knowledge in Swedish – as the "case book" must be written in Swedish and a patient has the right to understand what is written in it.

Further Postgraduate and Specialist Training

Continuing education

Continuing education is optional. The Swedish Dental Association has a continuing education programme (printed and sent to all members twice a year), but almost all county councils (public dental health) do as well; the dental industry gives courses and also there are private initiatives.

Specialist Training

Training for the specialities lasts three years, after two years in general practice. It takes place in university clinics or recognised postgraduate institutions approved by the Swedish Board of National Health and Welfare. The capacity of specialist training in 2007 was about 283 places – 50 % were being used. The major part of this training is paid for by the Counties, directly through education on request or indirectly through the co-ordinated County grant. In 2008 50% of the specialists were more than 54 years old and it is anticipated that there will be a shortage in some disciplines.

There is training in 8 specialties:

- Orthodontics
- Endodontics
- Paedodontics
- Periodontology
- Prosthodontics
- Dentomaxillofacial radiology
- Oral and maxillofacial surgery
- Stomatognathic physiology

The number of specialist training posts is limited. The systems for remuneration vary.

Those who complete specialist training in the EU recognised specialisms of Orthodontics and Oral Surgery receive the following:

- 'bevis om specialistkompetens i ortodonti' (certificate awarding the right to use the title of dental practitioner specialising in orthodontics) issued by the National Board of Health and Welfare.

- 'bevis om specialistkompetens i oral kirurgi' (certificate awarding the right to use the title of dental practitioner specialising in oral surgery) issued by the National Board of Health and Welfare.

Workforce

Dentists

Year of data:	2005
Total Registered	14,355
In active practice	7,414
Dentist to population ratio*	1,238
Percentage female	49%
Qualified overseas**	2,193

* active dentists

** dentists under 65 years of age

The dental association reports that the number of active dentists is decreasing. Retirement is increasing due to the dispersion of age. In the mid 1990s the Government reduced undergraduate numbers by 40%. Additionally, emigration is higher than the immigration of dentists.

However, the loss of retired dentists is balanced by the newly-qualified, so the reduction of the active workforce is only from this emigration. There is no information about any unemployment amongst Swedish dentists.

Movement of dentists across borders

During a number of years there has been a net loss of dentists. Most of the emigrated Swedish dentists have moved to the United Kingdom and Norway. However, by 2008, the trend of a great movement out of Sweden appeared to be ending. During 2004 and 2005 the net immigration of dentists was positive.

Specialists

Year of data:	2005*
Orthodontics	255
Endodontics	42
Paedodontics	85
Periodontics	105
Prosthodontics	117
Dentomaxillofacial radiology	41
Oral Surgery	0
OMFS	143
Dental Public Health	
Stomatognathic pathology	30

* figures refer to active specialists

In 2008 about 11% of dentists were specialists.

Patients are referred by a dentist to the specialist. Most specialists work in the Public Dental Service or the universities. A small number work in private practice, but many of these are approaching retirement age. There are many associations and societies for specialists - a list of these is available from the Swedish Dental Association.

Auxiliaries

The system of use of dental auxiliaries is well developed in Sweden and much oral health care is carried out by them. Apart from (chairside) dental nurses, there are three types of dental auxiliary:

- Dental hygienists
- Dental technicians
- Orthodontic Auxiliaries

Year of data:	2008
Hygienists (2005 figures)	3,194
Technicians*	1,200
Denturists	0
Assistants	11,274
Therapists	0
Orthodontic assistants	360

* estimated figures 1,000 to 1,200

These figures are for "active" dental auxiliaries

Dental Hygienists

To train as a hygienist requires an academic entry of two "A" levels, and then 2-3 years of undergraduate academic education, in oral health science, at one of several University Colleges in Sweden. Oral health science is multidisciplinary and composed of medical/odontological and behavioural sciences.

After qualification all hygienists are licensed by the National Board of Health and Welfare. They have to have a registerable qualification and may work independently. Their duties may include diagnosis of caries and periodontal disease, and they may provide temporary fillings and local anaesthesia (mandibular and infiltration).

Most dental hygienists work in locations where dentists work, with about 40% employed in private practice and 60% in the public dental health sector. They are required to obtain professional indemnity insurance.

About 225 were self employed in 2008. They take legal responsibility for their work and charge fees to patients, which may vary from what dentists charge. About 30 of the 225 self employed hygienists own their own private practice.

Dental Technicians

To train as a dental technician requires an academic entry of two "A" levels, and then three years of lectures and practical training at a dental school. After qualification technicians are licensed by the National Board of Health and Welfare, but they do not have to have a registerable qualification to work. Their duties include the production of fixed and removable prosthetic and orthodontic appliances. They may not deal directly with the public.

Just less than 20% are employed by the Counties and 80% work in private practice. In 2006/2007 65 dental technicians were qualified.

Denturists do not exist in Sweden.

Orthodontic Auxiliaries

Orthodontic operating auxiliaries' training lasts one year and takes place where orthodontists are trained. This enables

them to carry out specified procedures, but they must work under the direction of an orthodontist.

There are no official figures of the number of orthodontic auxiliaries, but the above figures are an estimate by the Dental Association.

Dental Nurses

About 65% of dental nurses are employed by the Counties. A high number of them is middle aged (in 2008). Since January 2008 there has been a common national education for dental nurses.

Practice in Sweden

Year of data:	2007
Private (general) practice	3,290
Public dental service	4,124
University	263
Hospital	150
Armed Forces	2
General Practice as a proportion is	44%

Working in Private/General Practice

In Sweden, dentists who practice on their own or as small groups, outside the Public Dental Service, hospitals or dental schools are said to be in *private practice*. The term 'general practice' refers to dental practitioners who are not specialists.

Dentists in private practice are self-employed and are remunerated mainly by charging fees for treatments, supplemented by social security subsidies. The most common way of remunerating a dentist is to pay a fee for each treatment (item of service). If the treatment is one included in the NDS the dentist gets reimbursed by the dental insurance.

In 2008, very few dentists (less than 1%) accepted only private fee-paying patients.

Fee scales

A new system was introduced in 2008 (referred to earlier in the Oral Healthcare section).

Joining or establishing a practice

There are no rules which limit the number of dentists or other staff who may work in a single practice. Most newly qualifying dentists who enter practice do so as associates in a group practice. There is no state assistance for establishing a new practice and generally practitioners take out commercial loans from a bank.

The dental practice can be housed in any premises and there are no constraints on the opening of new practices. The responsible practitioner has to make certain environmental and technical adjustments to the premises, such as installing an amalgam-separator.

No standard contractual arrangements are prescribed for dental practitioners working in the same practice, though that is highly recommended by the professional organisations. They may be employees of a principal dentist, in partnership or employed under a lease arrangement. This lease arrangement is the renting of a room, equipment and sometimes staff from the dentist-owner. Such dentists have their own patients and pay either a monthly rent or a percentage of their income.

Dentists would normally have about 1,500 patients on their list.

The controls for monitoring of the standard of care are the same as already described above.

Working in the Public Dental Service

There is a public dental service with responsibility for free services to children up to 19 years of age. Apart from children, the service also provides dental care for adults as stated earlier. The Public Dental Service is funded by the Counties. It broadly provides the same types of treatment for which national insurance subsidies are available. For adults the same system of national insurance reimbursements and fee-scales apply as in private practice.

The service employs about 55% of all practising dentists, approximately 700 as specialists. Specialists receive patients from dentists in private practice, as well as from dentists in the Public Dental Service. All these dentists are salaried.

Besides the dental degree, the only formal qualification required to work in the public dental service is for specialists, who should have received recognised additional training.

The monitoring of dentists in the Public Dental Service is the same as that for dentists in private practice, except where services are provided free of charge.

The provision of domiciliary (home) care is not very common in Sweden, and is usually provided by public health dentists.

Working in Hospitals

In Sweden dentists work in hospitals as salaried employees of the counties. There are usually no restrictions on seeing patients outside the hospital. They provide conventional dental treatment to disabled or medically compromised patients. Dental treatment under general sedation and/or nitrous oxygen is also available but the sedation/anaesthesia cannot be performed by a dentist. For this, formal postgraduate training is required.

Working in Universities and Dental Faculties

Dentists work in universities and dental faculties, as employees of the university. They are allowed to combine their work in the dental faculty with part-time employment

elsewhere and, with the permission of the university, may work in private practice outside the faculty. Academic titles within a Swedish dental faculty are: *professor* (responsible for education and research), *associate professor* (teaching and research), and *assistant professor* (teaching). There are no formal age or training requirements, but most promotions are made on the basis of scientific research experience.

The time of a typical full-time faculty member of staff is spent 1/3 on teaching, 1/3 on their own patients, 1/3 on administration and research. The complaints procedures are as described above.

Working in the Armed Forces

2 dentists work full-time as staff officers in the Swedish Armed Forces.

Professional Matters

Professional associations

The Swedish Dental Association (SDA) has four member associations:

- the Swedish Association of Private Dental Practitioners,
- the Swedish Association of Public Dental Officers,
- the Swedish Association of Dental Teachers and
- the Swedish Association of Dental Students.

Through the membership in one of these associations, the dentist automatically gets a membership in the SDA as well. Almost 95 % of all active dentists in Sweden are members of the SDA.

	Number	Year	Source
Swedish Dental Association	7,005	2008	FDI

The SDA has, through a membership in the Swedish Confederation of Professional Associations (SACO), close links to other professional organisations in Sweden.

Ethics and Regulation

The SDA has formulated a number of ethical guidelines for the members. The guidelines are imbedded in the rules of the SDA and are formulated by the Association's highest decision-making body. The Swedish Association of Private Dental Practitioners has formulated an ethical code for their members.

As far as the relationship of the dentist with their employees and with other dentists is concerned, there are no specific contractual requirements between practitioners working in the same practice; however a dentist's employees are protected by the national and European laws on equal employment opportunities, maternity benefits, occupational health, minimum vacations and health and safety.

Fitness to Practise/Disciplinary Matters

If a patient complains, and the dentist cannot resolve the matter directly, there are two processes through which the issues may be considered. Local Boards for Private Practice (composed of dentists) and Local Boards for Public Dental Services (may consist of people from another profession than dentistry) is one way, and the Medical Responsibility Board (HSAN), on behalf of the National Board of Health and Welfare is the other.

Members of the Medical Responsibility Board are appointed by the government and must have special knowledge and insight into questions concerning healthcare. The person who submits the report concerning dental matters is always a dentist. The Medical Responsibility Board (HSAN) is the only authority that can apply sanctions. There are four alternative sanctions: an admonition, a caution, to keep the licence for a trial period or the licence is suspended. The most common reason for a dentist to lose his licence is illness - less common is crime and lack of skill.

An appeal against a decision made by the Medical Responsibility Board (HSAN) can be made to the County Court in Stockholm.

Data Protection

A new Patient Data Act was implemented from July 1st 2008. The new Act, which applies to all care providers regardless of who is the manager, regulates, among other things, such issues as the obligation to keep patient records, internal secrecy and electronic access within a care provider's operation, the disclosure of data and documents through direct access or by other electronic means, and national and regional quality registers. Moreover, there are amendments to, among other things, the secrecy legislation within the area of the health and medical care services.

Advertising

Advertising is regulated by law. A dentist cannot compare himself with other dentists nor say he is better than somebody else. Only basic information may be given in an advertisement. Advertising should be "reliable, impartial and accurate".

Dentists are allowed to promote their practices through websites but they are required to respect the legislation on Data Protection, Electronic Commerce and the Act of Marketing.

Insurance and professional indemnity

Liability insurance is compulsory for dentists. For dentists working in the Public Dental Service there is a national scheme. Insurance for private practitioners is provided by the Swedish Association of Private Dental Practitioners and by the producers' cooperative Praktikertjänst, for the dentists joined to Praktikertjänst. (The Praktikertjänst group is a private provider of healthcare, schools and welfare, with the owners themselves healthcare practitioners).

The liability insurance for the private practitioners provides financial support for the cost of further medical and dental treatment, compensation for loss of income, damages for pain and suffering, physical disability and injury and other inconveniences. A private dental practitioner currently pays annually between €180 to €582 (2008), according to his income, for this cover. The insurance is valid for dentist working only in Sweden.

Corporate Dentistry

Dentists are able to form limited liability companies. Non-dentists may fully or partly own these companies.

Tooth whitening

Tooth whitening products are not regulated as Medical products in Sweden. For tooth whitening products, classified as cosmetics, sold in retail trade the highest allowed limit for hydrogen peroxide is 0.1%. Although the regulation of products prescribes a maximum of 0.1%, products with higher limit of hydrogen peroxide are often sold in the retail trade because the companies expect new, less strict rules to come from the EU.

Health and Safety at Work

Inoculations are not compulsory for the workforce, but there is a general recommendation to undertake inoculations, such as Hep B.

Ionising Radiation

Using the most common X-ray machines (up to 75 kilovolt intraoral receiver) demands no regulatory permission. However, to operate the equipment, the dentist must fulfil obligations in the Swedish Radiation Protection Ordinance. Continuing education and training is not mandatory.

To be able to buy and use a panoramic x-ray the dentist needs to undergo further education. Panoramic x-rays and more advanced x-rays (more than 75 kilovolt intraoral receiver) must be registered.

The equipment must be operated by a dentist or be supervised by a dentist.

Hazardous waste

Amalgam separators are *required* by a national law, since January 1999. The requirement applies to all units or premises.

If waste is not disposed of according to national regulations the dentist is liable.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Swedish Radiation Protection Authority, SE-171 16 Stockholm
Electrical installations	The county authorities
Infection control	The National Board of Health and Welfare, SE-106 30 Stockholm
Medical devices	Medical Products Agency, P.O. Box 26, SE-751 03 Uppsala
Waste disposal	Swedish Environmental Protection Agency, SE-106 48 Stockholm

Financial Matters

Retirement pensions and Healthcare

People born before 1937 receive a supplementary payment according to the old rules, and those born between 1938 and 1953 receive part of the pension according to the new system and part according to the old system. Anyone born after 1954 will receive pensions according to the new system only. The new pension system will base payments on lifetime income and individuals contribute 18.5% of their pay.

The normal retirement age is between 65 and 67. A dentist is allowed to practice dentistry until the age of 70. There is also a disability pension (again from the Försäkringskassan) for those unable to work due to chronic illness or disability.

Taxes

National income tax:

The highest rate of income tax is about 58% on earnings over about €52,436 (2008) per year.

VAT/sales tax

VAT is 25% of the value of some types of goods, including dental equipment, instruments and materials. There are also reduced rates of 12% (on public transportation, hotels and provisions etc.) and 6% (on newspapers and cinema tickets).

Various Financial Comparators

Zurich = 100 Stockholm	2003	2008
Prices (excluding rent)	91.1	97.8
Prices (including rent)	88.1	92.9
Wage levels (net)	56.5	65.7
Domestic Purchasing Power	59.9	70.6

Source: UBS August 2003 & January 2008

Other Useful Information

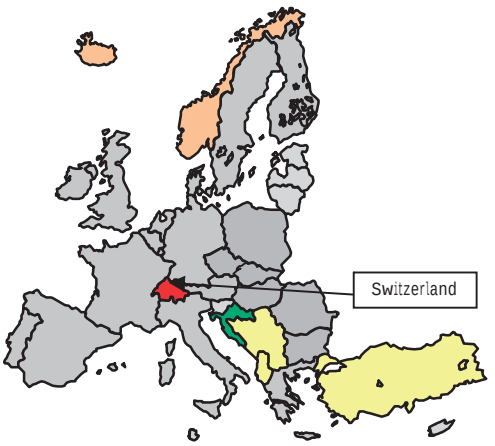
Main national associations and Information Centres:	
Swedish Dental Association *Sveriges Tandläkarförbund* PO Box 1217 S-111 82 Stockholm Tel: +46 8 666 1500 Fax: +46 8 662 5842 Email: kansli@tandlakarforbundet.se Website: www.tandlakarforbundet.se	The Swedish Association of Private Dental Practitioners *Privattandläkarna* Tel: +46 8 555 446 00 Fax: +46 8 555 446 66 E-mail: info@ptl.se Website: www.ptl.se
Association of Public Health Dentists In Sweden *Tjänstetandläkarföreningen* Tel: +46 8 545 159 80 Fax: +46 8 660 3434 E-mail: kansliet@stf-tt.org Website: www.stf-tt.org	
The Swedish Association of Dental Teachers *Per Tidehag* E-mail: per.tidehag@odont.umu.se	The Swedish Association of Dental Students Tel: +46 8 666 1500 E-mail: kansli@tandlakarforbundet.se
Publications: Journal of the Swedish Dental Association (*Tandläkartidningen)* and *Swedish Dental Journal* (the scientific journal of the SDA), *both at*: PO Box 1217 S-111 82 Stockholm, Sweden Tel: +46 8 666 1500 Fax: +46 8 666 1595 E-mail: redaktionen@tandlakarforbundet.se	*Competent Authority* The National Board of Health and Welfare *Socialstyrelsen* Rålambsvägen 3 S-106 30 Stockholm Tel: +46 75 247 30 00 Fax: +46 75 247 32 52 Email: socialstyrelsen@socialstyrelsen.se Website: www.socialstyrelsen.se

Dental Schools:[8]

Huddinge Karolinska Institutet Odontologiska Institutionen Box 4064 S – 141 04 Huddinge Tel: +46 8 524 800 00 Fax: +46 8 711 83 43 Email: info@ofa.ki.se Website: www.ki.se/odont/ Annual intake: approx 73 Dentists graduating each year: approx. 48 Number of students: approx. 329	Göteborg Göteborg University Odontologiska fakulteten Medicinaregatan 12 Odontologen, Göteborg Tel: +46 31 741 13 00 Fax +46 31 786 32 07 Email: info@odontologi.gu.se Website www.odontology.gu.se Annual intake: approx 64 Dentists graduating each year: approx. 48 Number of students: approx. 298
Malmö Malmö Högskola Odontologiska Fakulteten S-205 06 Malmö Tel: +46 40 665 84 28 Fax: +46 40 925 359 Email: does not exist Website: www..mah.se/od Annual intake: approx 54 Dentists graduating each year: approx. 38 Number of students: approx. 207	Umeå Institutionen för odontologi Umeå Universitet S-901 85 Umeå Tel: +46 90 785 0000 Fax: +46 90 770 580 Email: info@odont.umu.se Website www.umu.se/odont Annual intake: approx 56 Dentists graduating each year: approx. 32 Number of students: approx. 239

[8] Annual intakte likställs med "faktiskt antal nybörjare" i Tandläkarförbundets statistik

Switzerland



Date of last revision: 1st October 2008

Associate of the EEA	
Population (2008)	7,591,414
GDP PPP per capita (2006)	€33,962
Currency	Swiss Franc (CHF)
	1.60 CHF = €1
Main language	German, French, Italian

The main form of healthcare provision is mandatory insurance against the effects of diseases including accidents, which is provided by private insurance companies (Kassen). Patients, except those on low income, pay a basic annual fee of approx. CHF 3,000 (€1,950). Most oral healthcare is provided by independent private practitioners and paid for directly by individual patients.

Number of dentists:	4,500
Population to (active) dentist ratio:	1,687
Membership of SSO:	90%

Specialists are available and the use of clinical auxiliaries is extensive and well advanced.
Continuing education for dentists is mandatory, and non-participation can lead to lower fees for dental practitioners.

Government and healthcare in Switzerland

Switzerland is a completely landlocked country. The capital is Bern.

In Switzerland most public policy is organised at the *cantonal* level of regional government. Central government legislates in a Federal Parliament whose members are elected by proportional representation. If supported by substantial numbers in a petition, some laws must be approved by referendum.

The main form of healthcare provision is mandatory insurance against the effects of diseases including accidents. This insurance is provided by private insurance companies (*Kassen*), which are recognised by Federal Office for Social Insurance. The system is established by Federal Law, and is compulsory for everyone living in Switzerland, who pay a basic annual fee of approximately CHF 3,000 (€1,950). For those on low incomes the fee is reduced by up to 100%. The reduction is subsidised by Cantonal and Federal taxes and approximately 30% of the Swiss population are eligible. The government also reimburses the cost of treatment for patients on extremely low incomes by providing *Welfare* cover through local authorities.

Although the largest insurance companies have members nationwide, subscribers in different Cantons pay different contributions to reflect the varying demand and cost of healthcare in each area. The *Kassen* are not subsidised by Cantonal and Federal taxes. They are not allowed to make profits from the basic statutory insurance, but can benefit from any additional coverage, such as dental care. In addition to the main programmes for medical insurance and accident insurance, there are smaller health schemes of disability insurance and military insurance.

The insurance covers the cost of hospital care, drugs, specialist and general practitioner services. For primary medical care and some dental services a payment mechanism, the "franchise" system operates. Under this arrangement everyone pays up to 300 CHF (€195) per year towards their bills, and 10% of the cost of any treatments covered by the Health Insurance System, up to an upper maximum, CHF 700 (€455) in 2003.

		Year	Source
% GDP spent on health	11.3%	2006	OECD
% of this spent by governm't	60.3%	2006	OECD

Oral healthcare

Oral Health Services

Apart from a minority of dentists employed by hospitals or the school dental service, most oral healthcare is provided by independent private practitioners and paid for directly by individual patients. Unless dental treatment is necessary because of an accident, the medical insurance system only subsidises the cost when a patient has a prescribed disease and only 10-15% of care is eligible. Disability insurance entitles children and young adults aged up to 20 years, to any necessary treatment for a defined set of facial congenital abnormalities. Over the age of 20, the general medical insurance system provides cover for this group.

There is a dental service dedicated to children in Switzerland, provided by private practitioners and a small public service. The practitioners or the service receive government subsidies, and parents pay set fees for each item of treatment according to their income.

There is no reported any difficulty for patients to access the limited public health care.

It is estimated that regular patients normally visit their dentist for re-examinations every 6 to 12 months. About 90% of the population access dentistry in a 2-year period, and a dentist would normally have a "list" of between 2,000 and 3,000 regular patients.

		Year	Source
% GDP spent on oral health	0.12%	2004	SSO
% of OH expenditure private	99%	2004	SSO

Private insurance for dental care

In Switzerland, about 10% of the population are members of private insurance schemes which cover some dental care costs, especially orthodontics. All such schemes are personal and premiums are paid directly to the insurance companies which are self-regulating and bear all the financial risks. The level of the premiums is linked to the cover required, and the insurance company determines whether an entrant's oral health is good enough to join the scheme.

The Quality of Care

The standards of dental care are monitored by the insurance agencies and by dental councils within each *Kasse*. By law all treatment has to be appropriate, economical and 'evidence based'. However, there are no statistical checks on dentists whose treatment patterns exceed the average.

The only other control on the quality of care is through patient complaints.

Health data

		Year	Source
DMFT at age 12	0.90	2005	OECD
DMFT zero at age 12	No data		
Edentulous at age 65	No data		

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

There is no water or milk fluoridation, however there is extensive salt fluoridation. Consumed table salt contains fluoride as an additive.

Education, Training and Registration

Undergraduate Training

All the dental schools in Switzerland are publicly funded and are part of the Faculties of Medicine within the relevant universities. To enter dental school students must pass an examination for university ability. There is no other vocational type entry.

Year of data:	2007
Number of schools	4
Student intake	173
Number of graduates	126
Percentage female	45%

The course lasts 5 years - 2 years at the university learning the theory without any chairside work and 3 years combined university and practice.

The responsibility for quality assurance in the faculties is by the University board.

Qualification and Vocational Training

Primary dental qualification

The main degree which may be included in the register is the Swiss Federal Diploma for Dentistry. However, "fully harmonised" EU primary qualifications are also accepted.

Vocational Training (VT)

There is no post-qualification vocational training in Switzerland.

Registration

To register as a dentist in Switzerland, a practitioner must have a recognised diploma with a minimum of 5 years' study, evidence of 2 years' additional postgraduate experience and be able to demonstrate ongoing participation in continuing education. Applications must be made to the Federal Board (of the national government), but the registers are kept by each of the 26 Cantonal authorities. The additional dental experience can be earned in university clinics, public dental clinics and as a private practitioner.

There is no fee payable for registration.

Language requirements

The dentist must be able to speak German, French or Italian depending in which part of Switzerland they are going to work.

Further Postgraduate and Specialist Training

Continuing education

There is a minimum level of compulsory participation in continuing education, 10 days per year. If a dentist does not undertake this he/she may suffer a reduction of reimbursement by the social health insurance. Every year 10% of all dentists are checked; if they do not fulfil the requested time, the social insurance agency reimburses the dentist at a lower level.

Specialist Training

In Switzerland there are four specialties – orthodontics, periodontics, oral surgery and prosthetics are officially recognised by the SSO. Maxillo Facial surgery is recognised as a medical speciality, by the Swiss Medical Association.

- Orthodontics: 4 years training and exam, leading to the title - Fachzahnarzt für Kieferorthopädie
- Periodontics: 3 years training and exam, leading to the title - Fachzahnarzt für Parodontologie
- Prosthetics: 3 years training and exam, leading to the title - Fachzahnarzt für Rekonstruktive Zahnmedizin
- Oral surgery: 3 years training and exam, leading to the title - Fachzahnarzt für Oralchirurgie

Training is provided in dental university centres and at private specialists' practice. Examinations and registration are organised by Schweizerische Zahnärzte-Gesellschaft, in collaboration with the Swiss federal health office.

Workforce

Dentists

Year of data:	2008
Total Registered	4,500
In active practice	4,500
Dentist to population ratio*	1,680
Percentage female	22%
Qualified overseas	2,000

**active dentists only*

The total number of practitioners is stable. It was reported by the SSO that there were no unemployed dentists.

Movement of dentists across borders

There is (described by the SSO as) a large immigration of dentists into Switzerland, especially from Germany, France and Italy. The Swiss authorithy has recognised almost 2,000 diplomas from EU countries, which corresponds to about 45% of all dentists in Switzerland.

Specialists

Year of data:	2007
Orthodontics	260
Endodontics	
Paedodontics	
Periodontics	102
Prosthodontics	61
Oral Radiologists	
Oral Surgery	154
OMFS	
Dental Public Health	
Others	

There is no specific system for access to specialists and in most cases patients are referred by another dentist.

Auxiliaries

Other than dental chairside assistants, there are four types of dental auxiliary: Dental hygienists, Dental therapists, Dental technicians and Denturists (only recognised in 3 of 26 cantons)

Year of data:	2008
Hygienists	1,500
Technicians	2,200
Denturists	60
Assistants	5,500
Therapists	250

Dental Hygienists

Hygienist training is for 3 years at Hygienist School and there are four such colleges. They must hold a dental hygienist qualification and this has to be registered with the professional education department of the Swiss Red Cross.

Their duties include scaling and simple gum treatment and Oral Health Instruction, and the insertion of preventive sealants. In some cantons they are permitted to administer local anaesthetics.

Dental Hygienists are employed by private practitioners or the public dental service, and must work under the supervision of a dentist. In 13 cantons they may be self-employed and accept money from patients. But the working field is restricted and the patients are assigned by a dentist. Indemnity or insurance cover is not compulsory.

Dental Technicians

Technicians train for 4 years in dental technicians' laboratories. A federal registerable qualification is required in some cantons.

Dental technicians duties are the construction of prostheses and they are not allowed to work in the mouths of patients. They normally work in commercial laboratories and receive fees for appliances. A few work in practices for a salary.

Denturists

Denturists are permitted to work in private practice, but only in the cantons of Zurich, Nidwalden and Schwyz. They are only allowed to provide removable prostheses. They are not accepted for the provision of treatments covered by the health insurance.

They train under postgraduate modules for dental technicians and this requires an additional training period of 1,500 hours. The denturists have to register with the cantonal health department.

Dental Therapists

In Switzerland dental therapists are allowed to undertake simple operative treatments under the supervision of a dentist. In reality, the majority of the work they do is the removal of supragingival calculus, so their role is very similar to that of a dental hygienist. They are SSO-trained and are also registered with the association. Most work with dentists in private practices, although they are also employed in the public dental service. Self-employment is not permitted.

Dental Chairside Assistants

The training for a chairside assistant is 3 years, with a final examination for qualification. This education is federally recognised. They do not have to register. The average is 2.5 Chairside Assistants for every dentist.

Practice in Switzerland

Year of data:	2008
General (private) practice	4,050
Public dental service	180
University	240
Hospital	30
Armed Forces	0
General Practice as a proportion is	90%

Working in General Practice

Dentists who practice on their own or as small groups and who provide a broad range of general treatments are said to be in *Private Practice*. 40 to 50 per cent of dentists in private practice work in isolation from other dentists ("single-handed").

Most dentists in private practice are self-employed and earn their living through charging fees for treatments. Almost all are also contracted to treat patients under the social insurance system. This contract is established by the *santésuisse* which is a corporate body representing the health insurance companies. The contract includes a scale of fees, for a limited range of treatments, which must be applied for all work carried out within the social or medical insurance scheme. The dentist charges a patient according to the special rate, the patient then sends the invoice to the insurance company for reimbursement. Apart from the insurance premium, the treatment is therefore free for the patient.

However, even though the SSO signs the tariff contract on behalf of its members, dentists retain the right to treat patients outside the scheme where most care is provided.

Fee scales

The fee-scale incorporates both a points-system reflecting the relative cost of different treatments, and an established monetary value per point. The scale is calculated using the standard income, running expenses and level of service of a "standard practice". The "standard income" uses the principle that a dentist in private practice should earn approximately the same as one employed by the state and the expenses of a "standard practice" which is based upon a practice of a defined size, in terms of space and manpower. The standard rates of treatment are determined by a large survey of private surgeries and state-run dental clinics.

Under the health insurance agreement, prior approval for treatment may be required for more expensive forms of treatment. In contrast, for those patients who pay the whole cost of care themselves, the level of fees is set by each individual dentist. However, the SSO sets maximum prices for its members.

Joining or establishing a practice

Although premises can only be rented or owned by dentists, they can be located anywhere where there is sufficient demand for services. For SSO members the practice cannot be a limited company, and in certain Cantons dentists can only work as the sole owner of the business. There is no state assistance for establishing a new practice, and dentists must take out commercial loans from a bank.

There is no restriction on the opening of new practices, but recognition for health insurance is limited.

There are no specific contractual requirements between practitioners working in the same practice. A dentist's employees however are protected by the national laws on equal employment opportunities, maternity benefits, occupational health, minimum vacations and health and safety.

Working in the Public Clinics

In certain parts of Switzerland a small public dental service provides care for school children and some disabled people, usually free of charge.

The work of the public dental service is increasingly being undertaken by private practitioners. Usually the service is provided in school clinics or another public building. However, in some rural areas the service is contracted to private dentists in their own practices. Working in the public dental service requires no additional postgraduate training and there is no career structure.

Working in Hospitals

Dentists practise in hospitals either as salaried employees of the cantonal governments or on a fee-per-item basis. Working as *dentists* or *dental surgeons*, they provide dental care in the major hospitals at Bern, Basel, Geneva and Zurich where the dental schools are also located and in about twenty other hospitals. There are usually no restrictions on seeing other patients outside the hospital. Some doctors working in hospitals also carry out oral surgery. Hospital clinical employees and public officials are appointed by the Cantonal government.

Working in Universities and Dental Faculties

Dentists work in universities and dental faculties as employees of the university. If their contract allows, University dentists can work in private practice outside the faculty.

The main academic titles within a Swiss dental faculty are those of Ordinary Professor, Extraordinary Professor, Lecturer and Assistant and First Assistant to help instruct students. There are no formal requirements for postgraduate training but professors generally qualify by a process called *habilitation*. This requires a recognised research record and delivering a special lecture or seminar. Dentists who are professors through habilitation also become *faculty members*, on the permanent body of the university with tenured positions. As public employees the retirement age for professors is 65.

A typical full-time dental faculty member will spend most time (50%) on teaching, approximately 20% of their time on research, 15-20% on administration and the remaining 10-15% on seeing their own patients.

Epidemiological surveys are undertaken by the dental faculties.

Working in the Armed Forces

In 2003, no dentists served full-time in the Armed Forces.

Professional Matters

Professional associations

	Number	Year	Source
Société Suisse d'Odonto-Stomatologie	4,350	2008	FDI

There is a single main national dental association, the *Société Suisse d'Odonto-stomatologie* - or *SSO*, supported by a strong system of Cantonal Sections. The Sections have an important role in organising continuing education, and working with the Cantonal government to produce legislation. The *Liechtenstein Dental Association* is also a Section of the *SSO*.

About 90% of Swiss dentists are members of the SSO (2007).

Ethics and Regulation

Ethical Code

Dentists in Switzerland work within an ethical code which covers relationships and behaviour between dentists, contracts with patients, consent and confidentiality, continuing education, and advertising. This code is administered by the SSO and the cantonal governments. Cantonal laws cover some ethical aspects of practice, including advertising regulations and obligations to provide emergency out-of-hours services.

Fitness to Practise/Disciplinary Matters

If a patient is concerned about the treatment they have received they may complain to an ombudsman within their Canton. The Canton Section of the SSO will then set up a "supervision commission" to determine whether the treatment was appropriate, or the level of the cost. The sanctions which may be applied for complaints include financial penalties and warnings, and on rare occasions limitation of the right to practise. Rules relating to these sanctions vary from Canton to Canton.

Data Protection

Generally, Switzerland follows the EU Directive on Data Protection.

Advertising

Advertising is allowed providing it is open and the content is not misleading. There is no available information about rules relating to the use of websites.

Indemnity Insurance

Liability insurance is not compulsory for dentists but all have it. The insurance is provided by private insurance companies. A general practitioner pays approximately 2,000 CHF (€1,300) annually for this, although the sum depends on the level of coverage. However, this insurance does not cover dentists for working in other countries.

Corporate Dentistry

Dentists are allowed to form corporate bodies (companies). However, it is not required that Board members are dentists; the dentist has full clinical responsibility and he is also subject to official control/supervision.

Tooth whitening

The Swiss had not made decision (by 2008) whether tooth whitening was cosmetic or medicinal. However, products may only be applied by dentists or hygienists.

Health and Safety at Work

Dentists and those who work for them are recommended to be inoculated against Hepatitis B and later be checked regularly for sero-conversion. The employer usually pays for inoculation of the dental staff.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Private agency (for the national government)
Electrical installations	There are no regulations or laws concerning this
Waste disposal	Cantonal government
Infection control	Swiss Federal Office of Public Health
Medical Devices	Swiss Medic, a federal agency

Ionising Radiation

Training in ionising radiation is part of the undergraduate course. Whilst there is this special training once, there is no continuing training.

Radiation equipment must be registered.

Hazardous waste

Whilst the Swiss are not enacting the EU Directive, there are regulations to cover the disposal of clinical waste, including the installation of amalgam separators.

Amalgam separators have been required by law for many years.

Financial Matters

Retirement pensions and Healthcare

Pension premiums are paid at about 15 - 20% of earnings for national and professional schemes. Retirement pensions in Switzerland are typically 50 - 80% of a person's salary on retirement.

For the majority of the Swiss population accident insurance is paid for at about 1 - 1.5% of annual earnings, and for disease insurance coverage an individual would typically pay around 2,000CHF (€1,300) per year.

Ordinary retirement is 65; dentists are allowed to practice beyond this age.

Taxes

There is a national income tax, social security tax, and cantonal taxes. Social security tax is approximately 18% of salary. There is also a cantonal wealth and inheritance tax which is payable on certain types of earnings up to a level of 1%.

The top tax rate is at 40% and is levied to on incomes above approximately CHF 200,000 (€128,000).

VAT/sales tax

VAT is 7.6 % on some goods including most dental equipment and consumables. Costs for dental treatment are not subject to VAT.

Other Useful Information

Dental Association (and competent authority):	*Publications:*
Schweizerische Zahnärzte-Gesellschaft Société Suisse d'Odonto-stomatologie (SSO) Società Svizzera di Odontologia e Stomatologia Münzgraben 2 CH-3000 Bern 7 SWITZERLAND Tel: +41 31 311 76 28 Fax: +41 31 311 74 70 Email: sekretariat@sso.ch Website: www.sso.ch	Schweizer Monatsschrift für Zahnmedizin Postgasse 19 3000 Berne 8, SWITZERLAND Tel: +41 31 310 20 80 Fax: +41 31 310 20 82 Website: www.sso.ch
Details of information centre:	*Placement Service for dental professionals:*
Schweiz. Konferenz der kantonalen Gesundheitsdirektorinnen und -direktoren Speichergasse 6 PF 684 3000 Bern 7 SWITZERLAND Tel: +41 31 356 20 20 Fax +41 31 356 20 30 Email: office@gdk-cds.ch Wesite: www.gdk-cds.ch	Stellenvermittlung SSO Münzgraben 2 CH-3000 Bern 7, SWITZERLAND Tel: +41 31 311 67 32 Fax: +41 31 311 74 70 Email: jobs@sso.ch

Dental Schools:

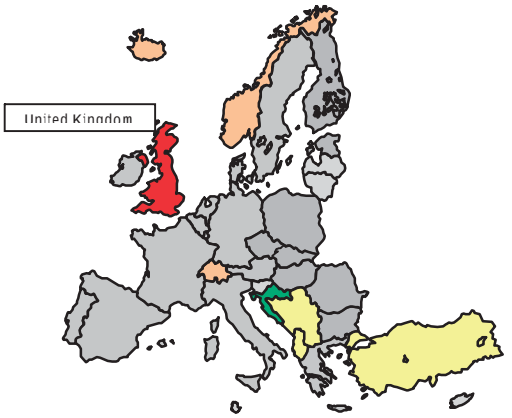
Geneva
Université de Genève
Faculté de Médecine
Section de Médecine Dentaire
19, rue Barthélémy-Menn, CH-1211 Genève 4
Tel: +41 22 379 40 13
Fax: +41 22 379 40 00
e-mail: firstname.name@medecine.unige.ch
website: www.medicine.unige.ch
Dentists graduating each year: 23
Number of students: 100

Basel
Universitätskliniken für Zahnmedizin
Hebelstrasse 3, CH – 4056 Basel
Tel: +41 61 267 25 84
Fax: +41 61 267 26 56
e-mail: firstname.name@unibas.ch
website: www.unibas.ch/zfz
Dentists graduating each year: 27
Number of students: 110

Zürich
Universität Zürich
Zentrum für Zahn-, Mund- und Kieferheilkunde
Plattenstrasse 11 Postfach, CH – 8028 Zürich
Tel: +41 01 634 33 11
Fax: +41 01 634 43 11
e-mail: name@zzmk.unizh.ch
website: www.zzmk.unizh.ch
Dentists graduating each year: 44
Number of students: 132

Bern
Zahnmedizinische Kliniken der
Universität Bern, Postfach 64
Freiburgstrasse 7, CH – 3010 Bern
Tel: +41 31 632 25 78
Fax: +41 31 632 49 06
e-mail: firstname.name@zmk.unibe.ch
website: www.dent.unibe.ch
Dentists graduating each year: 32
Number of students: 125

The United Kingdom



Date of last revision: 1st October 2008

In the EU/EEA since	1973
Population (2008)	61,185,981
GDP PPP per capita (2006)	€29,052
Currency	British Pound £ €1.25 = £1.00 (2008)
Main language	English Also Welsh & Gaelic

The National Health Service (NHS) is largely funded through general taxation and providing healthcare to all. Approximately 80% of NHS funds are from general taxation, with the balance coming from charges to patients for prescriptions, dental & optical care. About 40% of all primary dental care is paid from the state system and the balance is through patients' co-payments and fully private practice.

Number of dentists:	35,873
Population to (active) dentist ratio:	1,974
Membership of the Dental Association::	60%

Specialists are widely used and the use of clinical auxiliaries is well developed.
Participation in continuing education is mandatory for all registered dentists and dental auxiliaries, whether in clinical practice or not.

Government and healthcare in the UK

The United Kingdom of Great Britain and Northern Ireland is both a parliamentary democracy and a monarchy. Although the Queen plays a ceremonial part in the legislative process, the parliament is bi-cameral. The first chamber of locally elected members, the House of Commons, is the main forum for debating and changing government policies. The second chamber, the House of Lords, is a fully appointed one, a small proportion whose members are hereditary peers. It plays a significant part in the revision and passing of legislation. Politics in the UK is historically polarised between three main political parties: the Labour Party, Conservative Party and Liberal Democrat Party.

The Government is led by a Prime Minister with a cabinet of Ministers called Secretaries of State. Most Ministries with a seat in the Cabinet represent particular aspects of the economy such as Health or Business. Some powers, in particular health, have recently been devolved to varying degrees to an elected Parliament in Scotland and Assemblies in Wales and Northern Ireland. The UK's capital is London.

The UK has had a comprehensive *National Health Service* (NHS) since 1948, which is largely funded through general taxation and provides healthcare to all. Approximately 95% of NHS funds are provided by general taxation, with the balance coming from charges to patients for prescriptions, dental and optical care.

The amount of funding to the NHS is decided by the Parliaments and Assemblies. Policy is implemented by the Departments of Health in the four home countries and local health authorities based on municipalities in England (Primary Care Trusts – PCTs) and "regions" in the other three countries.

All forms of primary *medical* care services are free at the point of delivery, for all adults and children and there is a nationwide system of patient registration with general medical practitioners. These medical practitioners (*GPs*) also act as 'gatekeepers' to the rest of the NHS with most access to specialist and hospital services being via a GP referral.

Funding of NHS drug prescriptions, dental and optical services has gradually altered to the point where many in the population now pay a significant contribution to the cost of these services. Indeed, the effect of an increased expenditure by patients on private oral healthcare and the high proportion paid by them as co-payments, when obtaining treatment in the dental NHS, means that patients are funding directly about 60% of all spending on dentistry, with only 40% being funded by general taxation (*British Dental Association* estimate, 2007).

Both in terms of funding and population coverage, private health insurance is a small but growing part of medical healthcare.

		Year	Source
% GDP spent on health	8.3%	2005	OECD
% of this spent by gov ernm't	87.1%	2005	OECD

Oral healthcare

Oral healthcare in the UK is available from three distinct services. As with all other European countries, the majority of care is provided by non-salaried dental practitioners, working outside hospitals usually in privately owned premises. These *General Dental Practitioners* (GDPs), if they accept NHS patients, are part of the *General Dental Service*, which is locally coordinated by health authorities. There are different contractual arrangements in general dental practice in Scotland and Northern Ireland, from England and Wales.

England and Wales

In England and Wales, patients are not formally registered with their dental practice and appointments are technically given on a first-come-first-served basis. Patients pay one of four fixed charges relating to the treatment received, rather than a proportion of the treatment cost. These charges are reviewed annually; in 2007, they ranged from £16.20 for routine treatments such as check-up, scale and polishing, to £198 for complex treatment such as crown and bridgework.

Further details are in the "Practice" section, later.

Scotland and Northern Ireland

The bulk of payments to the GDPs are by fees for items of treatment, but some capitation fees, allowances and direct reimbursement of expenses also occur.

In Scotland, NHS patients may be treated under a 36 months contract, which can be "rolled" forwards, as 'registered patients' for *continuing care*, or for *occasional* (episodic) treatment. Only a limited range of treatments is available for occasional treatment.

Most patients who receive dental treatment under NHS terms from a GDP are charged a percentage co-payment of a set 'NHS fee' (currently 80%); there is also a maximum charge payable in one course of treatment (about €550 in 2008).

Across the UK

Specific groups may receive NHS dental care from a GDP without any patient charge, for example children under 18 years-old, pregnant or nursing mothers, individuals on welfare benefits, and those under 19 years old who are also in full-time education. Some NHS treatments, which are often provided by GDPs, are free of charges for all patients, such as domiciliary care for the housebound and repairs to dentures.

NHS charges are typically about half, or less, of those that would be paid privately.

Access to NHS dental care is difficult for patients in many parts of the UK and the four governments have opened "Access Centres", staffed by salaried GDPs and Public Health Dentists, which offer a variable range of clinical services, at normal NHS charge rates.

Access to a GDP is, in principle, available to all. However, many dentists will not accept everyone who wants to receive and pay for treatment under NHS terms. A large majority of dentists in the UK do have some commitment to the NHS, while only a few hundred only accept private fee-paying patients. Dentists contracted to provide care under NHS terms may provide as much or as little NHS care, and as much private care as they wish.

In reality about 50% of adults and 60% of children (aged 0 to 18 years) see GDPs for continuing care on an annual basis.

There is also a *Community Dental Service* (CDS). This provides public health dentistry by salaried dentists for groups who have poor access to other dental services, for example 'special needs' children and adults, and communities where there are few GDPs. They also provide dental public health and epidemiological support, for data collection.

Finally, dental care is also provided in most large general hospitals and all dental teaching hospitals. In the UK much specialist dental treatment is carried out within the Hospital Dental Service (HDS), usually after referral from a dentist in the general or community dental services. However, an increasing amount of specialist care is being provided in 'high street' practices, especially in oral surgery. Traditionally, the bulk of orthodontic care has been undertaken in general dental practices.

All dental services provided by hospitals and many services provided by the CDS are free.

All four services - the GDS, CDS, PDS and HDS are planned and coordinated at regional and local geographical level by health authorities and public "trusts". The services are purchased by the health authority from local healthcare providers usually under service contracts.

The level of NHS income for dentists working in the system is set by a quasi-independent committee, the Doctors' and Dentists' Review Body (DDRB), which makes annual recommendations on pay. The governments do not always follow the recommendations. Newly qualified dentists work as salaried Vocational GDPs, and are salaried at a national rate.

Many patients attend six-monthly for their routine re-examinations, but it is thought that less than 50% adults are now keeping to this timetable, because of improvements in oral health.

		Year	Source
% GDP spent on oral health	0.60%	2004	Manual
% of OH expenditure private	50%	2008	BDA

Private insurance for dental care

In the UK, less than 10% of people use private care plans or insurance schemes to pay for the cost of dental care. This can either be a separate policy or an extra to general medical cover.

Most private schemes are personal schemes, where individuals insure themselves by paying premiums directly to the company. The largest scheme (*Denplan*) is a pre-payment plan where participating dentists receive capitation payments *and* bear the financial risk of treatments provided. During the last few years general insurance companies have also begun to enter the market for dental care insurance.

Private care plans and insurance companies are self-regulating and set their own levels of fees. Generally the level of the premiums will be part of a standard scale for all members, but for personal care plans the company will usually only provide cover for those with good oral health.

The Quality of Care

The way in which standards of dental care are monitored depends on which service provides the care. NHS GDPs who receive payment through the NHS have their treatment statistics compared to national norms. A Dental Reference Officer (DRO) may investigate the treatment of one or a number of patients in a practice where the results are outside normal limits. Health authorities, if they receive complaints, may ask a DRO to examine patients. DROs also examine patients selected from any practice participating in the General Dental Service/Personal Dental Service.

Each NHS practice and clinic must have a complaints procedure. Any patient complaint must first be made to the dentist. If it is not possible to resolve the complaint through the practice procedure then the matter may be referred to the health authority. In Scotland and Northern Ireland serious complaints are dealt with through an NHS Disciplinary Committee. If they find a breach of regulations this may result in the dentist having to repeat the treatment, a withholding of fees, or removal from the list of dentists who may work in the NHS. In England and Wales a dentist can be removed from an NHS dental list if they do not provide care to a high enough standard. They may refer the matter to the General Dental Council (GDC), for professional conduct issues. The GDC may censure a dentist or remove the right to practise. There is a right of appeal against both health authority and GDC decisions.

For treatment undertaken within the hospital or community service there is a health service complaints procedure.

For treatment delivered outside NHS regulations, a Dental Complaints Service was set up in 2006. The service works by providing advice to patients and dental professionals. It is an arms-length organisation of the GDC. The website is www.dentalcomplaints.org.uk.

It is also possible for patients to seek redress through litigation independently.

Health data

		Year	Source
DMFT at age 12	0.80	2005	CECDO
DMFT zero at age 12	62%	2005	OECD
Edentulous at age 65	36%	2005	OECD

"DMFT zero at age 12" refers to the number of 12 years old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Fluoridation

Approximately 6 million people in the UK receive water in which the fluoride content has been adjusted to the optimum level for dental health of around one part of fluoride per million parts of water, or that has a naturally occurring fluoride level of around this level. This means that around one in ten of the total population of the UK is currently receiving water with a fluoride level that is capable of providing protection against tooth decay.

In some areas people drink water containing what can be described as a 'sub-optimal' natural fluoride content of between 0.3 and 0.7 parts per million. This is thought to offer some protection against tooth decay but is below the level at which the optimal benefit is obtained.

In some areas (for example parts of Essex, Wiltshire and Norfolk) naturally occurring fluoride levels can vary substantially between places and over time and it is very difficult to quantify this accurately.

In many areas of the UK, Primary Care Trusts and Boards have arrangements with dental practices and clinics for the distribution of fluoride containing toothpastes to children free of charge.

Dentists may also be contracted to provide fluoride varnishes to children, on a targeted basis, as part of their overall care.

Following a government announcement in early 2008 in support of water fluoridation, it is expected that local areas will consult over fluoridating water supplies in some areas of the UK where dental decay in children is prevalent.

Education, Training and Registration

Undergraduate Training

There are 14 UK dental schools, all part of medical faculties of state-funded universities. The newest school, in Aberdeen, Scotland, opened in September 2008.

To enter most dental schools a student must normally have passed at least 3 "A-level" science subjects studied at high school and because of the competition for places these would normally all have to be at the highest pass level. Three schools, two in England (Preston and Plymouth) and one in Scotland (Aberdeen) have an exclusively "graduate" intake – the students must have a primary degree, usually in a biological science. Liverpool and King's College London also have graduate programmes.

Students may have to pay a sum towards the costs of tuition, except in Scotland, for which they may claim a low-interest loan from the state – which is repayable after graduation when earnings have passed a minimum threshold.

Year of data:	2008
Number of schools	15
Student intake	1,063
Number of graduates (2007)	844
Percentage female	52%

Many of the schools have expanded their intake since 2004, so the number of graduates will increase from 2009.

Quality assurance

The responsibility for quality assurance of the courses in the schools is undertaken by the General Dental Council, who conduct a regular programme of visits to dental schools to check the content and quality of training in the undergraduate dentist and dental care professionals' courses.

Qualification and Vocational Training

Primary dental qualification

All the universities award a degree, Bachelor of Dental Surgery (BDS or BChD), upon graduation, although until the late 1960s most offered a diploma of Licentiate in Dental Surgery (LDS) as an alternative. LDS diplomas formerly awarded by the Royal Colleges of England, Edinburgh and Glasgow, have not been available since 2003.

Vocational Training (VT)

VT in the UK is post-qualification. Dentists may practise outside the NHS system without undertaking VT.

Registration

All dentists who wish to practise dentistry in the United Kingdom have to be registered with the General Dental Council (GDC). The GDC is the 'competent authority' and maintains the register of dentists as well as those on the specialist lists.

Cost of registration (2008)	€ 550

To register as a dentist in the UK, a qualified practitioner must present evidence of their recognised first qualification in an EU/EEA dental school, a letter of good standing from their current registering body (if qualification was outside the UK), a passport and a statement attesting to their good health.

EU nationals with non-EU degrees have the option of GDC assessment, in which their qualifications, skills, knowledge and experience are compared to that of a UK dentist at graduation. If the GDC feels that there is a lack in any area of this assessment of the candidate's equivalence, he/she will be required to sit the Overseas Registration Examination (ORE).

Language requirements

EU nationals are not required to pass an English test at registration level.

However, there is a requirement to pass an English language test (the IELTS or one of a list of other qualifications), at a set standard, for working in NHS general dental practice (see below).

Non-EU nationals are generally required to acquire IELTS and then pass the GDC's Overseas Registration Examination (ORE) before they can register.

Further Postgraduate and Specialist Training

Vocational Training (VT)

In order to practise in the NHS in the UK a dentist must normally complete a period of supervised vocational training, in a practice, public health clinic or hospital. GDP and Community VT are based on clinical practice for 4 days a week and day release courses for one day a week. A certificate of completion of VT must be obtained before independent, unsupervised practice is possible.

Graduates of non-UK EU dental schools are exempt from the VT requirement, although they may undertake this if they wish. Graduates from outside the EU are required either to undertake VT or, if they have substantial experience in general dental practice, to undergo 'competency training' (formerly called equivalence training). By arrangement with an employing practice, a Primary Care Trust (PCT) and the local postgraduate deanery, the dentist is given a set amount of time to work through a set of competencies, with the help and support of the practice owner. Only after completion of VT or competency training are dentists able to be included in a local performer list and thus allowed to treat NHS patients in practice.

In Scotland and Northern Ireland, dentists from outside the EU can be employed as assistants while being included in a supplementary list and working under a main list number of the practice principal, and after a set period of time (usually one year full-time or equivalent part-time) are able to show their equivalence and be included in a main list.

Continuing education

All dentists (including specialists, administrative and registered retired dentists) must participate in continuing education, of 250 hours in five years. This requirement is subdivided into 75 hours *verifiable* postgraduate education and 175 hours of general (informal) postgraduate education. Verifiable activity would include participation in courses, interactive distance learning, clinical audit, peer review – all of which must have defined learning objectives and outcomes. Since 2007 certain core subjects must be included in the verifiable activity – including radiation and infection control. Dentists must keep a record of their activity and certify compliance annually. The scheme is administered by the GDC.

NHS dentists participate in regular peer review and clinical audit as part of the mandatory continuing education. In Scotland NHS GDPs may claim allowances for loss of practice income, for attending courses.

There are two schools of postgraduate dentistry (London and Edinburgh) and also postgraduate institutes attached to many undergraduate schools.

Specialist Training

The training for all specialties takes place in recognised hospital, PCT or other health authority training posts, is supervised by the Medical Royal Colleges and lasts from 3 to 5 years, following a period of 2-year *general professional training* (which includes the year of VT). So, depending upon the specialty, it may take 5 to 7 years to become a recognised specialist.

The GDC administers lists of registered dentists who meet certain conditions and have been given the right by the GDC to use a specialist title. Two dental specialties, Oral Surgery and Orthodontics, are recognised by the EU but UK law allows the GDC to recognise any specialty where this would be justified in the interests of the public and the dental profession. The lists indicate the registered dentists who are entitled to use a specialist title, but do not restrict the right of any registered dentist to practise in any particular field of dentistry or the right of any specialist to practise in other fields of dentistry.

In the UK the following dental specialties are recognised in 2008:

- Oral Surgery
- Endodontics
- Orthodontics
- Periodontics
- Restorative dentistry
- Prosthodontics
- Dental Public Health
- Oral Medicine
- Paediatric dentistry
- Oral Microbiology
- Oral Pathology
- Dental and Maxillofacial Radiology

There are a number of degrees and diplomas associated with specialist qualifications, and these may be awarded by universities (such as Masters' degrees and Doctorates) and the Royal Colleges (such as Memberships and Fellowships).

Workforce

Dentists

Despite the fact that the workforce is slowly growing, there is a severe shortage of dental workforce in the UK in parts of the country. The reasons for this are complex, but the gender change towards more females qualifying as dentists, with part-time working may be a major factor. The four UK governments are applying varying measures to address workforce issues.

Year of data:	2008
Total Registered	35,873
In active practice	31,000
Dentist to population ratio*	1,976
Percentage female	40%
Qualified overseas	8,672

** active dentists only*

Despite the reported shortage of dentists mentioned above, there is some (small) reported unemployment amongst dentists in the UK especially immediately following qualification.

Newly qualified dentists are required to undertake vocational training in the NHS before they can work unsupervised (in the NHS) and whilst sufficient places are available across the UK, often the newly qualified dentists cannot, or do not wish to move to areas of availability.

Movement of dentists into and out of the UK

UK qualified	27,201
EU/EEA qualified	4,865
Qualified by examination	1,622
Qualified others	2,185

There has been a net inflow of dentist into the UK during the early part of this century – particularly from dentists moving to the UK from the new EU countries since 2004.

UK qualified	27,201
Irish	613
Swedish	957
Other EU/EEA	3,278
South African	1,420
Other overseas	2,404

Specialists

Some Specialists are known as Consultants and work in hospitals. However, Consultants in Dental Public Health are employed by Primary Care Trusts and other health authorities and a few work in teaching hospitals, which are part of the universities.

Many specialists now work in general practice, where they may restrict their services to their specialty – but may also undertake general dentistry, if they wish. However, when practising as a specialist it is usual to receive patients only by referral from general dental practitioners, or from other specialists. Most orthodontists now work out of hospital for part or all of their time – with hospital practice being increasingly reserved for exceptionally complex cases, including those needing surgical intervention.

Year of data:	2008
Orthodontics	1,158
Endodontics	187
Paedodontics	224
Periodontics	280
Prosthodontics	377
Restorative Dentistry	290
Dental Maxillo-facial Radiology	25
Oral Surgery	768
OMFS	220
Dental Public Health	116
Oral Medicine	82
Others	33

There are many associations and societies for specialists.

Auxiliaries (Dental Care Professionals)

In the UK, dental auxiliaries are known as Dental Care Professionals (DCPs). Other than dental nurses (chairside assistants), there are six types of dental auxiliary:

- Dental Hygienists
- Dental Therapists
- Orthodontic Therapists
- Dental Technicians
- Clinical Dental Technicians
- Oral Health Educators

All DCPs, except Oral Health Educators, have to be registered with the General Dental Council (or in a formal training programme) and are required to comply with the strict ethical guidance, as laid down by the GDC, including awareness of all regulations pertaining to the practice of dentistry. They have to undertake continuing professional development – DCPs must complete, and keep records of, at least 150 hours of CPD over five years. A minimum of 50 of these hours must be verifiable CPD. To be verifiable CPD, the activity must have concise educational aims and objectives, clear anticipated outcomes, quality controls and documentary proof of attendance/participation from an appropriate third party.

There is some illegal dental practice by non-registered persons, who are routinely prosecuted in the courts upon the instigation of the GDC.

Year of data:	2008
Hygienists	5,340
Technicians	7,094
Clinical Dental Technicians	93
Dental Nurses	40,665
Therapists	1,154
Orthodontic Therapists	10
Other	0
Total number of DCPs	51,951

Note: some DCPs are registered with more than one title, so the total is greater than the sum of the individual numbers.

Dental Hygienists

Dental hygienist training is usually for 24 or 27 months at dental hygiene school, normally in dental schools alongside dental students. To enter hygiene school a student usually needs to be a qualified dental nurse and may be required to have an "A-level". Upon qualification a diploma is awarded. Some schools, such as Dundee, have now extended the course to 3 years and a degree is awarded.

Dental hygienists may only work under the direction of a dentist, who must prepare a treatment plan, but need not be on the premises during treatment. Their duties were subject to a proscribed list (by the GDC) until 2003, but legislative changes mean that now their permitted duties depend upon the training they have undergone. They may:

- provide dental hygiene care to a wide range of patients
- plan the delivery of patient care to improve and maintain periodontal health
- obtain a detailed dental history and evaluate medical history
- complete periodontal examination and charting and use indices to screen and monitor periodontal disease
- provide preventive oral care to patients and liaise with dentists over the treatment of caries, periodontal disease and tooth wear
- undertake supragingival and subgingival scaling and root debridement, using manual and powered instruments
- use appropriate anti-microbial therapy in the management of plaque related diseases
- adjust restored surfaces in relation to periodontal treatment
- apply topical treatments and fissure sealants
- provide smoking cessation advice for patients
- take, process and interpret various film views used in general dental practice
- give infiltration and inferior dental block analgesia
- place temporary dressings and re-cement crowns with temporary cement
- take impressions
- identify anatomical features, recognise abnormalities and interpret common pathology, and carry out oral cancer screening and make appropriate referrals to other healthcare professionals
- Placing rubber dam
- Carry out resuscitation

Additional skills which a dental hygienist might develop during their career:

- tooth whitening to the prescription of a dentist
- prescribing radiographs
- administering inhalational sedation
- suture removal after the wound has been checked by a dentist

Dental hygienists do not:

- diagnose disease
- restore teeth
- carry out pulp treatments
- adjust unrestored surfaces or
- extract teeth

Hygienists would normally be salaried when working in hospitals and clinics, but would be paid per hour or even as a share of fees earned in general practice. Earnings for a full-time hygienist are dependent on the type of working environment, general practice offering higher sums. Some hygienists own dental practices, in which they employ one or more dentists.

Dental Therapists

Dental therapist training is now a different arrangement of courses, depending upon the school attended by the trainee and the qualification for entry. Entry often requires the student to have an A-level or 6 or more GSCEs. In most schools dental therapy training is for 27 months full-time alongside dental students. They also train as hygienists at the same time. Some schools have now extended the course to 3 years and a degree is awarded.

In addition, some of the schools now hold "conversion courses" of 6 to 12 months (depending upon whether this is full or part-time), for hygienists to re-train as dental therapists. In 2004 two dental therapy schools opened (in Salford and Portsmouth) which allow entry for qualified dental nurses without A-levels, who attend a 6-months' foundation course first.

Upon qualification a diploma (or degree) is awarded. They must be qualified to register with the GDC, which they must do before they can practise. Their type and amount of earnings is similar to hygienists.

Dental therapists do not carry out initial diagnosis or take overall responsibility for planning a patient's treatment. The dentist must prepare a treatment plan but need not be on the premises during treatment.

Dental therapy covers the same areas as dental hygiene, but dental therapists also:

- carry out direct restorations on permanent and primary teeth
- carry out pulpotomies on primary teeth
- extract primary teeth
- place pre-formed crowns on primary teeth
- plan the delivery of a patient's care

Additional skills which dental therapists could develop during their careers:

- administering inhalational sedation
- varying the detail of a prescription but not the direction of a prescription
- prescribing radiographs
- tooth whitening to the prescription of a dentist
- suture removal after the wound has been checked by a dentist

Therapists are able to work in any sphere of practice.

Orthodontic Therapists

This is a new class of DCP and the first 10 registered in August 2008. The first courses (leading to qualification) started in July 2007.

The training, which is a minimum of a year and leads to a diploma, is being offered by six universities – Bristol, Cardiff, Edinburgh, Leeds, Manchester and Warwick. Entry on to the course is open to qualified dental nurses, hygienists and therapists and dental technicians with appropriate clinical experience.

An orthodontic therapist can deliver a range of treatments within the scope of their role:

- clean and prepare tooth surfaces ready for orthodontic treatment
- identify, select, use and maintain appropriate instruments
- insert passive removable orthodontic appliances
- insert active removable appliances adjusted by a dentist
- remove fixed appliances, orthodontic adhesives and cement
- take impressions
- pour, cast and trim study models
- make a patient's orthodontic appliance safe in the absence of a dentist
- fit orthodontic headgear
- fit orthodontic facebows which have been adjusted by a dentist
- take occlusal records including orthognathic facebow readings
- place brackets and bands
- prepare, insert adjust and remove archwires
- give advice on appliance care and oral health instruction
- fit tooth separators
- fit bonded retainers
- make appropriate referrals to other healthcare professionals
- carry out resuscitation

Additional skills which orthodontic therapists could develop during their career:

- applying fluoride varnish to the prescription of a dentist
- repairing the acrylic component of orthodontic appliances
- measure and record plaque indices and gingival indices
- suture removal after the wound has been checked by a dentist.

Orthodontic therapists do not:

- remove *sub-gingival* deposits
- give local analgesia
- re-cement crowns
- place temporary dressings or
- place active medicaments

They cannot diagnose disease, treatment plan or activate orthodontic wires, as these areas are reserved to dentists.

Dental Technicians

Training as a dental technician is provided by 11 Universities and Colleges, leading to a diploma/certificate (*BTEC* - Business and Technician Education Councils, *Scotvec* in Scotland) or degree (Birmingham, Liverpool, London and Nottingham colleges offer a Foundation Degree Dental Technology programme). Basic training would normally be 4 years, with an additional up to 2 years for more specialised work.

They must be qualified to register with the GDC, which they must do before they can work independently. Their type and amount of earnings is unknown. Dental Technicians are permitted to produce dental technical work to the prescription of the dentist, but cannot work in the mouth. They may:

- review cases coming into the laboratory to decide how they should be progressed
- work with the dentist or CDT on treatment planning and outline design
- design, plan and manufacture a range of custom-made dental devices according to a prescription
- repair and modify dental devices
- undertake shade taking
- carry out infection control procedures to prevent physical, chemical and microbiological contamination in the laboratory
- keep full and accurate laboratory records
- verify and take responsibility for the quality and safety of devices leaving a laboratory
- make appropriate referrals to other healthcare professionals

Additional skills which dental technicians could develop during their careers:

- working with a dentist in the clinic assisting with treatment by:
  - taking impressions
  - recording facebows
  - intra-oral and extra-oral tracing
  - implant frame assessment
  - recording occlusal registrations
  - intra-oral scanning for Cad Cam
  - helping dentists with fitting attachments at chairside
- working with a Clinical Dental Technician (CDT) in the clinic assisting with treatment by:
  - taking impressions
  - recording facebows
  - intra-oral and extra-oral tracing
  - recording occlusal registrations
  - tracing cephalographs
  - intra-oral photography

Dental technicians do not:

- work independently in the clinic
- perform clinical procedures related to providing removable dental appliances
- undertake independent clinical examinations
- identify abnormal oral mucosa and related underlying structures
- fit removable appliances

They are permitted to undertake denture repairs directly for the public, provided that they do not need to work in the oral cavity. Historically, they worked in a laboratory alongside dental practices, as employees of dentists, but by 2008 this has become very rare – most now work in commercial dental laboratories which charge fees to dentists, PCTs or other health authorities. Some work as salaried employees in hospitals.

Clinical Dental Technicians (CDTs)

Until 2008 there were no courses available wholly within the UK to achieve this qualification. The course by the George Brown City College in Canada matches the requirements of the GDC's curriculum but is not recognised, in full, as a registerable qualification as it is awarded from outside the EU. However, the Faculty of General Dental Practice (http://www.fgdp.org.uk/) has accredited this diploma and awards their own diploma to George Brown College graduates, by a process of accredited prior learning. The FGDP diploma is a registerable qualification for CDTs and currently only those holding the George Brown College qualification are able to access this accreditation.

In July 2008 it was announced that the first UK-based course will commence at the Edinburgh Dental Institute later in 2008.

Clinical dental technicians specialise in the manufacture and fitting of removable dental appliances directly to patients. The main type of work they undertake is in the provision of dentures. They are able to provide complete dentures to edentulous patients independently of other members of the dental team. Currently, they can provide partial dentures as long as the patient has been seen by a dentist who has

issued a certificate of oral health and a treatment plan. So, they may:

- take detailed dental history and relevant medical history
- perform technical and clinical procedures related to providing removable dental appliances
- undertake clinical examinations
- take and process radiographs and other images related to providing removable dental appliances
- distinguish between normal and abnormal consequences of ageing
- recognise abnormal oral mucosa and related underlying structures and make appropriate referrals
- fit removable appliances
- provide appropriate advice to patients

Additional skills which a CDT could develop during their career:

- oral health education
- provide sports mouthguards
- re-cement crowns with temporary cement
- provide anti-snoring devices on prescription of a dentist
- remove sutures after the wound has been checked by a dentist

They must be qualified to register with the GDC, which they must do before they can work independently. Their type of earnings is unknown and they are subject to similar disciplinary procedures as other DCPs.

Dental Nurses

Dental nurses work at the chairside to assist dentists. In the UK they are usually responsible for infection control and are often called upon to write patient records.

Education and training will often be undertaken informally initially by the employing dentist, but there is an extensive range of educational establishment which offer off-site education, in colleges and schools, typically as "day-release" for one day a week, or as evening courses, which the trainee dental nurse must undertake.

There are established qualifications, following a final examination, under an Examination Board (www.nebdn.org), or as vocational qualifications (NVQ and SVQ) accepted by a national accrediting body. Qualified dental nurses must register with the GDC to enable them to work with dentists and they are subject to the same continuing education requirements and disciplinary procedures as other DCPs. Their duties include:

- prepare and maintain the clinical environment, including the equipment
- carry out infection control procedures to prevent physical, chemical and microbiological contamination in the surgery or laboratory
- record dental charting carried out by other appropriate registrants
- prepare, mix and handle dental materials
- provide chairside support to the operator during treatment
- maintain full, accurate patient records
- prepare equipment, materials and patients for dental radiography
- process dental radiographs
- monitor, support and reassure patients
- give appropriate advice to patients
- support the patient and their colleagues in the event of a medical emergency
- carry out resuscitation
- make appropriate referrals to other health professionals

Additional skills which dental nurses could develop during their careers:

- further skills in oral health education and oral health promotion
- assisting in the treatment of patients who are under conscious sedation
- further skills in assisting in the treatment of patients with special needs
- intra-oral photography
- shade taking
- placing rubber dam
- measuring and recording plaque indices
- pour, cast and trim study models
- suture removal after the wound has been checked by a dentist
- constructing occlusal registration rims and special trays
- repair the acrylic component of removable appliances
- tracing cephalographs

Additional skills on prescription:

- taking radiographs to the prescription of a dentist
- applying topical anaesthetic to the prescription of a dentist
- applying fluoride varnish to the prescription of a dentist
- constructing mouthguards and bleaching trays to the prescription of a dentist
- impressions to the prescription of a dentist or a CDT (where appropriate)

Dental nurses do not diagnose disease or treatment plan. All other skills are reserved to one or more of the other registrant groups.

Oral Health Educators

Oral Health Educators give advice to individuals or groups on oral health care. This takes place in any setting, with or without the supervision of a dentist. There are diplomas available but there is no registerable qualification for oral health educators. They are often general teachers who have changed careers, or dental nurses who have undertaken additional training.

Practice in the United Kingdom

Year of data:	2008
General (private) practice	24,000
Public dental service	1,800
University	400
Hospital	2,000
Armed Forces	210
Administrative	250
General Practice as a proportion is	77%
Number of general practices	11,000

To be able to work in unsupervised practice in the NHS all dentists need to demonstrate that they understand English. They have to undertake an examination (IELTS) and receive a certificate which indicates that they have achieved a score of at least "6" in each of the four, separate modules (listening, speaking, academic reading and academic writing).

Also, there are requirements to declare that they have had no criminal convictions *anywhere in the world* which has led to a prison sentence of more than 6 months. Two clinical references must be obtained.

Working in General Practice

In the UK dentists who practise on their own or as small groups, outside hospitals or schools, and who provide a broad range of general treatments are said to be in *General Practice*. It is estimated that there are about 11,000 practices in the UK. Practitioners work without another dentist in the same practice in about a third of practices. However, most practices have two or more dentists working together with dental hygienists and/or dental therapists. These are known as "group practices".

Some practices are owned and run by clinical dental technicians, to provide dental protheses to patients. However, these practices are not yet able to obtain contracts to provide NHS care. Clinical dental technicians must work to the prescription of a dentist unless they are providing full sets of dentures to edentulous patients.

Most dentists in general practice are self-employed and earn their living partly through charging fees for treatments and partly by claiming payments from the government. A growing number of dentists in general practice accept only private fee-paying patients, but this was still thought to be less than 20% of all GDPs in 2008.

England and Wales

The general practice system for payments to dentists is based on a fixed annual sum (a Contract Value) being paid to each practice (to a "provider"), divided into 12 equal monthly payments. This sum is to cover all expenses connected with the delivery of oral healthcare to patients and the income of all the dentists ("performers") and dental care professionals and other staff in the practice. Associated with this is a "target" of activity (Units of Dental Activity or UDAs) which the practice has to produce in the year. Failure to achieve the target may lead to a clawback of funds paid and a reduced contract value the following year.

For practices which were open on April 1st 2006 and were offered a contract, the Contract Value was based on their activity in the 12 months from October 1st 2004 to September 30th 2005 – uprated by inflation. The number of UDAs was supposed to be based on an analysis of their activity during the same period, but many dentists believe that the figures produced were flawed.

Other payments may be made as direct allowances, especially for additional services that are not included in the normal Contract Value (such a sedation services).

Scotland and Northern Ireland

There is a prescribed NHS fee scale with defined contributions from the government and the patient. Prior approval for treatment, from a central authority (the Practice Services (Dental) Division or Central Services Agency respectively), is required for complex treatment which costs more than €570, orthodontics for adults and some other treatments.

In addition there are allowances for various items such as a basic practice allowance, seniority, continuing education etc.

The United Kingdom

For private patients who pay the whole cost of care themselves, there is no restriction upon the fees charged. Private insurance schemes are described earlier.

There are no specific contractual requirements between practitioners working in the same practice. Draft contracts are available from the BDA and other similar organisations and form the basis for such arrangements. This is particularly important as most of these arrangements are on a self-employed basis, which provides for no or very limited employment rights. A dentist's employees however are protected by the national and European laws on employment rights, equal employment opportunities, maternity benefits, occupational health, minimum vacations and health and safety.

Joining or establishing a practice

There are no stated regulations which specifically aim to control the location of dental practices. A dental practice which does not intend to work within the NHS may be opened anywhere, subject to local planning laws.

For sedation services, and for a new practice, the PCT or local health authority has the right to inspect the premises first (before first opening) to ensure compliance with health and safety regulations. Any type of building may be used which fulfils the legislative claims to dental practice. There are also no rules which limit the size of a dental practice in terms of the number of associate dentists or other staff. Premises may be rented or owned. There is little state assistance for establishing a new practice, so dentists usually negotiate commercial loans from a bank.

Dentists starting in practice usually work for a general practitioner as an associate, provided they have completed VT. They then either buy into that practice or purchase their

own. Traditionally, dental practices were opened in converted private homes and above shops, but increasingly practices can now be found in ground floor, modern-fronted "high street" shops, shopping malls and purpose built clinics.

Dental practices may only be owned by GDC registrants (but see Corporate Dentistry). However, widows or widowers may continue to own a dental practice for up to three years after their spouse's death.

To participate in NHS general practice a dentist must also have evidence of indemnity insurance, and a practice address, when they apply to the local health authority to be included in their list of dentists.

NHS General Dental Practitioners see on average about 160 patients a week and have about 2,500 patients on their NHS "list". Typically they also have a few fully private patients.

A GDP who is fully private would see about 100 patients a week. BDA figures show that an increasing number of dentists are increasing the proportion of their practices to provide private-only care, independent of the NHS.

England and Wales

All practices with a contract on March 31st 2006 were allowed to join the "new" NHS.

However, for providers wishing to open a practice offering NHS care who did not have a contract on March 31st 2006 the potential provider of services must bid for any available funding to open in the preferred locality. Whether they receive funding is subject to available funds and (in theory) a local needs assessment by the PCT.

Scotland and Northern Ireland

There are no regulations which prevent an NHS practice opening anywhere (subject to local planning laws) but practice allowances may not be available. Indeed, there are incentive schemes to persuade dentists to open practices in certain areas.

Working in the Public Clinics

The public dental service is known as the Community Dental Service (or Salaried Primary Dental Care Service) and mostly provides care for children, domiciliary care, treatment for people with disabilities and for those who have problems receiving dental care from another source. The service employs dentists as *clinical dental officers, senior dental officers or dental service managers* and the size is reducing. Working in the Community Dental Service requires no formal postgraduate training but promotion is usually given to those who have additional qualifications. A high proportion dentists working in the community dental service are female.

Increasingly public health dentistry is being offered through the Personal Dental Services (see above), where access to NHS dentistry is perceived by the health authorities to be problematic.

The monitoring of dentists in the public dental service is usually within guidelines prescribed by the health authority. All dental staff are required to participate in clinical audit. The complaints procedures are the same as those for dentists working in other settings, as already described.

Working in Hospitals

Dentists who work in hospitals are salaried employees of NHS Trusts. Hospital dentists may treat patients outside the hospital with the agreement of their employer, if they work part-time and there are no earnings restrictions.

Dentists work as hospital consultants, associate specialists or in staff grade positions. There are career grade posts and there are also junior training grade posts – for example, house officer or specialist registrar. In order to be promoted to a consultant it is necessary to follow a formal specialist training pathway, as described above. To be offered a post in maxillo-facial surgery normally requires a medical qualification in addition to any dental qualification.

Dentists in the service are monitored through clinical audit and by the Faculties of the Royal Surgical Colleges. All hospital dentists are required to participate in clinical audit.

Working in Universities and Dental Faculties

Again, the dentists who work in university dental faculties are employees. Private practice is often restricted and dentists need to negotiate this right with their employer. However, many Community dentists and GDPs work part-time as lecturers.

The main academic title within a UK dental faculty is that of university professor, supported by senior lecturer and lecturer. Dental academics in the UK hold an academic title but also an honorary hospital title. For promotion a dentist must undergo clinical specialist training as well as academic training usually by obtaining a PhD, or Master's degree and publishing their work. There are no other regulations or restrictions on the promotion of dentists within faculties. Academic dentists spend approximately 60% of their time on clinical duties and the remainder on teaching, research and administration.

Working in the Armed Forces

In 2008, about a third of the full-time dentists in the Armed Forces were female.

Number of dentists in 2008:

Army	121
Royal Air Force	47
Royal Navy	42

Professional Matters

Professional associations

The main dental organisation for dentists in the UK is the *British Dental Association* (or *BDA*).

	Number	Year	Source
British Dental Association	20,680	2008	BDA
Dental Practitioners Association	2,500	2008	DPA

About 60% of active dentists are members of the BDA. As well as being a professional association it is also the trade union for dentists, being responsible for negotiations with the four UK governments on terms and conditions of service for dentists working in the NHS. It is also a scientific society. There are four professional branches each headed by a central committee, for General Dental Practice, Hospital Dental Services, Community and Public Dental Services and Clinical Academic Staff. The BDA also has an extensive structure of regional branches and local sections.

There are also some other, smaller general practitioner associations and scientific interest groupings (besides the specialist societies).

Ethics and Regulation

Ethical Code

Guidance on most aspects of professional behaviour is contained in a series of guidance documents produced by the registration body, the *General Dental Council* (GDC). The guidance includes the contracts with patients, consent and confidentiality, continuing education and advertising. This code is administered by the GDC. Guidance and advice on relationships and behaviour between dentists, and between dentists and their staff, is provided by the BDA and the other associations.

Fitness to Practise/Disciplinary Matters

The GDC is the main disciplinary body for dentists in the UK, through a Fitness to Practise Panel (FTPP) of over 70 people (including dentists, DCPs and non-dentists) who form panels for Professional Conduct, Health Matters, Re-registration and Performance Review.

Hearings are conducted as a court of law, with (usually) lawyers conducting the case for the "prosecution" and "defence" and witnesses called. The panel is assisted by legal counsel. Upon the recommendation of a FTPP panel a dentist who has an "Impairment to Practise" may be admonished, put on probation, suspended, or erased from the register and therefore lose the right to practise – depending upon the severity of the misdemeanour.

There is a right of appeal to the Courts.

Data Protection

The provisions of the various Data Protection Regulations are taken seriously in the UK and all dentists have to comply with these. Annual notification to the Information Commissioner (at €50 per year) is compulsory for all practising dentists who keep records on computer.

Advertising

A dentist may only use publicity or advertising material that is legal, decent, honest, truthful and has regard for professional propriety. They may advertise in newspapers, magazines, on the radio and TV. All advertisements and printed material must include the name of at least one dentist normally in attendance at the practice in question. Publicity or advertising material should not be of a character which could bring the profession into disrepute. It should not make a claim that is not capable of substantiation nor suggest superiority over any other dentist or practice and it should not contain any reference to the efficiency, skills or knowledge of any other dentist or practice.

Dentists may use websites to publicise their practices and the BDA has advised its members about the need to follow the guidelines set out by the CED, following the enactment of the Directive on Electronic Commerce in 2001.

Indemnity Insurance

Liability insurance is compulsory for all dentists working in the NHS. Professional indemnity insurance is provided by *Dental Protection Ltd*, the *Dental Defence Union*, and the *Medical and Dental Defence Union of Scotland* and some commercial companies. They provide cover for advice, legal costs and virtually unlimited indemnity. There are different prices for different types of dentists, but a full-time general dental practitioner pays approximately €1,950 annually (€2,150 for those who own a practice – with the extra responsibilities).

The indemnity may cover the dentist for working overseas.

Corporate Dentistry

Until 2006, only dentists were able to own dental practices. Under new regulations, all GDC registrants can own practices and can also incorporate. Some are owned by external commercial organisations (*bodies corporate*). There are several large chains of bodies corporate, which trade on the stock market, and own upwards of 300 practices each. Many dentists in group practices have found it financially advantageous to incorporate and occasionally dental care professionals who own practices have done the same.

Nevertheless, in all cases the majority of directors currently must be dentists or dental care professionals.

Tooth whitening

A House of Lords judgement in June 2001 confirmed that tooth whitening agents were covered by the EU Cosmetics Directive (implemented by the UK Cosmetic Products (Safety) Regulations 1996), and not by the Medical Devices Directive. This means that it is a criminal offence to supply products with more than 0.1% hydrogen peroxide or compounds that release it. Tooth whitening agents typically contain 3.6% hydrogen peroxide.

Since 2007 it has been the General Dental Council's view that applying materials and carrying out procedures designed to improve the aesthetic appearance of teeth amounts to the practice of dentistry and should only be

carried out by a registered dentist. So too does the giving of clinical advice about such procedures. Anyone who practises dentistry illegally risks being prosecuted by the GDC in the criminal courts.

Health and Safety at Work

Dentists and those who work for them must be inoculated against Hepatitis B and later be checked regularly for sero-conversion. The employer usually pays for inoculation of the dental staff, although in many parts of the UK this is now provided free of charge by the Occupational Health Services of the local health authorities.

Ionising Radiation

Dental practices are subject to the Ionising Radiation Regulations 2000. Dentists and dental care professionals learn about ionising radiation as part of their initial training. Once in practice they must update their knowledge by undertaking further training in every subsequent 5-year period. Only a fully trained person is permitted to take radiographs in a dental practice. Dentists are encouraged to undertake regular audit of the quality of their radiographs.

There are also rules about the practice establishment. Dental equipment has to be sited, used and maintained subject to local rules relevant to the particular practice layout. Certificates of compliance must be displayed and regular inspections are carried out.

Hazardous waste

Clinical waste is considered 'hazardous' under the *Hazardous Waste (England & Wales) Regulations 2005*. Similar regulations cover Scotland and Northern Ireland. As such clinical waste has to be collected by a licensed company along with appropriate documentation including waste descriptions and the relevant waste codes. Clinical waste will either be incinerated or rendered safe before final disposal.

The regulations also mean that all waste dental amalgam is now classified as hazardous waste and, as such, discharge to sewer is not allowed. To comply with the regulations dental practices (both existing and new) require amalgam separation units to be installed and ensure the amalgam collected is disposed of in accordance with the regulations.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Health and Safety Executive at local level
Electrical installations	Health and Safety Executive at local level
Waste disposal	Health and Safety Executive at local level
Medical devices	Medical Devices Agency
Infection control	Local health authorities

Financial Matters

Retirement pensions and Healthcare

Dentists who work in the NHS are usually members of the NHS superannuation scheme, a retirement pension scheme. The dentist contributes between 5% and 8.5% of net income (after practice expenses) and the NHS 14.2%, to produce a retirement fund (which is uprated each year, for inflation). After 40 years they can take a pension based on 1/80th of the fund (if they have been in practice) or if a salaried dentist in a hospital or community setting a proportion of their final salary. They can retire earlier than this, from the age of 50 or from 55 after 2010, at a reduced pension. There is a similar but independent arrangement for University staff who are members of the University Superannuation Scheme.

Dentists working outside the NHS are responsible for their own pension and contribute to private pension schemes where the final payment is dependent upon the amount of money saved.

The normal retirement age in the UK is 65, although NHS general practitioners can carry on as practice owners until they are 70. Dentists working as assistants (or "performers") in the NHS and/or in private practice have no fixed retirement age.

Taxes

There is a national income tax (dependent on salary), and a local council tax.

Basic tax is 20% of income which is above a personal allowance of approximately €7,000. A higher rate of tax of 40% is levied on income above approximately €60,000. National Insurance payments are also made (at a further 10% of income to about €60,000 and 1% on all income thereafter).

VAT/sales tax is 17.5%, which is payable on all equipment, instruments and materials. There is a reduced rate of 5% for certain items such as energy costs.

Various Financial Comparators

Zurich = 100	London 2003	London 2008
Prices (excluding rent)	97.6	104.7
Prices (including rent)	111.4	123.0
Wage levels (net)	63.9	78.4
Domestic Purchasing Power	63.6	63.7

(Source: UBS August 2003 & January 2008)

Other Useful Information

Main national association: British Dental Association 64 Wimpole Street London W1G 8YS UK Tel: +44 20 7563 4563 Fax: +44 20 7487 5232 E-mail: enquiries@bda.org Website: www.bda.org	*Competent Authority and official information centre:* General Dental Council 37 Wimpole Street London W1M 8DQ UK Tel: +44 20 7887 3800 Fax: +44 20 7224 3294 Email: Information@gdc-uk.org Website: www.gdc-uk.org
British Society for Dental Hygiene and Therapy Email: enquiries@bsdht.org.uk Website: www.bsdht.org.uk *British Association of Dental Therapists* Email: badtadmin@badt.org.uk Website: www.badt.org.uk *The Clinical Dental Technicians' Association* Email: info@cdta-online.co.uk Website: www.cdta.org.uk/	*British Association of Dental Nurses* Email: admin@badn.org.uk Website: www.badn.org.uk *The Dental Technicians' Association* Email: info@dta-uk.org Website: www.dta-uk.org
The BDA produces a wide range of *Advice Sheets* on aspects of practice management, health and safety, finance, ethical and legal matters and employing staff. The BDA also has a comprehensive list of specialist societies and other useful addresses.	
Publications: British Dental Journal Editorial Office 64 Wimpole Street London W1G 8YS UK Tel: +44 20 7535 5830 Fax: +44 20 7535 5843 Email: bdj@bda.org Website: www.bdj.co.uk	*For advertising:* BDJ Classified Advertising Department Porters South 4 Crinan Street London N1 9WX Tel: +44 20 7843 4729 Fax: +44 20 7843 4725 Email: bdj@nature.com Website: www.bdjjobs.co.uk

Dental Schools:

Belfast
Queen's University of Belfast
School of Clinical Dentistry
Grosvenor Road
Belfast BT12 6BP
Tel: +44 28 90 263122
Fax: +44 28 90 438861
http://www.qub.ac.uk/cd/
Dentists graduating each year: 38
Number of students: 209

Bristol
University of Bristol
Dental School
Lower Maudlin Street
Bristol BS1 2LY
Tel: +44 117 923 0050
Fax: +44 117 928 4994
http://www.dentalschool.bris.ac.uk/
Dentists graduating each year: 48
Number of students: 324

Glasgow
Glasgow Dental Hospital & School
378 Sauchiehall Street
Glasgow G2 3JZ
Tel: +44 141 211 9703
Fax: +44 141 331 2798
http://www.gla.ac.uk/schools/dental/
Dentists graduating each year: 75
Number of students: 419

London
Barts and The London Campus
Queen Mary's School of Medicine and Dentistry
Turner Street
London E1 2AD
Tel: +44 20 377 7000
Fax: +44 20 377 7612 http://www.mds.qmw.ac.uk/dental/
Dentists graduating each year: 60
Number of students: 404
Number of therapists in training: 12

Leeds
Leeds Dental Institute
Clarendon Way
Leeds LS2 9LU
Tel: +44 113 343 6172
Fax: +44 113 343 6165
www.leeds.ac.uk/dental
Dentists graduating each year: 51
Number of students: 387
Number of therapists in training: 8

Manchester
Turner Dental School
Higher Cambridge Street
Manchester M15 6FH
Tel: +44 161 275 6601
Fax: +44 161 275 6604
http://www.den.man.ac.uk/
Dentists graduating each year: 72
Number of students: 407
Number of therapists in training: 12

Plymouth/Exeter
Peninsular Dental School
Universities of Exeter & Plymouth
The John Bull Building

Birmingham
University of Birmingham
School of Dentistry
St Chad's Queensway
Birmingham B4 6NN
Tel: +44 121 237 2763
Fax: +44 121 625 8815
http://www.dentistry.bham.ac.uk/
Dentists graduating each year: 65
Number of students: 408

Cardiff
University of Wales College of Medicine
Dental School
Heath Park
Cardiff, CF14 4XN
Tel: +44 29 2074 7747
Fax: +44 29 2076 6343
http://www.uwcm.ac.uk/
Dentists graduating each year: 57
Number of students: 325
Number of therapists in training: 9

Dundee
University of Dundee Dental School
Park Place
Dundee DD1 4HN
Tel: +44 1382 635976/7
Fax: +44 1382 225 163
http://www.dundee.ac.uk/dentalschool/
Dentists graduating each year: 54
Number of students: 353

London
Guy's, King's and St Thomas' Dental Institute Campus
Hodgkin Building
Guy's Campus St Thomas's Street
London SE1 1UL
Tel: +44 20 7848 6963
Fax: +44 20 7848 6982
http://www.kcl.ac.uk/depsta/dentistry/
Dentists graduating each year: 151
Number of students: 799

Liverpool
University of Liverpool
Liverpool University Dental Hospital
Pembroke Place
Liverpool L3 5PS
Tel: +44 151 706 5203
Fax: +44 151 706 5652
http://www.liv.ac.uk/luds/index.htm
Dentists graduating each year: 50
Number of students: 378
Number of therapists in training: 47

Newcastle upon Tyne
Dental School
Framlington Place
Newcastle upon Tyne NE2 4BW
Tel: +44 191 222 8347
Fax +44 191 222 6137
http://www.ncl.ac.uk/dental/
Dentists graduating each year: 70
Number of students: 427

Preston
Central Lancashire School of Dentistry
Faculty of Health
University of Central Lancashire

Tamar Science Park, Research Way, Plymouth, PL6 8BU Tel: +44 1752 437 333 Fax: Website: http://www.pms.ac.uk/dentistry Dentists graduating each year: new school – none yet Number of students: 63	Preston, PR1 2HE Tel: +44 1772 893 805 Fax: +44 1772 892 995 Website: http://www.uclan.ac.uk/facs/health/dentistry/school/index.htm Dentists graduating each year: new school – none yet Number of students: 32 Sheffield University of Sheffield School of Clinical Dentistry Claremont Crescent Sheffield S10 2TA Tel: +44 114 271 7801 Fax: +44 114 279 7050 http://www.shef.ac.uk/dentalschool/ Dentists graduating each year: 53 Number of students: 371
Edinburgh (postgraduate only) Postgraduate Dental Institute Centre for Dental Education Lauriston Building Lauriston Place Edinburgh EH3 9YW Tel: +44 131 536 4961 Fax: +44 131 536 4962 http://www.epdi.org.uk/index.asp (currently under redevelopment)	*London (postgraduate only)* Eastman Dental Institute for Oral Health Care Sciences (postgraduate only) University of London 256 Gray's Inn Road London WC1X 8LD Tel: +44 20 7915 1038 Fax: +44 20 7915 1039 http://www.eastman.ucl.ac.uk/ Number of therapists in training: 10

	Number of Undergrads		Annual Graduates	
Aberdeen	None yet		None yet	
Belfast	209		38	
Birmingham	408		65	
Bristol	324		48	
Cardiff	325		57	
Dundee	353		54	
Glasgow	419		75	
Leeds	387		51	
Liverpool	378		50	
London	1193		211	
Manchester	407		72	
Newcastle	427		70	
Plymouth	120		None yet	
Preston	64		None yet	
Sheffield	371		53	
	5,385		844	
Many of the schools have expanded their intake since 2004				
so their number of graduates will increase from 2009				

The British Dependent Islands

All the islands are English speaking British Crown dependencies. Officially, they are not part of the UK. Their head of state is Queen Elizabeth II, who appoints a Lieutenant Governor for each of Jersey, Guernsey (and its dependent islands), and the Isle of Man.

The dental workforce numbers enumerated here are already included within the numbers for the UK.

Year of data:	2008
Dentists	163
Hygienists	28
Technicians	12
Clinical Dental Technicians	0
Dental Nurses	143
Therapists	3

The Channel Islands

The Channel Islands represent the last remnants of the medieval Dukedom of Normandy, which held sway in both France and England. They are located in the English Channel, off the northwest coast of France. The two largest islands are Jersey and Guernsey, and there are a number of smaller islands. The islands follow English law but with local statute; justice is administered by the Royal Courts of Guernsey and Jersey. The islands of Guernsey, Alderney, Herm and Sark are normally referred to as "The Bailiwick of Guernsey".

Guernsey and Jersey have separate unicameral Assemblies.

Financial services - banking, fund management, insurance, etc. - account for about 55% of total income in the tiny Channel Islands economy. Tourism, manufacturing, and horticulture, mainly tomatoes and cut flowers, have been declining. Light taxes and no death duties make them popular tax havens (taxes are relatively low and there is no VAT levied on goods and services).

The islands are not members of the European Union, but enjoy a relationship with the EU under the terms of Protocol 3 to the United Kingdom's 1972 Treaty of Accession. Briefly this gives the islands the benefit of access to the free trade area without the obligation to harmonise their laws and taxes. Specifically the islands are not bound by EU Directives on tax or any other matters. So, although the islands are within the EU's customs territory, EU competition rules do not apply to them, except so far as is necessary to permit the United Kingdom, of which they are dependencies, to observe its obligations under the 1972 Treaty of Accession. Channel Islanders do not benefit from the EU rules on the free movement of persons and services within the Union, but EU natural and legal persons enjoy "equal treatment" under EU law.

There are no dental schools in the Channel Islands, and registration as a dentist is with the UK General Dental Council, whose ethical rules must be followed.

Numbers 2008	Guernsey*	Jersey
Registered dentists	32	70
General practice	29	63
Public Dentistry	2	7
Hospitals	0	5

*including Alderney (1)

Guernsey

Guernsey has a land area of 78 sq km and a population of 65,726 (July 2008). Its capital is St Peter Port. The GDP was €28,000 PPP in 2005 (latest figures) and the currency used is the Guernsey Pound, which has parity with the GB Pound. There is no National Health Service on Guernsey, for dentistry or medicine.

The registered dentists in Guernsey include 1 orthodontist, 1 surgical dentist and 1 periodontist. Oral healthcare is normally provided in private practice, by the general practitioners who are in 14 practices (including one on Alderney There is a part-time surgery in the summer months only on Sark, run by one of the dentists from Guernsey. The Guernsey dental practitioners also attend to their patients in hospital. The hospital "Dental Unit" is the GDPs who access the hospital facilities for their patients. Emergencies are covered on a rota of GDPs. It is a requirement of practising and of the Guernsey Dental Association (GDA) membership to take part in the rota. There is one visiting Oral Surgeon for more complex cases on referral.

Dental auxiliaries on Guernsey: there are 13 hygienists, 6 technicians (including 2 on Alderney) and one dental nurse for each dentist (it is thought that 18 are qualified).

Public dental healthcare is provided for some eligible children up to the age of nineteen, in full time education. The Children's Dental Service has one full-time and two part-time dentists providing free dental care for those eligible children and those referred under special criteria. In 2006 the States decided to abolish free dental treatment for all children, with only the neediest and those referred being entitled to free treatment. Orthodontics is not available under this scheme.

The Guernsey Social Security Department will pay for treatment for adults on benefits, or after means testing. This treatment is provided in private practice paid for by the Guernsey Social Security Department on a scale of fees. The fee scale is agreed between the Guernsey Social Security Department and the Guernsey Dental Association (GDA).

All dentists on Guernsey are members of the GDA. Members fill the officer posts in rotation.

Guernsey is not open to dentist newcomers. The Health Department registers all dentists in the Bailiwick of Guernsey and monitors numbers with the GDA. Also, unless the individual dentist already has a housing rights

qualification, then the person requires a housing licence to reside in local market accommodation. These licences are issued by the Housing Department and numbers are restricted. The Housing Department also issues right to work documents. Usually entry to Guernsey by a dentist is when a dentist here retires or leaves the islands. Jobs are advertised in the usual dental press and the local "Guernsey Press" newspaper. The setting up of a practice premises is restricted by the Environment Department who govern either new premises or a change of use of existing premises. Both types of permission can be very difficult to obtain.

Jersey

Jersey has a land area of 116 sq km and a population of 91,533 (July 2008). Its capital is St Helier. The GDP was €36,000 (PPP) in 2005 and the currency used is the Jersey Pound, which has parity with the GB Pound.

Oral healthcare is provided mainly by the General Practitioners on the island, under private arrangements. There is a Jersey Dental Fitness scheme, for children only, which the *States* (government) subsidise at £6 (€8.50) a month to families whose income is less than £40,580 (€51,265) a year – and whose children are between 11 and 18 (or up to 21 if they are in full-time education).

There is also a Community and Hospital Dental Services Scheme, provided by salaried dentists, for those from 4 to 11 years of age. For the over-65s, who are on low income, they have access to a Dental/Optical state-funded scheme which reimburses charges at up to £250 (€316) per year. The programme is means tested to be restricted to those on low income (so being a non tax-payer, resident in Jersey and having less than £20,000 (€25,266) capital assets.

Based at the hospital there are two resident orthodontists, two oral surgeons, one restorative specialist and a community dental officer. The island also has a resident specialist endodontist. Various dental specialists visit the island by arrangement with the hospital or with individual practices. These include oral surgeons and orthodontists. There are also about ten dental hygienists and three independent laboratories. The practices and the hospital employ about 70 dental nurses in total.

Most of the dentists on the island (approx. 70) are members of The Jersey Dental Association. It is not possible for persons who are not residentially qualified for living on the island to set up practice as an independent dentist in Jersey.

The Isle of Man

The Isle of Man is a dependency of the British crown but has never formed part of the United Kingdom. It is situated in the Irish Sea approximately half way between Ireland and Great Britain, and the land area is 572 sq km. There is a population of 76,220 (2008) and the capital is Douglas.

The Isle of Man is politically stable and enjoys parliamentary government without party politics. Its 1,000 year-old parliament, Tynwald presides over the Island's domestic affairs including, specifically, taxation. The UK is responsible for the Island's defence and foreign affairs.

The island forms part of the EU single market and VAT area but is otherwise not part of the EU fiscal area. Under protocol 3 of the UK's Treaty of Accession, the Isle of Man is part of the customs territory of the Union. It follows that there is free movement of industrial and agricultural goods in trade between the Island and the Union. The Isle of Man neither contributes to, nor receives from, the funds of the European Union, thus guaranteeing the Isle of Man's fiscal independence. The Isle of Man has an English common law type legal system and tends to follow English legislation. There is an infrastructure of sophisticated legal and other professional services, and direct taxation is low.

The currency is the Isle of Man Pound, which also has parity with the GB Pound.

There is no dental school on the Island and dentists register as such with the UK's General Dental Council, whose ethical rules are followed. In 2008 there were 62 registered dentists on the island. Whilst the island does have a local dental committee, dentists are members of the BDA and are attached to an English Branch based around Liverpool. Two thirds of the dentists were members of the British Dental Association.

Oral Healthcare in the Island includes private care from 28 General Practitioners in 13 practices, who may also contract to work inside the Island's NHS – which follows closely the regulations and statutes of the NHS in England, but is wholly independent of this.

The Community Dental Service is an Island-wide service providing a range of appropriate oral health care services in 3 clinics within the NHS, for schoolchildren and for adults with special needs. Screening for oral health care services is carried out in all the Island's schools.

Annex 1 - Information collection and validation

The original information was collected in early 1996, in three stages. Firstly, a questionnaire was circulated to the main dental associations in each of the 18 countries i.e. the 15 countries of the EU, plus Norway, Switzerland and Iceland. For countries where there was no single main national association, more than one questionnaire was sent to obtain the most complete picture possible. The questionnaire collected data about the basic legal framework, the oral healthcare delivery system and the administrative structure within which dentists work. It covered any official oral health system recognised by government, private insurance and care plan schemes, and the organisation of dental practice including hospital and public dental services, dental faculties and auxiliary personnel.

After the initial exercise, validation interviews were conducted between the Spring and Autumn of 1996 to clarify and extend the information provided by the questionnaires. These interviews were broadly structured around the same topics as the questionnaire, and lasted between three and seven hours depending on the complexity of the dental health system in the country.

The interview stage of the information collection process was essential for identifying important differences between countries, resolving potential ambiguities and exploring in detail those issues briefly covered by the questionnaire, which were more important for dental practice in a particular country. Given the non-standard nature of health systems and the variable organisation of dental practice, the interviews captured information which a "standard" data-collection instrument such as a questionnaire alone would have missed.

The first draft of each country chapter was written primarily on the basis of the interview notes, supported by questionnaire answers, and any other documents which the national dental associations were able to supply. The draft of each country chapter was then checked for clarity, completeness and accuracy, before publication.

This process was repeated for the second edition and the content was extended to include information about women in dentistry, specialisation and remuneration trends where appropriate and available.

This third edition has been revised and updated using two methodologies: for the "candidate" (new) countries of the EU new questionnaires were devised, based on an analysis of the information supplied by the different countries in the first and second editions. Interviews were then conducted by the authors, with the representatives of the relevant countries, at various international meetings during 2003. The data was then validated by Email with dental associations of the countries, before publication.

The data and information for the existing EU countries was analysed and cross-checked for common information and then the individual country sections were marked by the authors for clarification, modification and revision, before being sent to the 18 dental associations in February 2003. Following receipt by the authors of the corrected country sections, clarification of any ambiguous information was undertaken, again at international meetings, before the revised sections were sent to the associations for validation before publication.

Documentary sources of information used were the websites of:

The European Commission & Eurostat
The Council of European Dentists (CED)
The Organisation for Economic Cooperation and Development (OECD)
Union Bank of Switzerland
The European Chief Dental Officers (CECDO)
Conference of Orders and Assimilated Bodies of Dental Practitioners in Europe (CODE)
The Federation Dentaire International (FDI)
The World Health Organisation (WHO)
The British Dental Association (BDA)
The CIA World Factbook
Wikipedia
The International Monetary Fund (IMF)

and information supplied by the dental associations in the 32 countries involved in the project

Annex 2 – EU Institutions

The major institutions of the Community include the European Commission, the Council, the European Parliament, the Court of Justice, the Economic and Social Committee and the Committee of the Regions, the Court of Auditors and the European Investment Bank. The role of each is briefly reviewed below.

The European Commission

The European Commission (formally the Commission of the European Communities) is the executive branch of the European Union and is the body responsible for developing and proposing Community policy and legislation. The Council of Ministers then discusses it and, if appropriate, adopts or amends the proposal. The Commission then implements the decision and supervises the day to day management of the policies. Essentially, therefore, it is the Civil Service of the Community.

The Commission operates in the method of cabinet government, with 27 Commissioners. There is one Commissioner per member state, though Commissioners are bound to represent the interests of the EU as a whole rather than their home state. One of the 27 is the Commission President (currently José Manuel Durão Barroso) appointed by the European Council with the approval of the European Parliament. The present Barroso Commission took office in late 2004 and should serve a five-year term.

The term "Commission" can mean either the college of Commissioners mentioned above, or the larger institution; including the administrative body of about 25,000 European civil servants who are in departments called Directorates-General (DG). It is primarily based in the Berlaymont building of Brussels and its internal working languages are English, French and German.

Each Commissioner is assigned particular areas of Community policy in which he/she formulates proposals aimed at implementing the Treaties. These are then discussed by the Commissioners as a body. Decisions are thus made on a Collegiate basis.

The DGs are staffed by career officials recruited from the member states who are responsible for the technical preparation of the legislation and its implementation. The number and role of the DGs is revised from time to time and matters relevant to dentists and dental services cross Directorate boundaries.

The Commissioners are supported by their individual cabinets of six or more permanent administrators, mainly drawn from their own countries. A structure of inter-cabinet committees ('chefs de cabinet') plays a valuable role in identifying issues for the weekly Commission meetings.

Future size of the Commission

The proposed Lisbon Treaty, which currently (in 2008) may not be ratified by its 2009 deadline, due to a referendum in which the people of Ireland voted 'No' to the Treaty, largely retains the reforms outlined in the earlier rejected Constitutional Treaty.

The constitution's reforms proposed a number of changes, notably the number of Commissioners would be reduced; from 2014 only two out of three member-states would have the right to representation. The representation would be rotated equally between all states and no state would have more than one in any single Commission. The Commission would also include the new High Representative of the Union for Foreign Affairs and Security Policy, as one of the Vice Presidents, replacing the External Relations Commissioner.

In the appointment of the Commission, the most recent European elections would have to be taken into account. It is thought this would create a stronger link between the elections and the Commission, however the President would still be proposed by the Council.

The Council

The Council is the EC's decision maker, adopting or amending the Commission's proposals. The term 'Council' is used to cover the meetings of ministers from the Member States (Council of Ministers) and the working groups of officials (Council Working Groups) and the Committee of Permanent Representatives of the member States in Brussels (COREPER) which prepares the discussions for the Council of Ministers.

Specialist Councils meet to deal with particular areas of policy such as Foreign Affairs and Agriculture. They are attended by the relevant Ministers from the Member States and by the Commission. Similarly, the Council Working Groups are attended by the officials from the relevant Department in the national capital, and/or by the desk officer from its Permanent Representation. The Permanent Representatives (Officials of Ambassador rank) attend the meetings of COREPER. In addition the Heads of State/Government meet twice a year for the European Council (European summit) to discuss broad areas of policy. Council meetings are chaired by the Member State holding the Presidency, which rotates on a half yearly basis.

The Treaties provide for three methods of decision taking, depending on the nature of the proposal and the Treaty Article on which it is based. This can be unanimous - none against, or by simple majority voting with at least seven Member States in favour, or by qualified majority.

The European Parliament

The European Parliament is a directly elected body of members. The number of MEPs from each country varies according to the size of the Member State, ranging from 99 from Germany to 5 from Malta (see below for numbers from

each country). Members are elected for five years and form political rather than national groups.

The Parliament's powers increased with the Single European Act and it now exercises democratic supervision over all Community activities. This power, which was originally applied to the activities of the Commission only, now also extends to the Council of Ministers, the European Council and the political co-operation bodies. The European Parliament can also set up committees of inquiry.

The Rome Treaties originally provided for the Commission to propose and the Council to decide, after consulting Parliament. A Community law becomes null and void if the obligation to consult Parliament is not met. However, the Parliament's role in the legislative process has been gradually widened and strengthened, and its influence extended to the drafting and adoption of Community legislation. The European Parliament and the Council now share the power of decision equally in a large number of areas.

The Parliament can ask the Commission to take a particular initiative where it considers it important. Its examination of the Commission's annual programme of work also gives Parliament the opportunity to emphasise its priorities.

	1999-2004	2004-2007	2007-2009
Austria	21	18	18
Belgium	25	24	24
Bulgaria	-	-	18
Cyprus	-	6	6
Czech Republic	-	24	24
Denmark	16	14	14
Estonia	-	6	6
Finland	16	14	14
France	87	78	78
Germany	99	99	99
Greece	25	24	24
Hungary	-	24	24
Ireland	15	13	13
Italy	87	78	78
Latvia	-	9	9
Lithuania	-	13	13
Luxembourg	6	6	6
Malta	-	5	5
Netherlands	31	27	27
Poland	-	54	54
Portugal	25	24	24
Romania	-	-	36
Slovakia	-	14	14
Slovenia	-	7	7
Spain	64	54	54
Sweden	22	19	19
United Kingdom	87	78	78
(MAX) TOTAL	626	732	786

Number of members of the European Parliament 1999 to 2009

There are four possible processes by which the European Parliament may exercise its legislative power, depending on the nature of the proposal concerned:

1. Consultation (single reading)
2. Co-operation procedure (two readings)
3. Co-decision procedure (three readings)
4. The assent procedure (Parliament's assent is now needed for decisions on the accession of new Member States, association agreements with third countries, the conclusion of international agreements, a uniform procedure for elections to the European Parliament, the right of residence for Union citizens, the organisation and goals of the Structural Funds and the Cohesion Funds and the tasks and powers of the European Central Bank).

Most of the detailed work in the Parliament is conducted by specialist committees, divided into subject areas, which examine the Commission's proposals before they are put to the Parliament. The Committees appoint a 'rapporteur' (an MEP) for each proposal, who is responsible for preparing a report on it. This report includes a draft opinion on the proposal, which is placed before the Parliament for adoption or amendment as policy.

The Parliament has the ultimate power to dismiss the Commission as a whole, with a two-thirds majority. It also has some input into the budgetary process since it has the final say on the draft budget drawn up by the Commission and agreed by the Council. However, its amendments can be overturned by a qualified majority in Council in the case of expenditure involving legal obligations to third parties, such as agriculture.

The Court of Justice (ECJ)

The Court of Justice of the European Communities, usually called the European Court of Justice (ECJ), is the highest court in the European Union (EU). It has the ultimate say on matters of EU law in order to ensure equal application across the various European Union member states.

The body was established in 1952 and is based in Luxembourg City — unlike most other Union institutions which are based in Brussels. The court is composed of one judge per member state although only 13 of them hear a case at any one time in the 'Grand Chamber'. The court is led by a president.

It has two roles, firstly to act on the request of any of the Community Institutions, Member States or individuals to suppress any measure adopted by any of the EC institutions or national governments deemed incompatible with the treaties and, secondly, to pass judgement on points of community law referred to it by national courts.

The court is assisted by a lower court, the Court of First Instance, dealing with certain issues. Two other courts deal with other responsibilities, the Civil Service Tribunal over employees of the Union's institutions and Court of Auditors (an institution in its own right) over the Union's accounts. It should not be confused with the European Court of Human Rights in Strasbourg, which is part of the Council of Europe.

The Economic and Social Committee (EESC)

Founded in 1957 under the Treaty of Rome, the European Economic and Social Committee (EESC) is an advisory body representing employers, trade unions, farmers, consumers and the other interest groups that collectively make up 'organised civil society'. It presents their views and defends their interests in policy discussions with the Commission, the Council and the European Parliament.

The Committee is an integral part of the EU's decision-making process: it must be consulted before decisions are taken on economic and social policy. On its own initiative, or at the request of another EU institution, it may also give its opinion on other matters.

The EESC has 344 members – the number from each EU country roughly reflecting the size of its population. The numbers per country.

The members are nominated by the EU governments but they work in complete political independence. They are appointed for four years, and may be re-appointed.

The Committee meets in Plenary Assembly, and its discussions are prepared by six subcommittees known as 'sections', each dealing with particular policy areas. It elects its President and two Vice-Presidents for a two-year term.

The Committee of the Regions

Set up in 1994 under the Treaty on European Union, the Committee of the Regions (CoR) is an advisory body composed of representatives of Europe's regional and local authorities. The CoR has to be consulted before EU decisions are taken on matters such as regional policy, the environment, education and transport – all of which concern local and regional government.

The Committee also has 344 members, again the number from each member state approximately reflects its population size.

The members of the Committee are elected municipal or regional politicians, often leaders of regional governments or mayors of cities.

They are nominated by the EU governments but they work in complete political independence. The Council of the European Union appoints them for four years, and they may be reappointed. They must also have a mandate from the authorities they represent, or must be politically accountable to them.

The Committee of the Regions chooses a President from among its members, for a term of two years.

The Court of Auditors

The European Court of Auditors is the EU Institution established by the Treaty to carry out the audit of EU finances. As the EU's external auditor it contributes to improving EU financial management and acts as the independent guardian of the financial interests of the citizens of the Union. The Court of Auditors is based in Luxembourg. Its 12 members are appointed by the Council of Ministers, to audit the Community's revenue and expenditure.

The European Investment Bank

The European Investment Bank is the Community's bank. It provides loans to help public and private investment in industry and infrastructure. The capital is provided by member states.

Types of Community Legislation

Under the treaties, the Council and the Commission may make regulations, issue Directives, take decisions, make recommendations or deliver opinions.

Regulations apply directly to all Member States. They do not have to be confirmed by national Parliaments, and if there is a conflict between national law and the regulation, the regulation prevails.

Directives are compulsory, but it is left to the Member States to translate them into national legislation. If a state does not introduce appropriate laws, the rights of an individual are protected by the Directive.

Decisions are binding only on the Member States, companies or individuals to which they are addressed.

Recommendations and Opinions are not binding, merely stating the view of the institution that issues them.

Annex 3 – European Health Strategy

Most competence for action in the field of health is held by Member States, but the EU has the responsibility, set out in the Treaty, to undertake certain actions which complement the work done by Member States, for example in relation to cross border health threats, patient mobility, and reducing health inequalities.

On 23 October 2007 the European Commission adopted a White Paper on a new Health Strategy[9], 'Together for Health: A Strategic Approach for the EU 2008-2013'. Building on current work, the Commission have written *"this Strategy aims to provide, for the first time, an overarching strategic framework spanning core issues in health as well as health in all policies and global health issues. The Strategy aims to set clear objectives to guide future work on health at the European level, and to put in place an implementation mechanism to achieve those objectives, working in partnership with Member States"*.

The Strategy focuses on four principles and three strategic themes for improving health in the EU:

PRINCIPLE 1: A STRATEGY BASED ON SHARED HEALTH VALUES

Actions

- Adoption of a Statement on fundamental health values (Commission, Member States);
- System of European Community Health Indicators with common mechanisms for collection of comparable health data at all levels, including a Communication on an exchange of health-related information (Commission);
- Further work on how to reduce inequities in health (Commission);
- Promotion of health literacy programmes for different age groups (Commission).

PRINCIPLE 2: "HEALTH IS THE GREATEST WEALTH"

Actions

- Development of a programme of analytical studies of the economic relationships between health status, health investment and economic growth and development (Commission, Member States).

PRINCIPLE 3: HEALTH IN ALL POLICIES (HIAP)

Actions

- Strengthening integration of health concerns into all policies at Community, Member State and regional levels, including use of Impact Assessment and evaluation tools (Commission, Member States).

PRINCIPLE 4: STRENGTHENING THE EU'S VOICE IN GLOBAL HEALTH

Actions

- Enhance the Community's status in international organisations and strengthen cooperation on health with strategic partners and countries (Commission);
- In line with the priorities agreed with third countries and with the policy dialogue and sectoral approaches developed for external assistance, ensure an adequate inclusion of health in the EU's external assistance and promote the implementation of international health agreements, in particular FCTC and IHR (Commission).

In order to meet the major challenges facing health in the EU, this strategy identifies three objectives as key areas for the coming years.

OBJECTIVE 1: FOSTERING GOOD HEALTH IN AN AGEING EUROPE

OBJECTIVE 2: PROTECTING CITIZENS FROM HEALTH THREATS

OBJECTIVE 3: SUPPORTING DYNAMIC HEALTH SYSTEMS AND NEW TECHNOLOGIES

The Commission will put forward a Structured Cooperation implementation mechanism (Commission)

The Health Strategy has been in development over the past years. In May 2000 a Communication on health strategy at EU level was adopted. This Communication called for concentrating resources where the Community can provide real added value, without duplicating work which can be better done by the Member States or international organisations. Supported by the public health programme, it led to the development of public health activities and to strengthening links to other health-related policies.

General health policy lines were set out in the concept of a "Europe of Health" in 2002. Work was undertaken on addressing health threats, including the creation of the European Centre for Disease Prevention and Control (ECDC), developing cross-border co-operation between health systems and tackling health determinants. The Community's health information system provides a key mechanism underpinning the development of health policy.
In 2004, in order to review the May 2000 Health Strategy and consider whether and how it needed to be revised in the light of developments, the Commission launched a reflection process on enabling good health for all. The results of this reflection process contributed to the development of the new Health Strategy.

The EU Health Policy Forum, which brings together stakeholders from the health area to advise the European Commission on health policy, is also a key element of the EU Health policy. The Forum enables the health community to participate in health policy making from the start. EU health policy increasingly involves co-operation with and between the Member States, in particular on cross-border issues such as patient mobility.

The CED is a member of this Forum.

9

http://ec.europa.eu/health/ph_overview/strategy/health_strategy_en.htm

Annex 4 – Directive 2005/36/EC

General system for the recognition of professional qualifications (Chapter I of the Directive).

When, in a host Member State, access to or pursuit of a profession is regulated, i.e. subject to possession of specific professional qualifications, the competent authority in this Member State allows access to the profession in question and pursuit thereof under the same conditions as for nationals, provided that the applicant holds a training qualification obtained in another Member State which attests to a level of training at least equivalent to the level immediately below that required in the host Member State.

When, on the other hand, in the Member State of the applicant, access to a profession is not subject to possession of specific professional qualifications, the applicant should, in order to be able to gain access to the profession in a host Member State which does regulate that profession, provide proof of two years of full-time professional experience over the preceding ten years on top of the qualification.

The Directive distinguishes five levels of professional qualifications:

- attestation of competence which corresponds to general primary or secondary education, attesting that the holder has acquired general knowledge, or an attestation of competence issued by a competent authority in the home Member State on the basis of a training course not forming part of a certificate or diploma, or of three years professional experience;
- certificate which corresponds to training at secondary level, of a technical or professional nature or general in character, supplemented by a professional course;
- diploma certifying successful completion of training at post-secondary level of a duration of at least one year, or professional training which is comparable in terms of responsibilities and functions;
- diploma certifying successful completion of training at higher or university level of a duration of at least three years and less than four years;
- diploma certifying successful completion of training at higher or university level of a duration of at least four years.

On an exceptional basis, other types of training can be treated as one of the five levels.

The host Member State can make recognition of qualifications subject to the applicant's completing a compensation measure (aptitude test or adaptation period of a maximum of three years) if:

- the training is one year shorter than that required by the host Member State or
- the training received covers substantially different matters to those covered by the evidence of formal training required in the host Member State or
- the profession as defined in the host Member State comprises one or more regulated professional activities which do not exist in the corresponding profession in the applicant's home Member State, and that difference consists of specific training which covers substantially different matters from those covered by the completed by the migrant.

The host Member State must, in principle, offer the applicant the choice between an adaptation period and an aptitude test. The host Member State can only derogate from this requirement in the cases specifically provided for, or with the Commission's authorisation.

The Directive provides for representative professional associations at both national and European level to establish common platforms by determining measures to compensate for the substantial differences identified between the training requirements in at least two thirds of the Member States, and in all the Member States which regulate that profession. That is, the platform must make it possible to provide adequate guarantees as to the level of qualification. If such a platform is likely to make the recognition of professional qualifications easier, the Commission may submit it to the Member States and adopt an implementing measure under the comitology procedure (regulation). Once this implementing measure has been adopted, the Member States shall waive the imposition of compensatory measures on applicants who meet the platform's conditions.

By late 2010, three years after the Directive is transposed by the Member States, the Commission shall submit to the European Parliament and the Council a report on the provision of the Directive relating to common platforms and, if necessary, make appropriate proposals for amending it.

System of automatic recognition of qualifications for the professions of doctor, nurse, dentist, veterinary surgeon, midwife, pharmacist and architect (Chapter III of the proposal)

Each Member State automatically recognises certificates of training giving access to professional activities as a dental practitioner, covered by Annex V to the Directive.

The Directive also adopts the principle of automatic recognition for medical and dental specialisations common to at least two Member States under existing law, but restricts futures additions to Directive 2005/36/EC of new medical specialisations - eligible for automatic recognition - to those that are common to at least two fifths of the Member States. Only medical specialties are eligible this way for automatic recognition.

For the purposes of equivalence in qualifications, this Directive sets minimum training conditions for dentists:

Dental practitioners: admission to training as a dental practitioner presupposes possession of a diploma or certificate giving access, for the studies in question, to universities or higher institutes of an equivalent level, and shall comprise a total of at least five years of full-time theoretical and practical study, comprising at least the programme as described in Annex 5 of this Manual.

The Directive extends the possibility for Member States to authorise part time training for all of these professions, provided that the overall duration, level and quality of such training is not lower than that of continuous full-time training;

The Directive provides a minimum programme of subjects to follow, which leaves room for the Member States to draw up

more detailed study programmes. These lists of subjects appear in Annex 5 and can be amended by a comitology procedure (regulation) to the extent required to adapt them to scientific and technical progress. Following the professional training they have received, aspiring dentists will possess a training qualification which has been issued by the competent bodies in the Member States bearing the titles described in Annex 6 and will enable them to practise their profession in any Member State. Without prejudice to the provisions relating to established rights, the Member States shall make access to, and pursuit of, the professional activities of dentists subject to possession of one of the qualifications listed in the corresponding annexes which give guarantees relating to the acquisition by the party concerned of the knowledge and aptitudes referred to in various Articles of the Directive.

Without prejudice to the specific established rights granted to the professions concerned, in cases where the evidence of training provides access to the professional activities of dental practitioners and specialised dental practitioners held by nationals of Member States do not satisfy all the training requirements described, each Member State shall recognise as sufficient proof certificates of training issued by those Member States insofar as they attest successful completion of training which began before the reference dates laid down in the Annexes to the Directive.

The full text of the Directive can be found at:

http://europa.eu/scadplus/leg/en/cha/c11065.htm

Annex 5 – Content of undergraduate training and education

The programme of undergraduate studies must include the following subjects. One or more of these may be taught in the context of the other disciplines or in conjunction with them.

1. Basic subjects:

   chemistry
   physics
   biology

2. Medico-biological subjects and general medical subjects

   anatomy
   embryology
   histology, including cytology
   physiology
   biochemistry (or physiological chemistry)
   pathological anatomy
   general pathology
   pharmacology
   microbiology
   hygiene
   preventive medicine and epidemiology
   radiology
   physiotherapy
   general surgery
   general medicine, including paediatrics
   oto-rhino-laryngology
   dermato-venereology
   general psychology,
   psychopathology,
   neuropathology
   anaesthetics

3. Subjects related to dentistry

   prosthodontics
   dental materials and equipment
   conservative dentistry
   preventive dentistry
   anaesthetics and sedation in dentistry
   special surgery
   special pathology
   clinical practice
   paedodontics
   orthodontics
   periodontics
   dental radiology
   dental occlusion and function of the jaw
   professional organisation, ethics and legislation
   social aspects of dental practice

   Source: The Official Journal of the European Union 30/9/05 page 115

Annex 6 – Diplomas and Qualifications

Diplomas, certificates and other evidence of formal qualifications that are mutually recognised Dentists		
	Title	Notes
Austria	Doctor of Medicine (Dr.Med.Univ.) with the Specialist Certificate (Fachartz fur Zahn-, Mund-, und Kieferheilkunde) (Dr.Med.Dent.). Bescheid über die Verleihung des akademischen Grades "Doktor der Zahnheilkunde"	Dentists from non-EU countries have to demonstrate the equivalence of their education and training to an expert panel of the Universities of Vienna, Graz or Innsbruck.
Belgium	'Diplome legal de licencie en science dentaire/wettelijk diploma van licentiaat in de tandheelkunde of tandarts'	The official diploma of graduate in dental science, awarded by the university faculties of medicine, or by the Central Board ("Jury Central") of university examiners.
Bulgaria	Диплома за висше образование на образователно-квалификационна степен "Магистър" по "Дентална медицина" с професионална квалификация "Магистър-лекар по дентална медицина"	
Croatia		
Cyprus	Πιστοποιητικό Εγγραφής Οδοντιάτρου	Diplomas are from other EU countries, as there is no undergraduate training
The Czech Republic	Medicinae universae doctor in disciplina medicinae stomatologicae". (MDDr) Diplom o ukončení studia ve studijním programmeu zubní lékařství (doktor zubního lékařství, MDDr.	Following qualification there is mandatory vocational training, with a completion examination (until 2009).
Denmark	'Bevis for tandlaegeeksamen (kandidateksamen)'	Official diploma certifying that the holder has passed the examination in dentistry, issued by schools of dentistry together with the document issued by the 'Sundhedsstyrelsen' (National Board of Health) certifying that he/she has worked as an assistant for the required length of time.
Estonia	DDS Dentist Diplom hambaarstiteaduse õppekava läbimise kohta	
Finland	'Todistus hammaslaaketieteen lisensiaatin tutkinnosta/bevis om odontologi licentiat examen'	Certificate of the degree of licentiate in odontology, awarded by a university faculty of medicine or faculty of medicine or faculty of dental medicine and a certificate of practical training issued by the competent public health authorities.
France	'Diplome d'Etat de chirurgien-dentiste' (State diploma of dental surgeon) 'Diplome d'Etat de docteur en chirurgie dentaire' (State diploma of doctor of dental surgery),	Awarded until 1973 by the university faculties of medicine or the university joint faculties of medicine and pharmacy. Awarded by the universities.
Germany	Zeugnis über die zahnärztliche Staatsprüfung (the State examination in dentistry)	Awarded by the competent authorities. The certificates from the competent authorities of the Federal Republic of Germany stating that the

		diplomas awarded after 8th May, 1945, by the competent authorities of the German Democratic Republic are recognised as equivalent to those listed
Greece	'Ptychio odontiatrikis tou Panepistimiou'	
Hungary	Fogorvos oklevél (doctor medicinae dentariae, abbrev.: dr.med.dent.) or DDS	Is followed by a period of mandatory vocational training as residents, known as "*Központi gyakornok*" and then a completion examination
Iceland	Candidatus odontologiae Próf frá tannlæknadeild Háskóla Íslands	
Ireland	The diploma of: Bachelor in Dental Science (B Dent Sc.) Bachelor of Dental Surgery (BDS) or Licentiate in Dental Surgery (LDS)	The diploma of LDS is no longer offered by Irish dental schools
Italy	Diploma di abilitazione all'esercizio della professione di odontoiatra	Awarded by the State examining board.
Latvia	zobarsta (dentist)	
Lithuania	Aukštojo mokslo diplomas, nurodantis suteikta gydytojo odontologo kvalifikacija Odontologist of General Practice	This title is followed by one-year's vocational training
Luxembourg	'Diplome d'Etat de docteur en médecine dentaire' (State diploma of doctor of dental medicine),	Issued by the State Board of Examiners.
Malta	Bachelor of Dental Surgery (BChD) Lawrja fil-Kirurgija Dentali	Issued by the University of Malta
Norway	Master of Dentistry Vitnemål for fullført grad *candidata/candidatus odontologiae*, short form: *cand. odont.*	
The Netherlands	'Universitair getuigschrift van een met goed gevolg afgelegd tandartsexamen'	University certificate indicating success in the dental surgeon's examination.
Poland	Stomatologist (1996 to 2004) Dental Doctor (lekarz dentysta) – from 2004 Dyplom ukonczenia studiów wyzszych z tytulem "lekarz dentysta"	
Portugal	'Carta de curso de licenciatura em medicina dentaria'	Diploma conferring official recognition of completion of studies in dentistry, awarded by an establishment of higher education.
Romania	Diploma de licenta de medic dentist	The newly qualified dentist becomes a "Probation physician stomatologist (1 year)/stagier" before receiving a licence.
Slovakia	MUDr – *Medicinae Universae Doctor*. Vysokoškolský diplom o udeleni akademického titulu "doktor zubného lekárstva" ("MDDr.")	There is mandatory post-qualification 36 months training, followed by an examination by interview. This will cease in 2009. The new title MDDr is introduced for graduates who commenced training from 2004.
Slovenia	"Doctor dentalne medicine"*(dr.dent.med.)* Diploma , s katero se podeljuje strokovni naslov "doktor dentalne medicine/doktorica dentalne medicine"	
Spain	Licenciado en odontologia -	

	• Medico especialista en estomotologia • Medico especialista en cirurgia maxilo-facial	
Sweden	'tandlakarexamen' (university diploma in dentistry)	Awarded by schools of dentistry and a certificate of practical training issued by the National Board of Health and Welfare.
Switzerland	Swiss Federal Diploma for Dentistry Titulaire du diplôme fédéral de médecin-dentiste, eidgenössisch diplomierter Zahnarzt, titolare di diploma federale di medico-dentista	
The United Kingdom	The diploma of: • Bachelor of Dental Surgery (BDS or BChD), or • Licentiate in Dental Surgery (LDS)	Issued by the universities and the royal colleges. The diploma of LDS is no longer offered by UK dental schools

Source: Official Journal of the European Union 20/12/06 with later amendments

Diplomas, certificates and other evidence of formal qualifications that are mutually recognised Stomatologists		
France	Stomatologie	
Italy	Odontostomatologia (*)	
Luxembourg	Stomatologie	
Portugal	Estomatologia	
Spain	Estomatologia	

Date of repeal within the meaning of Article 27(3): (*) 31 December 1994

Annex 7 – Dental Specialist Diplomas & Qualifications

Specialist Diplomas and certificates that are mutually recognised		
	Orthodontics	Oral Surgery
Austria	No dental specialists recognised	No dental specialists recognised
Belgium	Tandarts specialist in de Orthodontie, Dentiste Spécialiste en orthodontie	Maxillo-faciale chirurgie, Chirurgie Maxillo-faciale
Bulgaria	Свидетелство за призната спец-иалност по “Ортодонтия”	Свидетелство за призната спец-иалност по “Орална хирургия”
Cyprus	Πιστοποιητικό Αναγνώρισης του Ειδικού Οδοντιάτρου στην Ορθοδοντική	Πιστοποιητικό Αναγνώρισης του Ειδικού Οδοντιάτρου στην Στοματική Χειρουργική
The Czech Republic	Diplom o specializaci (v oboru ortodoncie)	Diplom o specializaci (v oboru orální a maxilofaciální Chirurgie)
Denmark	‘Bevis for tilladelse til at betegne sig som specialtandlaege I ortodonti' (certificate awarding the right to use the title of dental practitioner specializing in orthodontics), issued by the 'Sundhedsstyrelsen' (State Board of Health).	‘Bevis for tilladelse til at bretenge sig som specialtandlaege I hospalsodontologi' (certificate conferring the right to use the title of dental practitioner specialised in hospital odontology), issued by the 'Sundhedsstyrelsen' (State Board of Health).
Estonia	Specialist in Orthodontics Residentuuri lõputunnistus ortodontia erialal	Maxillofacial Surgeon
Finland	'Todistus erikoishammaslaakarin oikeudesta oikomishoidon alalla/bevis om specialisttandlakarrattigheten inom omradet tandreglering' (certificate of orthodontist) issued by the competent authorities.	'Todistus erikoishammaslaakarin oikeudesta suukirurgian (hammas- ja suukirurgian) alalla/bevis om specialisttandlakarrattigheten inom omradet oralkirurgi (tand- och munkirurgi)' (certificate of oral or dental and oral surgery) issued by the competent authorities.
France	Le titre de “spécialiste en orthodontie” (the title of orthodontic specialist), issued by the authority recognised competent for this purpose.	Médecine spécialiste qualifié en stomatologie
Germany	'Fachzahnärztliche Anerkennung fur Kieferorthopadie' (certificate of orthodontist), issued by the 'Landeszahnärztekammern' (Chamber of Dental Practitioners of the 'Lander').	'Fachzahnärztliche Anerkennung fur Oralchirurgie/Mundchirurgie' (certificate of oral surgery), issued by the 'Landeszahnärztekammern' (Chamber of Dental Practitioners of the 'Lander')
Greece	Titlos tis odontiatrikis idikotitas tis orthodontikis	'Titlos tis odontiatrikis idikotitas tis gnathochirourgikis'.
Hungary	Fogszabályozá szakorvosa bizonyítvány	Dento alveoláris szájsebész or Dento-alveoláris sebészet szakorvosa bizonyítvány
Iceland		There is no specialist training in Iceland. However, they do recognise specialists who have trained elsewhere (for at least 3 years)
Ireland	Certificate of specialist dentist in orthodontics, issued by the competent authority recognised for this purpose by the competent minister.	Certificate of specialist dentist in oral surgery, issued by the competent authority recognised for this purpose by the competent Minister.
Italy	Diploma di specialista in Ortognatodonzia	Diploma di specialista in Chirurgia Orale
Latvia	Specialist in orthodontics	Specialist in oral surgery

	"Sertifikats" – kompetentas iestades izsniegts dokuments, kas apliecina, ka persona ir nokartojusi	
Lithuania	License of Odontologist Specialist (orthodontist) Rezidenturos pažymejimas, nurodantis suteikta gydytojo ortodonto profesine kvalifikacija	License of Odontologist Specialist (oral surgeon). For the maxillofacial surgeon specialty, there is a License of Maxillofacial Surgeon. Rezidenturos pažymejimas, nurodantis suteikta burnos chirurgo profesine kvalifikacija
Luxembourg	No dental specialists recognised	No dental specialists recognised
Malta	Certifikat ta' specjalista dentali fl-Ortodonzja	Certifikat ta' specjalista dentali fil-Kirurgija tal-halq
The Netherlands	'Getuigschrift van erkenning en inschrijving als orthodontist in het Specialistenregister' (certificate showing that the person concerned is officially recognised and that their name is entered as an orthodontist in the specialists' register), issued by the 'Specialisten-Registratiecommissie (SRC)' (Specialists Registration Board).	'Getuigschrift van erkenning en inschrijving als kaakchirurg in het Specialistenregister' (certificate showing that the person concerned is officially recognised and that his name is entered as an oral surgeon in the specialists' register), issued by the 'Specialisten-Registratiecommissie (SRC)' (Specialists Registration Board).
Norway	Specialist in orthodontics Bevis for gjennomgått spesialistutdanning i kjeveortopedi	Specialist in oral surgery
Poland	Dental doctor specialist II° of orthodontics Dyplom uzyskania tytulu specjalisty w dziedzinie ortodoncji	Dental doctor specialist II° of oral maxillo-facial surgery Dyplom uzyskania tytulu specjalisty w dziedzinie chirurgii stomatologicznej
Portugal	Especialista em orthodontia (ortodontics)	Especialista em cirurgia oral (oral surgery)
Romania	Physician specialist orthodontist	Physician specialist maxillo-facial surgery
Slovakia	Specialist in dentofacial orthopaedics (celustný ortopéd)	Maxillofacial surgeon ("maxilofaciálny chirurg")
Slovenia	Specialist in orthodontics Potrdilo o opravljenem specialisticnem izpitu iz celjustne in zobne ortopedije	Specialist in Oral Surgery Potrdilo o opravljenem specialisticnem izpitu iz oralne kirurgije
Spain	No dental specialists recognised	No dental specialists recognised
Sweden	'Bevis om specialistkompetens i ortodonti' (certificate awarding the right to use the title of dental practitioner specializing in orthodontics) issued by the National Board of Health and Welfare.	'Bevis om specialistkompetens i oral kirurgi' (certificate awarding the right to use the title of dental practitioner specializing in oral surgery) issued by the National Board of Health and Welfare.
Switzerland	Fachzahnarzt für Kieferorthopädie Diplôme fédéral d'orthodontiste, Diplom als Kieferorthopäde, diploma di ortodontista	Fachzahnarzt für Oralchirurgie
The United Kingdom	Certificate of completion of specialist training in orthodontics, issued by the competent authority recognised for this purpose.	Certificate of completion of specialist training in oral surgery, issued by the competent authority recognised for this purpose.

Source: Official Journal of the European Union 20/12/06 Page 199, with later amendments (4/6/2008)

Annex 8 – Dental Specialist Qualifications (OMFS)

Further specialist Diplomas and certificates that are mutually recognised (Oral maxillo-facial Surgery)	
	Title of qualification
Belgium	Stomatologie et chirurgie orale et maxillo-faciale/stomatologie en mond-, kaak- en aangezichtschirurgie
Finland	Suu- ja leukakirurgia/oral och maxillofacial kirurgi
Greece	Στοματο-Γναθο-Προσωποχειρουργική
Germany	Mund-, Kiefer- und Gesichtschirurgie
Hungary	Arc-állcsont-szájsebészet
Ireland	Oral and maxillo-facial surgery
Luxembourg	Chirurgie dentaire, orale et maxillo-faciale
Malta	Kirurġija tal-għadam tal-wiċċ
The United Kingdom	Oral and maxillo-facial surgery

Source: Official Journal of the European Union 20/12/06 Page 196 with later amendments

Annex 9 – Acquired Rights; Freedom of Movement

General Acquired rights[10] in the Professional Qualifications Directive[11] [PQD]

Without prejudice to the acquired rights specific to the dental profession (see later), in cases where the evidence of formal qualifications as a dental practitioner or as a specialised dental practitioner, held by Member States nationals does not satisfy all the training requirements referred to in Articles 24, 25, 31, 34, 35, 38, 40 and 44 of the PQD each Member State has to recognise as sufficient proof evidence of formal qualifications issued by those Member States insofar as such evidence attests successful completion of training which began before the reference dates laid down in Annex V [of the PQD] and is accompanied by a certificate stating that the holders have been effectively and lawfully engaged in the activities in question for at least three consecutive years during the five years preceding the award of the certificate.

The same provisions apply to evidence of formal qualifications as a dental practitioner or as a specialised dental practitioner, obtained in the territory of the former German Democratic Republic, which does not satisfy all the minimum training requirements laid down in the same Articles, if this evidence certifies successful completion of training which began before 3 October 1990. The evidence of formal qualifications confers on the holder the right to pursue professional activities throughout German territory under the same conditions as evidence of formal qualifications issued by the competent German authorities referred to in Annex V,

Each Member State has to recognise evidence of formal qualifications as a dental practitioner or as a specialised dental practitioner, held by nationals of the Member States and issued by the former Soviet Union, or whose training commenced

(a) for Estonia, before 20 August 1991,
(b) for Latvia, before 21 August 1991,
(c) for Lithuania, before 11 March 1990,

where the authorities of any of the three Member States attest that such evidence has the same legal validity within their territory as the evidence which they issue as regards access to the professional activities of dental practitioner or specialised dental practitioner and the pursuit of such activities.

Such an attestation must be accompanied by a certificate issued by those same authorities stating that such persons have effectively and lawfully been engaged in the activities in question within their territory for at least three consecutive years during the five years prior to the date of issue of the certificate.

Each Member State shall recognise evidence of formal qualifications as a dental practitioner or as a specialised dental practitioner, held by nationals of the Member States and issued by the former Yugoslavia, or whose training commenced, for Slovenia, before 25 June 1991, where the authorities of the aforementioned Member State attest that such evidence has the same legal validity within their territory as the evidence which they issue and for a dental practitioner or a specialised dental practitioner and the pursuit of such activities. Such an attestation must be accompanied by a certificate issued by those same authorities stating that such persons have effectively and lawfully been engaged in the activities in question within their territory for at least three consecutive years during the five years prior to the date of issue of the certificate.

Each Member State shall recognise as sufficient proof for Member State nationals whose evidence of formal qualifications as a dental practitioner does not correspond to the titles given for that Member State in Annex V, evidence of formal qualifications issued by those Member States accompanied by a certificate issued by the competent authorities or bodies. The certificate referred to in the first subparagraph shall state that the evidence of formal qualifications certifies successful completion of training in accordance with Articles 24, 25, 28, 31, 34, 35, 38, 40 and 44 respectively and is treated by the Member State which issued it in the same way as the qualifications whose titles are listed in Annex V.

Acquired rights specific to dental practitioners

1. Every Member State shall, for the purposes of the pursuit of the professional activities of dental practitioners under the qualifications listed in Annex V [of the PQD] recognise evidence of formal qualifications as a doctor issued in Italy, Spain, Austria, the Czech Republic and Slovakia to persons who began their medical training on or before the reference date stated in that Annex for the Member State concerned, accompanied by a certificate issued by the competent authorities of that Member State. The certificate must show that the two following conditions are met:

(a) that the persons in question have been effectively, lawfully and principally engaged in that Member State in the activities referred to in Article 36 [*Pursuit of the professional activities of dental practitioners*] for at least three consecutive years during the five years preceding the award of the certificate;

(b) that those persons are authorised to pursue the said activities under the same conditions as holders of evidence of formal qualifications listed for that Member State in Annex V [of the PQD].

Persons who have successfully completed at least three years of study, certified by the competent authorities in the Member State concerned as being equivalent to the training referred to in Article 34, shall be exempt from the three-year practical work experience referred to in the second subparagraph [b].

[10] [10] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:255:0022:0142:EN:PDF page 22
[11] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:255:0022:0142:EN:PDF page 1

With regard to the Czech Republic and Slovakia, evidence of formal qualifications obtained in the former Czechoslovakia shall be accorded the same level of recognition as Czech and Slovak evidence of formal qualifications and under the same conditions as set out in the preceding subparagraphs.

2. Each Member State shall recognise evidence of formal qualifications as a doctor issued in Italy to persons who began their university medical training after 28 January 1980 and no later than 31 December 1984, accompanied by a certificate issued by the competent Italian authorities. The certificate must show that the three following conditions are met:

(a) that the persons in question passed the relevant aptitude test held by the competent Italian authorities with a view to establishing that those persons possess a level of knowledge and skills comparable to that of persons possessing evidence of formal qualifications listed for Italy in Annex V [of the PQD].

(c) that they are authorised to engage in or are effectively, lawfully and principally engaged in the activities referred to in Article 36, under the same conditions as the holders of evidence of formal qualifications listed for Italy in Annex V.

Persons who have successfully completed at least three years of study certified by the competent authorities as being equivalent to the training referred to in Article 34 [*Basic dental training*] shall be exempt from the aptitude test referred to in 2(a) above.

Persons who began their university medical training after 31 December 1984 shall be treated in the same way as those referred to above, provided that the abovementioned three years of study began before 31 December 1994.

Freedom of Movement for Family members[12]

European Parliament Directive 2004/38/EC legislates on the right of citizens of the European Union and their family members to move and reside freely within the territory of the Member States. The Directive was implemented on 30 April 2006 and is effective from that date.

The main principles of EU Directive 2004/38/EC are:

- a single, transparent instrument establishing conditions governing the right of EU citizens and their family members to freely move and reside within the territory of the Member States.
- This Directive applies to all EU citizens who move to or reside in a Member State other than that of which they are a national, and to their family members.
- EU citizens have the right to free movement and residence within the territory of the Member States. However, this right is also granted to their family members.
- This Directive requires that family members of EU citizens are treated as EU citizens. The specific rights of family members are

- Article 24: right of family members to equal treatment as Member State nationals providing they have the right of residence or permanent residence under Article 7.2.
- Article 23: right of family members to take up employment or self-employment, providing they have the right of residence or permanent residence.

So, the main conditions for a non-EEA national to be treated as an EEA national in a Member State (MS) are:

- The non-EEA national must be the family member of an EEA national (other than a national of the particular MS being applied to)
- The EEA national is moving to work or reside in the particular MS being applied to and their family member is accompanying them.

The entitlements given to the non- EEA family member are:

- They have the right to equal treatment in the particular MS being applied to as a national of that particular MS, in accordance with Article 24 of Directive 2004/38/EC.
- This right to equal treatment arises when the family member has the right to residence or permanent residence in the particular MS being applied to.

Persons who are EEA nationals themselves have rights from their own EEA nationality.

Rights conferred by this Directive do not extend to a substantive right to have professional qualifications recognised. Entitlement to be treated as an EEA national in the particular MS being applied to does not lead to automatic recognition of qualifications. But, the applicant is entitled to equal treatment of his/her qualifications as a national of the particular MS being applied to. The qualifications must be considered under the EU PQD in the same way that qualifications gained in the particular MS being applied are considered, if he/she possessed the same qualifications as the applicant.

Who is considered to be the family member of an EEA national?

To be considered to be the family member of an EEA national the applicant must be:

- Married to an EEA national (other than a national of the particular MS being applied to); or
- A partner of an EEA national (other than a national of the particular MS being applied to) with whom the applicant has contracted a registered partnership on the basis of legislation of a Member State; or
- A direct descendent of an EEA national (other than a national of the particular MS being applied to) or his/her spouse or partner and

- is under the age of 21 or
- above 21 years of age but is dependent on the EEA national (other than a national of the particular MS being applied to) or his/her spouse or partner, or

12 http://ec.europa.eu/justice_home/fsj/citizenship/movement/fsj_citizenship_movement_en.htm

- is the dependent direct relative in the ascending line of an EEA national (other than a national of the particular MS being applied to) or of his/her spouse or his/her partner; or
- is an extended family member of an EEA national (other than a national of the particular MS being applied to) and has been issued with an EEA family permit, a registration certificate or a residence card issued in accordance with regulations 12, 16 and 17 of the Immigration (European Economic Area) Regulations 2006.

Who is a direct descendent?

A persons child is considered to be a direct descendent.

Who is a direct relative in the ascending line?

A persons parents are considered to be direct relatives in the ascending line.

Why can't the right to be treated as an EEA national in the host country be derived from the applicant's relationship with the host country national?

The applicant cannot derive the right to be treated as an EEA national in the host country from a relationship to a host country national because:

- Article 3 of directive 2004/38/EC states that the directive shall only apply to those European Union citizens who move to or reside in a Member State other than that of which they are a national, and to their family members who accompany or join them.
- When a host country national remains in the host country he/she is not moving within the EU in order to exercise his/her right of free movement and residence.

The information about Freedom of Movement for family members was prepared in particular with the assistance of the website of the (UK) General Dental Council

Annex 10 – Data Protection

Information relating to individuals, called 'personal data', is collected and used in many aspects of everyday life. An individual gives personal data when he/she, for example, registers for dental treatment.

These data may subsequently be used for other purposes and/or shared with other parties, such as a sick fund or insurance company. Personal data can be any data that identifies an individual, such as a name, a telephone number, or a photo. Advancement in computer technology along with new telecommunications networks is allowing personal data to travel across borders with greater ease. As a result, data concerning the citizens of one Member State are sometimes processed in other Member States of the EU. Therefore, as personal data is collected and exchanged more frequently, the EC determined that regulation on data transfers became necessary.

In this context, national laws regarding data protection demanded good data management practices on the part of the entities who process data, called 'data controllers'. These included the obligation to process data fairly and in a secure manner and to use personal data for explicit and legitimate purposes. National laws also guaranteed a series of rights for individuals, such as the right to be informed when personal data was processed and the reason for this processing, the right to access the data and if necessary, the right to have the data amended or deleted.

Although national laws on data protection aimed to guarantee the same rights, some differences existed. The EC decided these differences could create potential obstacles to the free flow of information and additional burdens for economic operators and citizens. Some of these were:

- the need to register or be authorised to process data by supervisory authorities in several Member States,
- the need to comply with different standards and the possibility to be restricted from transferring data to other Member States of the EU.

Additionally, some Member States did not have laws on data protection. For these reasons, there was a need for action at European level, and this took the form of EC Directives.

In order to remove the obstacles to the free movement of data without diminishing the protection of personal data, Directive 95/46/EC (the Data Protection Directive) was enacted to harmonise national provisions in this field. As a result, the personal data of all citizens has the equivalent protection across the EU. The existing fifteen Member States of the EU were required to bring their national legislation in line with the provisions of the Directive by 24th October 1998. In fact, by the end of 2003 all then existing member states had done so.

The Data Protection Directive applies to "any operation or set of operations which is performed upon personal data" - called *processing* of data. Such operations include the collection of personal data, its storage, disclosure, etc. The Directive applies to data processed by automated means (for example computerized practice management systems) and to data that are part of or intended to be part of non automated filing systems in which they are accessible according to specific criteria, such as paper patient records.

The Data Protection Directive does not apply to data processed for purely personal reasons or household activities (such as an electronic personal diary or a file with details of family and friends).

In addition, there is a separate Directive, Directive 97/66/EC, which deals specifically with the protection of privacy in telecommunications. This Directive states that Member States must guarantee the confidentiality of communication through national regulations.

Who can be a data controller?

Data controllers are the people or body, 'which determines the purposes and the means of the processing,' both in the public and in the private sector. A dental practitioner would usually be the controller of the data processed on his patients.

Data controllers are required to observe several principles:

- Data must be processed fairly and lawfully.
- They must be collected for explicit and legitimate purposes and used accordingly.
- Data must be relevant and not excessive in relation to the purpose for which they are processed.
- Data must be accurate and where necessary, kept up to date.
- Data controllers are required to provide reasonable measures for data subjects to rectify, erase or block incorrect data about them.
- Data that identifies individuals must not be kept longer than necessary.
- The Directive states that each Member State must provide one or more supervisory authorities to monitor the application of the Directive. One responsibility of the supervisory authority is to maintain an updated public register so that the general public has access to the names of all data controllers and the type of processing they do.
- In principle, all data controllers must notify supervisory authorities when they process data.

Annex 11 – Code of Ethics for Dentists in the EU

1. Context

Against a background of cross-border mobility of patients and health professionals in the European Union and the European Economic Area, there is a need to create a framework of reference for all dentists in their cross-border practice.

The following principles reflect the standard of professional conduct and ethics which underpin high quality dental care and services throughout Europe. They have been developed by the Council of European Dentists.

These are general principles that underpin the codes in the individual Member States. The national codes reflect the different cultures, traditions and needs of the public and patients in the various countries of the EU. Dentists working in another country should familiarise themselves with the national codes of that country, and respect them.

1.1 Purpose and guiding principles of the dental profession

The purpose and the guiding principles of the dental profession reflect those of all liberal professions and are:

- to contribute to society's wellbeing by promoting the oral health of the community;
- to be dedicated to the promotion of independence, impartiality, professional confidentiality, integrity, honesty, competence and professionalism;
- to promote oral health as part of general health and contribute to ensuring equitable access to dental care;
- to contribute to society special and unique knowledge, professional skills, aptitudes and social values;
- to respect the dignity, autonomy and choices of the patient;
- to act always in the best interests of patients;
- to apply current standards of practice.

2. Commitment to the Patient

2.1 The dentist must consider the patient's best interests as paramount.

2.2 The dentist must safeguard the health of patients, and avoid discriminating against any individual patient or group of patients.

2.3 The dentist must prescribe indicated treatment that is appropriate to the patient's oral health and in accordance with the patient's needs, and not allow external influences to affect their independence or any commercial consideration to influence their care of patients or responsibility towards them.

2.4 The dentist must uphold the principle of free choice of practitioner by the patient.

2.5 Good communication is fundamental to the dentist-patient relationship. The dentist must enable the patient, or the legal representative of the patient, to give informed consent for the treatment that is to be carried out, and must provide information about the proposed treatment, other treatment options, relevant risks, as well as costs, so as to enable the patient to make an informed choice.

2.6 The dentist must inform the patient of any complications or of failed treatment and discuss the options for resolving them.

2.7 The dentist must facilitate continuity of care where treatment of a patient ceases.

2.8 The dentist must endeavour to enable a patient to obtain care from another dentist in the event of conflicts with moral or religious beliefs arising from the request for care, or where the practitioner-patient relationship breaks down and it is neither possible nor appropriate to continue care.

2.9 The dentist must undertake only those treatments that they are competent to perform, and must refer a patient if a recommended treatment is beyond their competence.

2.10 The dentist must at all times strive to justify the confidence of the patient and the public.

2.11 The dentist must do everything possible *to* enable the patient to have realistic expectations of the outcome of treatment.

2.12 The dentist must respect the right of the patient to complain, respond promptly, actively and openly and try to resolve the issue in the patient's best interests.

2.13 The dentist must comply and co-operate with the national procedures for protecting the public in relation to complaints and conduct.

2.14 The dentist should take out appropriate professional indemnity insurance cover.

2.15 The dentist must subscribe to the key principles of healthcare confidentiality, that is.:

- that individuals have a fundamental right to privacy and confidentiality of their health information;
- that individuals have the right to control access to and disclosure of their own health information by giving, withholding or withdrawing consent.

2.16 The dentist must ensure that accurate and relevant medico-dental records are kept and that dental staff are aware of their obligation to maintain confidentiality of patient data. Data must be obtained and processed fairly, for specified, explicit and legitimate purposes and according to data protection principles.

2.17 The dentist must keep all data relating to patients secure. Where data are stored electronically, special security precautions must be taken to prevent access from outside the premises during electronic transfer procedures or remote maintenance of the system.

2.18 The dentist must transmit patient data to third parties only when it is justified by the consent of the patient or

where it is required by legal provisions. Records must be kept of all data passed on to third parties.

3. Commitment to the Public

3.1 The dentist has a personal responsibility to contribute to the wellbeing of society by virtue of having special knowledge and skills.

3.2 The dentist must comply with national law and ethical custom governing the practice of the profession, the use of titles and establishment of dental practice.

3.3 The dentist must operate in compliance with EU and national legislation and the applicable professional code on the promotion and advertising of services, including the promotion and advertising of services using modern media related to the information society.

4. Practice of the Profession

4.1 The dentist must practise according to sound scientific principles and long-term experience.

4.2 When working in a managed environment, the dentist must be free to provide care in the best interest of patients, and to comply with the ethical principles of the profession and sound clinical practise.

4.3 The dentist must assure the quality of patient care by updating his or her professional knowledge and skills throughout his or her entire professional life.

4.4 The dentist must support and promote the professional associations, pass on knowledge, and respect divergences of professional opinion.

4.5 The dentist must not indulge in subjective disparagement of the skills or qualifications of colleagues.

4.6 The dentist must lead and support all members of the oral health team, ensuring that they have the knowledge and skills necessary to undertake their tasks effectively and efficiently and that they work strictly within the national law governing their scope of practice.

4.7 The dentist must employ and work only with individuals who are practising legally.

5. Electronic Commerce

The principles of the CED Code of Conduct for Electronic Commerce, including across borders, are in the next Annex and are an integral part of this Code of Ethics.

Annex 12 – Code of Ethics for Dentists in the EU for Electronic Commerce

Adopted in Helsinki in May 2002, and amended in Brussels in November 2007, against the background of Directive 2000/31/EC on electronic commerce.

This code is an integral part of the Code of Ethics for Dentists in the European Union and concerns information services and commercial communications on the internet and other methods of electronic communication. The code provides a guide for dentists' communications with other dentists and consumers who are not members of the dental profession. Dentists are responsible for their conduct as information service providers and for the content of their commercial communication.

1. Mandatory provider information on a website

A dental website must display the following information about the information service provider:

- the name and geographic address at which the service provider is established.
- details of the service provider, including e-mail address and telephone number (it may also provide a fax number).
- the professional title and the country from which that title is derived, where appropriate.
- licence and registration information, with the address and other contact details of the competent authorities or a link to these authorities' websites, where appropriate.

2. Requirements for the professional information (commercial communication)

When providing professional information through the internet, dentists must display truthfulness, fairness and dignity. When setting up a website, dentists must ensure that the contents do not contain unprofessional information, especially of an extolling, misleading or comparative nature. All the information on the website must be honest, objective, easily identifiable and conform to any national legislation and code of conduct in the Member State where the dentist is established or temporarily practising.

a) The professional information (commercial communication) must include the following:

- the name of the practice, if it has a legal status in the Member State where the dentist is established
- for all dentists providing dental care mentioned on the site:
  - the professional title and country from which their title is derived;
  - licence and registration information, with the address and other contact details of the competent authorities or a link to these authorities' websites, where appropriate;
  - the professional rules governing the practice of dentistry in the Member State where the dentist is established and temporarily practising, or the address and other contact details of the competent authorities governing these rules or have a link to these authorities' websites, where appropriate.

A dentist *must* have regard to professional propriety and the dignity of the profession when establishing a name for the website or an e-mail address.

When the dentist or other person with responsibility for the information service changes, the name of this person *must* be removed from the website within one month of the cessation of responsibility.

The relevant pages must show the date of the latest modification of the page.

When a description of care is given, such information must not be comparative.

b) The following information must be shown on a website:

The admissions or acceptance policy to any sickness fund, national health service or insurance scheme, when these are available at the practice.

c) The following discretionary information may be shown on a website:

- the hours during which the practice may be accessed by telephone or personal visit, if any;
- details of urgent and emergency care available at the practice;
- details of the provision of care by the responsible dentist or other dentists in the practice or at other locations;
- a link to the professional association;
- information that is permitted by the professional rules of the country in which the dentist is established;

If links to other websites are provided, the dentist must ensure that they are relevant and reflect the principles of this code.

d) The following information must not be placed on websites:

Comparison of skills or qualifications of any dentist providing any service with the skills and qualifications of other dentists.

Annex 13 – (Proposed) Directive on patients' rights in cross-border healthcare

The draft Directive was published on July 2nd 2008. The legislative process for draft Directives can take two to three years.

A number of principles with regard to rights of patients obtaining healthcare abroad have been established through judgements in the European Court of Justice (ECJ). The Commission therefore proposed to provide a firm grounding for these rights through a separate health services Directive

Major provisions:

- Patients have the right to seek healthcare abroad and be reimbursed up to what they would have received at home.

  The Directive will provide clarity over how these rights can be exercised, including the limits that Member States (MS) can place on such healthcare abroad, and the level of financial coverage that is provided for cross-border healthcare.

  MS must reimburse where the treatment would have been provided in the home state and up to the amount that would have been borne by the health system/insurance reimbursement; they must have a mechanism for calculation. Patients do not need prior authorisation for non-hospital care.

  Hospital care will be defined as care requiring overnight stay plus a to-be-defined list of treatments that require hospital-type infrastructure, equipment and facilities or which present a particular risk.

  MS may impose the same conditions, criteria of eligibility and regulatory and administrative formalities as in the home state, including the need for General Practitioner referral. But the conditions must be necessary, proportionate and not discretionary and discriminatory.

  They may also introduce prior authorisation to avoid a threat to the financial balance of the MS's social security system, overcapacity, wastage, fair access etc. The Directive explicitly states that the proposed system should not undermine health and social security systems, either through its direct financial impact or through its impact on overall planning and management of those systems. It may, however, require member states to make adjustments to those systems. Procedural systems must be proportionate and easily accessible and time limits for approval must take account of the specific medical condition, the degree of pain, the nature of the disability and the patient's ability to work.

  A system for patient reimbursement for hospital treatment for which prior authorisation has been sought is already in place (Regulation (EC) No 1408/71), as is a system for urgent or necessary treatment while someone is abroad temporarily (European Health Card). The new proposal does not seek to impact on these provisions.

- Patients should be confident that the quality and safety standards of the treatment they will receive in another Member State are regularly monitored and based on good medical practices.

  The Directive will provide for systems to ensure that the standards are regularly monitored and based on good practice. The Commission will work with member states to facilitate this.

  MS are responsible for ensuring compliance with operating principles set out in the EU's *Common values and principles in the EU health systems*, which include quality, safety, care that is based on evidence and ethics, patient involvement, redress, privacy in processing personal data and confidentiality.

  Healthcare providers must provide full information to patients, who must have a means of making complaints and guaranteed remedies and compensation.

- European cooperation on healthcare will be facilitated (through reference networks)

  This means the creation of European reference networks, which include the development of specialised centres in different member states in order to ease access and to pool resources, to provide quality and safety benchmarks and help develop and spread best practice. There will be specific criteria and conditions for the networks.

  There is also provision for the recognition of prescriptions issued by providers in other countries and there must be mechanisms for pharmacist to verify their authenticity through a Community prescription template and ePrescriptions. There could be exclusions.

- Health technology assessment is another clear area of European added-value. This initiative will help to reduce overlap and duplication of efforts in this field and hence promote the effective and efficient use of resources.

- Activities in the field of "e-Health" will also be strengthened.

  The Directive aims to facilitate the sharing of formats and standards that can be used between different systems and countries. It also looks at ensuring that confidentiality and data protection are assured in its processes. There will be a requirement for member states to provide information to patients on their rights and options through a national contact point.

This annex was prepared with the assistance of Ulrike Mathesius of the British Dental Association

Annex 14 – Consultation on Patient Safety

The European Commission launched (in March 2008) an eight week public consultation on patient safety. The results of this will help in the development of the Commission's proposal for on general patient safety issues planned for the end of 2008. That proposal will address the important issue of patient safety throughout the European Union (EU) and will include a detailed first pillar, addressing healthcare-associated infections (HCAI), on which separate public consultations have already been held.

The two primary objectives of the Commission's general patient safety proposal will be:

- to support Member States in their efforts to minimise harm to patients from adverse events in their health systems, through appropriate policies and actions to improve safety and, therefore, quality of care.
- to improve EU citizens' confidence that they will receive sufficient and comprehensible information available on levels of safety and available redress in EU health systems, including healthcare providers in their own country and in other Member States.

The dental profession is committed to providing safe dental care, which is necessary for ensuring good general health, and aims to minimise risks and establish an open culture of patient safety, in which practitioners can learn from their own and others' experiences.

It is essential that action to improve patient safety at national, European and international level take into account the various healthcare settings in which patients are treated, since the types of patient safety risk and most appropriate ways of minimising them may vary according to healthcare setting. Most dental care in Europe is provided in liberal practice, in small structures, and in an environment where the dentist generally has complete individual responsibility for the whole procedure of care of the patient.

The risk of adverse events is present throughout that whole procedure, relating, for example, to diagnosis, faulty equipment, general safety of the practice, poor communication with the patient or other health professionals, inadequate infection control or waste management. It is important to remember that in the field of medical care "zero risk" does not and cannot exist.

Reduction of adverse events and improvement of patient safety is most effectively achieved through prevention, and preventive action to reduce adverse events is in turn a facet of high quality healthcare. Quality cannot be promoted through force or sanctions from outside. It must be ensured that new measures ostensibly to improve patient safety, which can often add to the bureaucratic burden in the dental practice, do not hinder dentists from spending sufficient time with each patient, as this is an important parameter of high quality. The dental profession in every Member State has self-regulatory functions in promoting high quality, and works, when necessary, with its respective governments in a co-regulatory context to achieve the same objective. The dental profession seeks to promote quality in many ways, including providing for continuing professional development to keep skills up to date; establishing local study groups for dentists and dental practices to learn from each others' experiences; developing systems for reporting adverse events or near misses; and ensuring compliance with infection control and waste management laws. Much of this is implemented already in Member States, although action to improve patient safety is an ongoing preoccupation.

Particular patient safety issues arise where dental healthcare services are provided in a cross-border context, where either the patient or professional leaves their country of affiliation or of establishment.

The role of the Council of European Dentists

The CED believes it is well placed to act as a liaison between its national member organisations to facilitate exchange of knowledge and experience on improving patient safety; and to recommend corresponding action. The CED is able to communicate the dental profession's expertise in dealing with patient safety to the EU institutions and contribute to EU-level projects, such as the European Network on Patient Safety (EUNetPaS).

In May 2008, the CED recommended that its member organisations:

- Seek to ensure that patient safety is part of undergraduate and post-graduate dental training curricula, to strengthen further the patient safety culture in healthcare.
- Encourage their dentists to be actively aware of the various elements of their professional practice where patient safety can be compromised.
- Encourage their dentists and the rest of the dental team to participate in continuing professional development relating to patient safety, to keep knowledge and skills up to date.
- Ensure that dentists have a knowledge of languages necessary for practising in their country, in particular in order that they be able to communicate with patients and other professionals.
- Seek to ensure that patient data is safely stored and available to health professionals as and when required, in accordance with national law.
- Ensure official registration of qualifications of dentists.
- Ensure transparency of the qualifications and competences of all other members of the dental team, as required by national law.
- Consider establishing "study groups" to provide a forum for local dentists to discuss experiences openly and learn from each other.
- Seek to introduce national systems for voluntarily and anonymously reporting adverse events, near misses and problems with medical devices, to enable all dentists to learn from their own and others' experiences.

- Promote the CED code of ethics and national ethical codes, since strong ethics underpin high quality and safety.

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