Council of European Dentists

MANUAL OF DENTAL PRACTICE 2015

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Preface

The revised EU Manual of Dental Practice (Edition 5) was commissioned by the Council of European Dentists[1] in April 2013. The work has been undertaken by 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 Council.

This edition (5.1) corrects a number of errors identified after publication. All data are as 2013 and have not been updated to 2015 data.

About the authors[2]

Dr Anthony Kravitz graduated in dentistry 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 then EU Dental Liaison Committee.

He gained a Master's degree from the University of Wales in 2005 and subsequently was awarded Fellowships at both the Faculty of General Dental Practice and the Faculty of Dental Surgery, at the Royal College of Surgeons of England.

He is an Honorary Research Fellow at the Cardiff University, Wales and his research interests include healthcare systems and the use of dental auxiliaries. He is also co-chair of the General Dental Council's disciplinary body, the Fitness to Practise Panel.

Anthony was co-author (with Professor Elizabeth Treasure) of the third and fourth editions of the EU Manual of Dental Practice (2004 and 2009)

President of the BDA from May 2004 until May 2005, he was awarded an honour (OBE) by Her Majesty The Queen in 2002.

Professor Alison Bullock: After gaining a PhD in 1988, Alison taught for a year before taking up a research post at the School of Education, University of Birmingham in 1990. She was promoted to Reader in Medical and Dental Education in 2005 and served as co-Director of Research for three years from October 2005.

She took up her current post as Professor and Director of the Cardiff Unit for Research and Evaluation in Medical and Dental Education (CUREMeDE) at Cardiff University in 2009. With a focus on the education and development of health professionals, her research interests include: knowledge transfer and exchange; continuing professional development and impact on practice; workplace based learning.

She was President of the Education Research Group of the International Association of Dental Research (IADR) 2010-12.

Professor Jonathan Cowpe graduated in dentistry from the University of Manchester in 1975. Following training in Oral Surgery he was appointed Senior Lecturer/Consultant in Oral Surgery at Dundee Dental School in 1985. He gained his PhD, on the application of quantitative cyto-pathological techniques to the early diagnosis of oral malignancy, in 1984. He was appointed Senior Lecturer at the University of Wales College of Medicine in 1992 and then to the Chair in Oral Surgery at Bristol Dental School in 1996. He was Head of Bristol Dental School from 2001 to 20004.

He was Dean of the Faculty of Dental Surgery at the Royal College of Surgeons in Edinburgh from 2005 to 2008 and is Chair of the Joint Committee for Postgraduate Training in Dentistry (JCPTD). He has been Director of Dental Postgraduate Education in Wales since 2009. His particular interest now lies in the field of dental education. He was Co-ordinator for an EU six partner, 2-year project, DentCPD, providing a dental CPD inventory, including core topics, CPD delivery guidelines, an e-learning module and guidelines (2010-12).

Ms Emma Barnes: After completing a degree in psychology and sociology, Emma taught psychology and research methods for health and social care vocational courses, and later, to first year undergraduates. Following her MSc in Qualitative Research Methods she started her research career as a Research Assistant in the Graduate School of Education at the University of Bristol, before moving to Cardiff University in 2006, working firstly in the Department of Child Health and then the Department of Psychological Medicine and Clinical Neurosciences.

In 2010 Emma joined Cardiff Unit for Research and Evaluation in Medical and Dental Education (CUREMeDE) as a Research Associate. Working in close collaboration with the Wales Deanery, (School of Postgraduate Medical and Dental Education), her work focuses on topics around continuing professional development for medical and dental health professionals, and knowledge transfer and exchange.

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In addition, the authors obtained information from the websites of the following organisations, without direct contact with them:

The Federation Dentaire Internationale (FDI)
The European Commission, including Eurostat
The World Health Organisation (WHO)
Union Bank of Switzerland (UBS)
The Organisation for Economic Cooperation and Development (OECD)
The Committee of European Dental Officers (CECDO)
The CIA Worldfactbook
The International Monetary Fund (IMF)
The World Bank
Deloitte
Price Waterhouse Cooper

Disclaimer

The Manual was originally sent for publication in February 2014 and then re-publication in February 2015: data may have subsequently changed.

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Introduction

Background

In common with many other professionals, dentists and other dental professionals 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 many national dental associations have experienced a considerable increase in the number of enquiries from members about practising in another country. 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 32 European (EU and EEA) countries.

The scope and presentation of the review

The Manual's primary aim is to provide comprehensive and detailed information for dentists and dental professionals who are considering working in another country. In fact, the Manual has proved to be of value to governments and regulators also. It is widely quoted in professional journals and papers.

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 Directives which are directly relevant to dentists, and we have listed relevant internet weblinks.

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 28 countries of the EU, Iceland, Liechtenstein and Norway (the EEA), and Switzerland are included. Greenland and the Faroe Islands are described in the chapter for Denmark. There are self-governing islands in the British Isles and a British Dependency in Europe - these have been included in the UK section. Monaco and San Marino are also added for the first time in this edition. Although neither country is a member of the EU, they have strong ties with the EU.

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, website and email address of the main national dental associations, together with some other general data.

Information collection and validation

The history of the editions, the sources of information used, and the validation of these are listed in Annex 1.

Romania

There was no cooperation from the dental associations and other authorities, or the universities in Romania, to update the information relating to that country. To collect information, Cardiff University was greatly assisted by Dr Nicolae Cazacu, the recent Secretary-General, of the Romanian College of Dentists, but his access to information was limited. Some of the information has been collected from general sources on the internet.

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 2013, and so this should be assumed to be the reference year for the data**, except where another date is shown.

UK English language conventions have been used for expressing text, 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
- UK English conventions for spelling are used, for example organisation is spelt with an "s", rather than a "z", as in some English speaking countries
- The sign for the Euro is € and this is placed before the number, eg €100
- Data was finalised in January 2014, so any financial or currency problems after this date are not reflected here.
- The Manual was produced using Microsoft Word 2010, Build 14.0.7113.5005 (32-bit) and may display differently in any other version.

Edition 5.1

During 2014 several countries contacted the CED to advise that there were errors in the information published. Text changes have been made and corrected data inserted at the request of the following countries:

France
Germany
Hungary
Lithuania
Malta
Netherlands
Sweden

These were all effected in Jnauary 2015. The NMT (Netherlands) became the Royal Dutch Dental Association (KNMT) in June 2014, but the title has not been changed in the Manual to reflect that all text and data relate to January 2014 or earlier.

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 or private 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 practise in a non-supervised environment, and own his or her own dental practice.

Cost of registration

This refers to the annual cost of registration (if any) 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 host country.

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

References by countries to "abroad" refer to another country other than their own.

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, armed forces, 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 who no longer undertake any form of dentistry, including administrative dentistry.

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

This refers to a dental 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" refers 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 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 1st January 2014 the EU comprised 28 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)
- Croatia (July 2013)

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 1st May 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 13th December 2007, EU leaders officially signed a new Treaty at a Special Summit in Lisbon, which came into force on 1st December 2009.

Health

The EU Health Strategy has 3 main objectives:

- fostering good health in an ageing Europe
- protecting citizens from health threats
- supporting dynamic health system and new technologies

In 2007, the European Commission published a White Paper for an 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".

In 2013, a mid-term review of the Health Strategy was carried out, establishing that the strategy provides a coherent and comprehensive map of the main health-related issues.

The Member States can achieve more when working in coordination at EU level in certain areas. The Strategy serves as a consistent guiding framework and reference for actions taken at EU level.

For further information about the Strategy see Annex 5.

In 2009, there was a Commission initiative dealing with patient safety, including a Council recommendation on patient safety which in particular addressed the issue of Health Care Associated Infections. For further information see Annex 11.

The Institutions

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

- *European Parliament* (elected by the peoples of the Member States);
- *European Council* (which has the role of driving EU policy-making, headed by the President.);
- *The Council* (composed of representatives of each Member State at ministerial level)
- *European Commission* (driving force and executive body);
- *Court of Justice* (compliance with EU law);
- *European Central Bank*
- *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).

National Parliaments

The Lisbon Treaty, in 2009, gave the national parliaments of Member States greater powers at an EU level. Parliaments are now able to comment on draft legislations and other activities.

A number of agencies and bodies complete the system. For further information about each institution, please see 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, healthcare, 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.

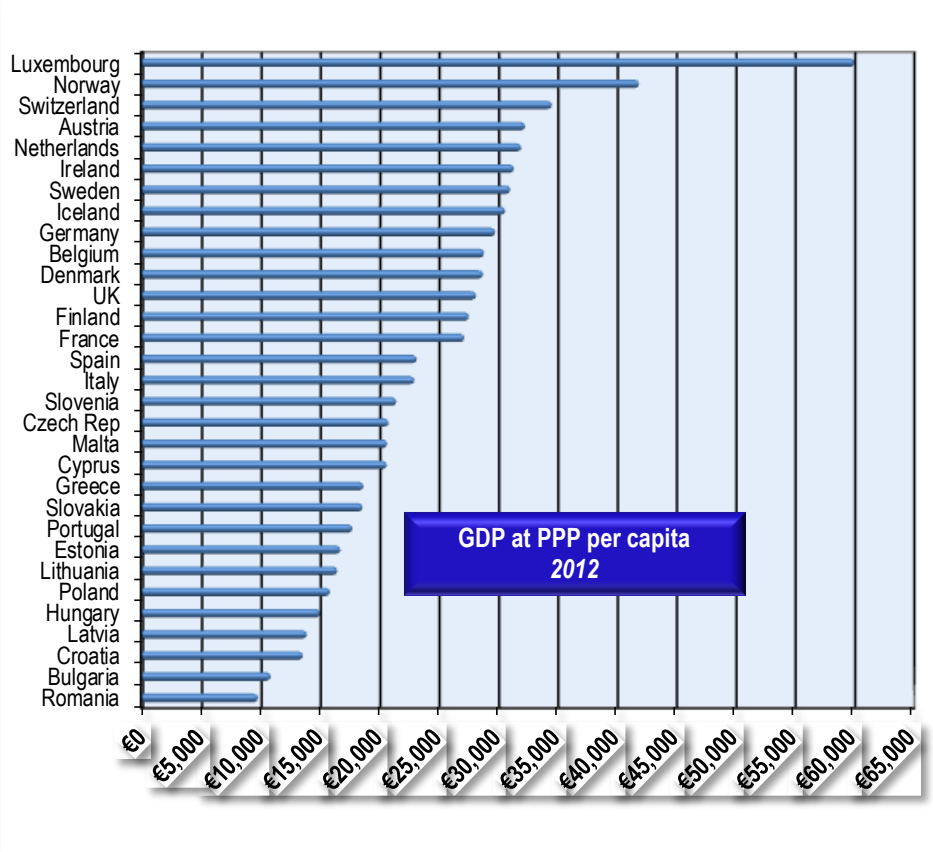
For example, a particular TV set that sells for €750 in Calais should cost £625 in Dover, when the exchange rate between the UK and France is €1.20 = £1. Clearly, PPP between different countries within the Eurozone is easier to measure. So, looking at relative wealth for all the EU/EEA countries using PPP has slightly changed the order of countries within the chart (Chart 1, next page), 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

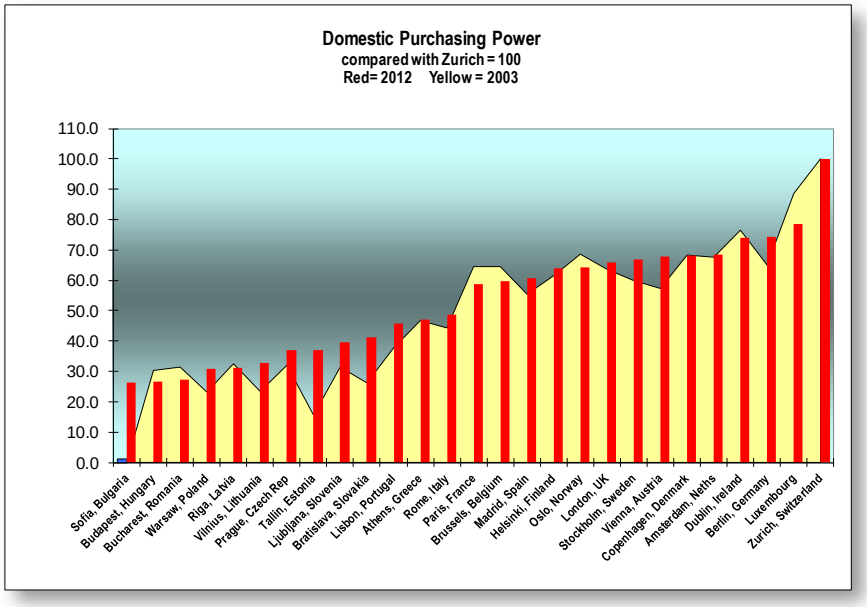
For individuals, however, their own income and what this will buy may have more relevance. UBS bank produces data which compares prices and earnings in the largest city in each EU/EEA country. The earnings data uses a basket of earnings from various trades and professions:

Chart 1 – Gross Domestic Product per capita at Purchasing Power Parity in 2012



Source: International Monetary Fund, World Economic Outlook Database, April 2013
http://www.imf.org/external/pubs/ft/weo/2013/01/weodata/weoselco.aspx?g=2001&sg=All+countries

Chart 2 – Domestic Purchasing Power, including rent, in 2012 – based on Zurich = 100



Source: UBS Price and Earnings November 2012

Chart 2 shows the relative purchasing power of all goods and rent, November 2012, based on Zurich, taking net wages or salary into consideration. So, people living in Luxembourg were in the second best position to purchase goods or services and those in Sofia the least. These comparisons also take into account currency as some of the countries are not in the Eurozone..

Part 2: The Freedom of Movement and Acquired Rights

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 State 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.

Regulations are the most direct form of EU law - as soon as they are passed, they have binding legal force throughout every Member State, on a par with national laws. National governments do not have to take action themselves to implement EU regulations. They are different from directives, which are addressed to national authorities who must then take action to make them part of national law, and decisions, which apply in specific cases only, involving particular authorities or individuals. Regulations are passed either jointly by the EU Council and European Parliament, or by the Commission alone.

The Freedom of Movement

The principle of freedom of movement of workers, which was established in 1969, was intended to "abolish any discrimination based on nationality between workers of the Member States (MS) 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 Union 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 (including patient safety).

Since 1980, freedom of movement has applied to dentists from those Member States whose dental education and training met the requirements of the relevant 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 Union.

Dentists wishing to practise in the EU must register with the competent authority in the country in which they wish to work. The details of the competent authority which is 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. Articles 4c and 4d of the Professional Qualifications Directive (PQD) 2013/55/EU (page 10), define the role of the home Member State authorities[3].

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.

Member States must be proportionate in relation to any additional obstacles to prevent an EU national with an EU qualification from practising. Also, 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[4].

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 EU 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 were 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,** when they joined the EU in 2004. However then, and in 2007 and 2013, for all the other countries, a common approach was used.

3 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2013:354:0132:0170:en:PDF

4 For more information, see: http://ec.europa.eu/dgs/internal_market/index_en.htm or http://europa.eu/youreurope/advice/index_en.htm

Under the transitional arrangement, the rights of nationals from new Member States who were already legally resident and employed in a MS 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 transition period for Bulgaria and Romania ended on 31st December 2013.[5]

Freedom of Movement and family members

European Parliament Directive 2004/38/EC legislated on the right of citizens of the EU and their family members to move and reside freely within the territory of the Member States. The Directive was implemented on 30th April 2006.

For further information, please go to Annex 3

Acquired Rights

Where the evidence of formal qualifications as a dental practitioner or as a specialised dental practitioner, held by Member State nationals, does not satisfy all the training requirements referred to in the Professional Qualifications Directive (PQD), each Member State has to recognise as sufficient proof evidence of formal qualifications issued by those Member States. This is only insofar as such evidence attests to 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 holder has 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.

Acquired Rights were also gained by those who were practising in the former East Germany, the Baltic States (having gained their qualifications in the Soviet Union) and some of those who had been practising in Italy. They were also gained by dental professionals practising in Spain (relating to earlier medical training); Austria; Slovenia; and Croatia (in relation to the former Yugoslavia),

Additonally, the main principles of the Directive give the right to free movement and residence within the territory of the Member States – also to their family members.

The Directive requires that family members of EU citizens are treated as EU citizens. This includes the right of family members to take up employment or self-employment, providing they have the right of residence or permanent residence.

The main conditions for a non-EEA national to be treated as an EEA national in a Member State (MS) are that the non-EEA national must be the family member of an EEA national (other than a national of the particular MS being applied to) and that 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 that they have the right to equal treatment in the particular MS being applied to as a national of that particular MS. 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 Member State 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 PQD of 2013 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.

For further, detailed information about Acquired Rights, please see Annex 3.

[5] There are arrangements following the accession of Croatia in 2013. Self-employed Croatians and students who are working only part-time should not be affected by any restrictions on the Freedom of Movement.

However, several Member States have put initial restrictions on other Croatian workers: Austria, Belgium, Germany, Luxembourg, the Netherlands, Slovenia, Spain and the United Kingdom have imposed restrictions on Croatians doing certain kinds of work. There is no restriction on searching for work done in the initial 3 months of residence.

Ten member states have not imposed any restrictions on Croatian job seekers: the Czech Republic, Denmark, Estonia, Finland, Hungary, Ireland, Lithuania, Romania, Slovakia and Sweden.

Part 3: Directives involving the Dental Profession

Recognition of Professional Qualifications

The recognition of professional qualifications in dentistry is currently regulated by Directive 2005/36/EC as amended by Directive 2013/55/EU (hereinafter PQD).

This Directive establishes the rules under which a host Member State recognises professional qualifications obtained in one or more other Member States and which will allow the holder of these qualifications to pursue the same profession in the host Member State. It is applicable to all Member State nationals.

Professional qualifications obtained in a third country may also be recognised by the host Member State under certain conditions specified in the Directive (Articles 2(2) and 3(1)(a) of the PQD). In case of dentistry, the initial recognition needs to respect the minimum training conditions laid down in Title III Chapter III sections 1 and 4.

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

On 20th October 2005, Directive 2005/36 EC came into force and replaced the earlier Dental Directives (78/686 and 78/687 EEC) and 13 others related to the recognition of professional qualifications of dental practitioners, doctors of medicine, nurses responsible for general care, midwifes, pharmacists, veterinary surgeons and architects. It improved and simplified the system of automatic recognition of dental qualifications.

A number of changes were introduced compared with the previous rules, including greater liberalisation of the provision of services and increased flexibility in the procedures for updating the Directive. The Directive also aimed 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.

Directive 2013/55/EU of the European Parliament and of the Council of 20th November 2013 (Amendments to Directive 2005/36 EC)[6]

On 18th January 2014, Directive 2013/55/EU came into force, amending several provisions of Directive 2005/36/EC. The review aimed at making the system of mutual recognition of professional qualifications more efficient in order to achieve greater mobility of skilled workers across the EU.

The main features of the amended Directive include:

- the creation of a European Professional Card;
- the introduction of the principle of partial access to certain professions (not applicable to professionals benefiting from automatic recognition of their professional qualifications such as dentists);
- the recognition of professional traineeships carried out in another Member State or in a third country;
- the clarification and update of training requirements for professions under the automatic principle regime (and for dental practitioners, changes to the minimum duration of training); and
- measures for a better use of existing instruments such as the Internal Market Information (IMI) system.

- ***Transparency of regulated professions***

A regulated profession means that access to the profession is subject to a person holding a specific qualification, such as a university diploma, and that activities are reserved to holders of such qualifications.

Article 59 of Directive 2013/55/EU established a transparency and mutual evaluation exercise to be carried out by Member States, which seeks to reduce the number of regulated professions and to remove unjustified regulatory barriers restricting the access to a profession or its pursuit. It involves examining the justification of the need for regulation against the principles of necessity, proportionality and non-discrimination.

- ***Continuous Professional Development***

Under Article 22(b), Member States will promote the continuous professional development of professionals who benefit from the principle of automatic recognition. These include, in particular, doctors of medicine, nurses responsible for general care, dental practitioners,, veterinary surgeons, midwives, pharmacists and architects also known as "sectoral professions".

Lifelong learning is of particular importance for a large number of professions. It is comprised of all general education, vocational education and training, non-formal education and informal learning undertaken throughout life, resulting in an improvement in knowledge, skills and competences, and may include professional ethics (see Article 3 (1) (l)). Recital 39 further 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"*.

System of automatic recognition of professional qualifications for dental practitioners (Chapter III of the PQD)

Each Member State automatically recognises evidence of formal qualifications (diplomas, certificates and other evidence attesting successful completion of professional training) giving access to professional activities as a dental practitioner and as a specialised dental practitioner, covered by Annex V, points 5.3.2 and 5.3.3 of the PQD.

Article 35(5) of the PQD also establishes the principle of automatic recognition for new dental specialties (and its inclusion in point 5.3.3 of Annex V of the Directive) that are common to at least two-fifths of the Member States.

The description of the professional activities of dental practitioners is defined under Article 36 of the PQD.

For the purposes of equivalence in qualifications, this Directive sets minimum training requirements for dentists:

- ***Minimum training requirements, including length of training and content***

Admission to training as a dental practitioner (basic dental training) presupposes possession of a diploma or certificate

[6] http://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:32013L0055

giving access, for the studies in question, to universities or higher institutes of an equivalent level, in a Member State.

The system of automatic recognition works on the basis of coordinated minimum training requirements. Basic dental training must be for at least 5 years' study, with the equivalent ECTS credits[7], and must consist of at least 5,000 hours of full-time theoretical and practical training. That comprises, at least, the programme described in point 5.3.1 of Annex V (of the PQD). This should guarantee that the person concerned has acquired commonly agreed knowledge and skills.

Under Article 22(a) of the PQD, Member States may authorise part-time training, provided that the overall duration, level and quality of such training is not lower than that of continuous full-time training.

The PQD provides a minimum programme of subjects to follow, which leaves room for the Member States to draw up more detailed study programmes. The list of subjects appears in Annex V (of the PQD), point 5.3.1 and can be amended by delegated acts 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 the PQD, and will enable them to practise their profession in any Member State.

Articles 23 and 37 of the PQD establish the conditions under which dental practitioners can see recognised their professional qualifications which were obtained before their country joined the EU. This is known as the "acquired rights' regime (see Annex 3 of this Manual). In these cases, where the evidence of formal qualifications providing 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 in Article 34 and 35, each Member State must 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 the Annexes 5.3.2 and 5.3.3 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. Further details specific to dental practitioners are mentioned under Article 37.

- ***Specialist training***

Full-time specialist dental courses must be of a minimum of three years' duration and must be supervised by the competent authorities or bodies. They must involve the personal participation of the dental practitioner who is training to be a specialist in the activity, and in the responsibilities of the establishment concerned.

Admission to specialist dental training is contingent upon completion and validation of basic dental training as defined in Article 34 of the PQD, or possession of the documents referred to in Articles 23 and 37.

The Commission is empowered to adopt delegated acts (in accordance with Article 57c) concerning the adaptation of the minimum period of specialist training to scientific and technical progress.

The Commission is also empowered to adopt delegated acts concerning the inclusion in point 5.3.3 of Annex V of the PQD of new dental specialties common to at least two-fifths of the Member States.

- ***Recognition of traineeships***

Given that national rules organising the access to regulated professions should not constitute an obstacle to the mobility of young graduates, when a graduate completes a professional traineeship in another Member State or in a third country, the professional traineeship will be recognised, under the conditions laid down by Article 55a of the PQD, when the graduate applies for access to a regulated profession in the home Member State. In particular, the traineeship must be in accordance with the Member State's guidelines on the organisation and recognition of traineeships. Member States may set a reasonable limit on the duration of the part of the professional traineeship which can be carried out abroad.

- ***Diplomas guaranteeing compliance***

The PQD 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[8].

- ***Knowledge of languages***

The knowledge of one official language of the host Member State is necessary in order for the professional (ie dental practitioner) to start practising in the host Member State. However, the control of the language by the host Member State can only be carried out after the recognition of the professional qualification. It is important for professions with patient safety implications, such as dentistry, that a language control is exercised before the professional accesses such a profession.

However, language controls have to be proportionate for the job in question and should not aim at excluding professionals from the labour market in the host Member State. The professional should be able to appeal against such controls under national law.

Employers will also continue to play an important role in ascertaining the knowledge of languages necessary to carry out professional activities in their workplaces.

- ***Partial access – Article 4f of the PQD***

The PQD applies to professionals who want to pursue the same profession in another Member State. However, there are cases where the activities concerned are part of a profession with a

[7] Recital 17 of the Amended PQD - European Credit Transfer and Accumulation System (ECTS) credits are already used in a large majority of higher education institutions in the Union and their use is becoming more common also in courses leading to the qualifications required for the exercise of a regulated profession. Therefore, it is necessary to introduce the possibility to express the duration of a programme also in ECTS. That possibility should not affect the other requirements for automatic recognition. One ECTS credit corresponds to 25-30 hours of study whereas 60 credits are normally required for the completion of one academic year. Source: EN L 354/134 Official Journal of the European Union 28.12.2013

[8] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:255:0022:0142:en:PDF

larger scope of activities in the host Member State. If the differences between the fields of activity are so large that in reality a full programme of education and training is required for the professional to compensate for shortcomings - if the professional so requests - a host Member State must grant partial access, determined on a case-by-case basis, to a professional activity in its territory, only when all the following conditions are fulfilled:

(i) the professional is fully qualified to exercise in the home Member State the professional activity for which partial access is sought in the host Member State;
(ii) differences between the professional activity legally exercised in the home Member State and the regulated profession in the host Member State as such are so large that the application of compensation measures would amount to requiring the applicant to complete the full programme of education and training required in the host Member State to have access to the full regulated profession in the host Member State;
(iii) the professional activity can objectively be separated from other activities falling under the regulated profession in the host Member State.

A Member State is able to refuse partial access to a profession, if it is justified by overriding reasons of general interest.

The principle of partial access does not apply for professionals benefiting from the principle of automatic recognition, ie the sectoral professions, which include dental practitioners.

- ***Principle of the free provision of services[9]***
    - ***Article 5 of the PQD***

This provision establishes the principle that Member States must not restrict, for any reason relating to professional qualifications, the free provision of services in another Member State if the service provider - a dental practitioner - is legally established in a Member State as a dental practitioner. This principle, and the provisions laid down in Title II of the PQD, only applies when the dental practitioner moves to the host Member State to pursue his/her activity on a temporary and occasional basis. The *"temporary and occasional nature"* of the services provided are 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 of judgement by competent authorities (regulatory bodies) in each case. The European Court of Justice has already ruled on this issue, providing further guidance on these terms.

The dental practitioner under this regime is subject to the same rules as national dental practitioners to practise the profession, in particular disciplinary provisions and other rules related to professional qualifications.

- ***Exemptions***

One of the key aspects of the principle of the free provision of services in the PQD is the exemption, under certain conditions, from the requirement for migrants to be registered in a professional organisation or body (see Article 6(a)).

However, in order to ensure the application of disciplinary provisions to the dental practitioner, Member States may provide for automatic temporary registration with the competent authority or for pro forma membership with the professional organisation or body. This is done when a copy of the declaration referred in Article 7(1) of the PQD accompanied by a copy of the documents referred in Article 7(2) are sent by the host competent authority to the relevant professional organisation or body. Competent authorities may not however charge any additional costs for this.

- ***Article 7 - declaration to be made in advance for the first provision of services in the Host Member State***

Member States may require service providers (ie dental practitioners) to inform competent authorities of their intention to provide services on a "temporary and occasional" basis, 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. It is of course open to regulators to review cases periodically once the migrant is registered in the Member State, to assess whether or not the service provision is genuinely temporary and occasional.

The service provider may provide this written declaration by any means.

Member States may require under Article 7.2 of the PQD that the declaration is accompanied by the following documents:

(i) proof of the service provider's nationality,
(ii) an attestation certifying that the holder is legally established in a Member State for the purpose of pursuing the activities concerned and that he is not prohibited from practising, even temporarily, at the moment of delivering the attestation;
(iii) evidence of professional qualifications;
(iv) an attestation confirming the absence of temporary or final suspensions from exercising the profession or of criminal convictions; and,
(v) a declaration about the applicant's knowledge of the language necessary for practising the profession in the host Member State.

A Member State may require additional information of the listed above if:

(i) the profession is regulated in parts of that Member State's territory in a different manner;

[9] The Principle of the free provision of services is explained in the Lisbon Treaty. The freedom of establishment, set out in Article 49 (ex Article 43 TEC) of the Treaty and the freedom to provide cross border services, set out in Article 56 (ex Article 49 TEC), are two of the "fundamental freedoms" which are central to the effective functioning of the EU Internal Market.

The principle of freedom of establishment enables an economic operator (whether a person or a company) to carry on an economic activity in a stable and continuous way in one or more Member States. The principle of the freedom to provide services enables an economic operator providing services in one Member State to offer services on a temporary basis in another Member State, without having to be established.

These provisions have direct effect. This means, in practice, that Member States must modify national laws that restrict freedom of establishment, or the freedom to provide services, and are therefore incompatible with these principles. Member States may only maintain such restrictions in specific circumstances where these are justified by overriding reasons of general interest, for instance on grounds of public policy, public security or public health; and where they are proportionate.
http://ec.europa.eu/internal_market/top_layer/services/index_en.htm

(ii) such regulation is applicable also to all nationals of that Member State;
(iii) the differences in such regulation are justified by overriding reasons of general interest relating to public health or safety of service recipients; and
(iv) the Member State has no other means of obtaining such information.

Under the PQD, the service provider is entitled to practise once he/she has complied with all of the above.

- ***Use of professional and academic titles***

Articles 52 and 53 of the PQD regulate the use of professional and academic titles.

Dental practitioners should use the professional title of the host Member State.

Dental practitioners also have the right to use the academic title conferred on them in the home Member State in the language of the home Member State.

Where this academic title is liable to be confused in the host Member State with a title which requires additional training not acquired by the beneficiary, then the host Member State may decide on which terms the home academic title can be used.

General system for the recognition of professional qualifications (Chapter I of the PQD).

This system applies as a fallback for 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 under the automatic recognition regime (Chapter III of the PQD).

The conditions of recognition under the general system are specified in Article 13 of the PQD. If the competent authority of the host Member State thinks the training that the applicant has received differs significantly from the training required in the host Member State, the applicant may have to sit an aptitude test, or complete an adaptation period of up to three years.

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 under Article 14(3) of the PQD.

The PQD distinguishes under Article 11 five levels of professional qualifications so that they can be compared:

- 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.

For more details regarding the general system regime see Articles 10 to 15 of the PQD.

Automatic recognition on the basis of common training principles (Chapter IIIA of the PQD)

While taking into account the competence of Member States to decide on the qualifications required for the pursuit of professions in their territory and on the organisation of their education systems, the new provisions on common training principles intend to promote a more automatic character of recognition of professional qualifications for those professions which do not currently benefit from it. Indeed, the **professions** subject to automatic recognition, such as dental practitioner, are excluded from this regime (see Article 49a (2) (e) of the PQD).

The novelty, however, is the possibility for common training frameworks to also cover **dental specialties** that currently do not benefit from automatic recognition provisions under the PQD (see Article 49a(7) of the PQD). Common training frameworks on such specialties should offer a high level of public health and patient safety.

Common training principles can take the form of common training frameworks (meaning a common set of knowledge, skills and competences necessary for the pursuit of a specific profession) or of common training tests (meaning a standardised aptitude test available in participating Member States and reserved to holders of a particular professional qualification).

Professional qualifications obtained under common training frameworks should automatically be recognised by Member States. Article 49a(5) lays down the conditions under which Member States can be exempt of this regime.

Professional associations and organisations which are representative at national or Union level will be able to propose common training frameworks and common training tests.

Matters relating to sectoral and general system professions

- ***European professional card***

The PQD introduces a “European Professional Card”, which is an electronic certificate issued by the professional's home Member State, which will facilitate automatic recognition in the host Member State. The introduction of professional cards will be considered for a particular profession where:

  - there is clear interest from professionals, the national authorities and the business community;
  - the mobility of the professionals concerned has significant potential; and
  - the profession is regulated in a significant number of Member States.

- ***Alert mechanism***

The existing rules already provide for detailed obligations for Member States to exchange information. These obligations will be reinforced. In future, competent authorities of Member States will have to proactively alert the authorities of other Member States, using the IMI system, about professionals who are no longer entitled to practise their profession due to a disciplinary action or criminal conviction, through a specific alert mechanism. The alert should be made at the latest three days from the date of adoption of the decision restricting or prohibiting pursuit of the professional activity (in part or in its entirety).

- ***First provision of services***

For the first provision of services of certain service providers, Member States are given the option, under Article 7(4) of the Directive, of requiring competent authorities to check the professional qualifications. This applies to

(i) professions which fall under the general system with public health or safety implications
(ii) sectoral professions, in cases which fall within Article 10 of the Directive.

- ***Deadlines***

The PQD does not allow much flexibility in stipulating the deadlines 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 (see Article 51 of the PQD).

Directive on Patients' Rights in Cross-border Healthcare

On 24th April 2011, **Directive 2011/24/EU on patients' rights in cross-border healthcare** entered into force. The objective of the Directive is to clarify patients' existing rights of access to healthcare services in EU Member States.
For further information see Annex 6.

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[10] (**the Data Protection Directive**) was enacted to harmonise national provisions in this field. In January 2012, it was announced that there would be a redrafting of the current Data Protection Directive to create the **General Data Protection Regulation** (GDPR).

For further information, especially how this relates to dentistry, see Annex 7.

Consumer Liability

The main features of the **Directive on Liability for Defective Products** (85/374/EEC)[11] 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.

Producers are freed from all liability if they prove (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 producers to limit their 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.

10 http://ec.europa.eu/justice/policies/privacy/docs/95-46-ce/dir1995-46_part1_en.pdf

11 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31985L0374:en:HTML

Misleading and Comparative Advertising

The **Directives on Misleading and Comparative Advertising**[12] 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 its 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.

Cosmetics Regulation

In the early 1970s, 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 Directive was then recast with the adoption of Regulation (EC) No 1223/2009, of 30th November 2009.

This new **EU Regulation 1223/2009 - Cosmetics Regulation** came into force on 11th July 2013.

However, even before that new regulation, in the Summer of 2008 the European Commission commenced consultations, resulting in **Directive 2011/84/EU**[13] of 20th September 2011, amending the 1976 Directive. Article 2 stated that by 30th October 2012 all Member States had to adopt and publish the provisions necessary to comply with this Directive. Directive 2011/84/EC introduced only limited changes to the Annex of the Regulation and is not the main legislation governing cosmetics in the EU.

For further information see Annex 8.

Electronic Commerce

The E-Commerce Directive[14] was adopted on 8 June 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 cross-border provision throughout the European Union 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 audio-visual streamed content), online direct marketing and advertising and services providing access to the Internet.

The chief aim of the Directive is to ensure that the EU 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 10.

Unfair Commercial Practices Directive

The **Directive 2005/29/EC**[15] on **Unfair Commercial Practices** (UCPD) was adopted on 11 May 2005. There are 4 key elements in the Directive, which are:

- a far reaching general clause defining practices which are unfair and therefore prohibited;
- the two main categories of unfair commercial practices - Misleading Practices (Actions and Omissions) and Aggressive Practices - - are defined in detail;
- provisions that aim at preventing exploitation of vulnerable consumers;
- 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 plugs gaps in existing EU consumer protection legislation and sets standards against which new practices are judged.

The Directive's broad scope means that it overlaps with many existing laws. In addition, because the UCPD is a maximum

12 http://ec.europa.eu/justice/consumer-marketing/files/communication_misleading_practices_protection_en.pdf

13 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:283:0036:0038:en:PDF

14 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32000L0031:EN:NOT

15 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32005L0029:en:NOT

harmonisation Directive (i.e. setting out the maximum level of restriction permissible in respect of unfair commercial practices which harm consumers' economic interests) a supplementary objective was introduced to achieve, where possible, some regulatory simplification.

Implementation of this Directive is said to help Member States to ensure their consumer regimes are amongst the best in the world. A review published in 14th March 2013, stated that the Directive had helped enhance consumer protection and required no amendment.[16]

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 2001/83/EC** and **EC Regulation 726/2004.**[17]

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[18]. The Agency is responsible for co-ordinating the evaluation and supervision of medicinal products for human and veterinary use in the Union, 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.

Medical devices

The **Medical Devices Directive** (93/42/EEC)[19], 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, IIa, IIb or III, depending upon the nature of the device.

The EU Member States applied a new **Directive 2007/47/EC**[20] 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 changed, or affected, some of the existing provisions under 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.
- Custom-made devices are excluded from the obligation to carry CE marking.
- According to the Directive the patient is to be identified by name, acronym or a numerical code.
- The Directive requires that software which is used in medical devices or is a medical device itself (e.g. electronics in the unit, UV lamp, x-ray machine) has to be validated by the manufacturer. The burden on the dentist will depend on the instructions of the manufacturer – e.g. if the manufacturer insists on revalidation every three years, then the dentist will have to comply.
- 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.

In 2012 a Proposal was submitted outlining several amendments to the Directive to address changes in medical technology, standardise laws and improve access to information on devices. It was expected that the proposal will be adopted in 2014. For more information, please see Annex 11.

Directive on Prevention from Sharp Injuries in the Hospital and Healthcare Sector

Directive 2010/32/EU[21] recognises that health and safety of workers is an important issue and is linked with the health of patients. Health and safety is a hospital and healthcare sector-wide issue, and a responsibility for all workforce members.

The framework agreement applies to all workers in the hospital and healthcare sector with the aim of providing the safest working environment possible, minimising needlestick injuries through integrated risk assessment practices. For further information see Annex 11.

16 http://ec.europa.eu/justice/consumer-marketing/files/ucpd_report_en.pdf

17 http://ec.europa.eu/health/human-use/legal-framework/index_en.htm

18 http://www.emea.europa.eu/

19 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:1993L0042:20071011:en:PDF

20 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:247:0021:0055:EN:PDF

21 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2010:134:0066:0072:EN:PDF

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.

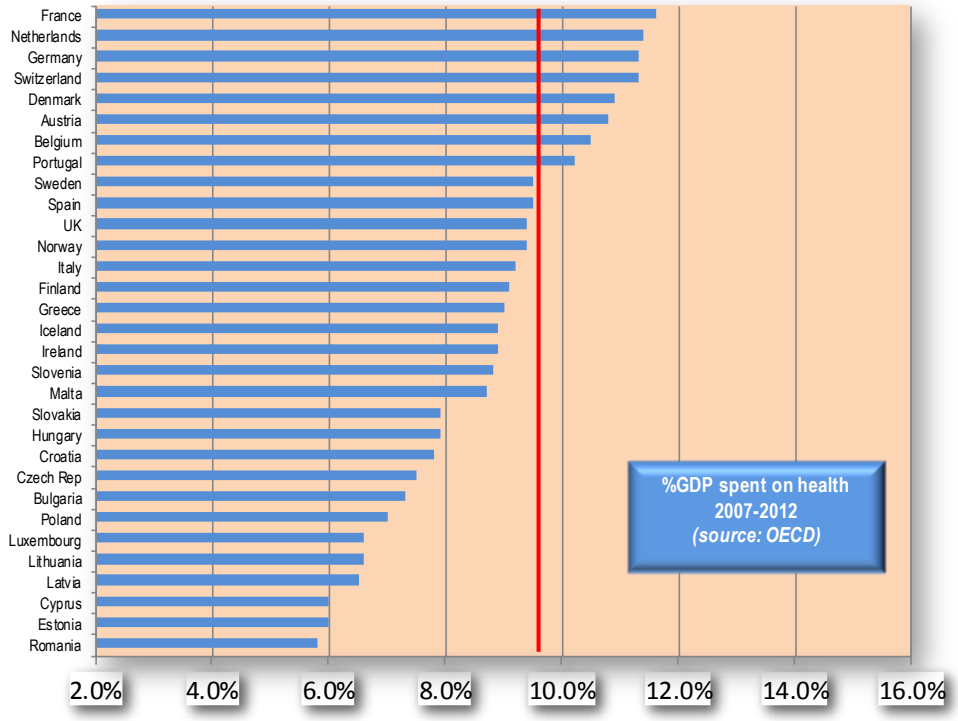
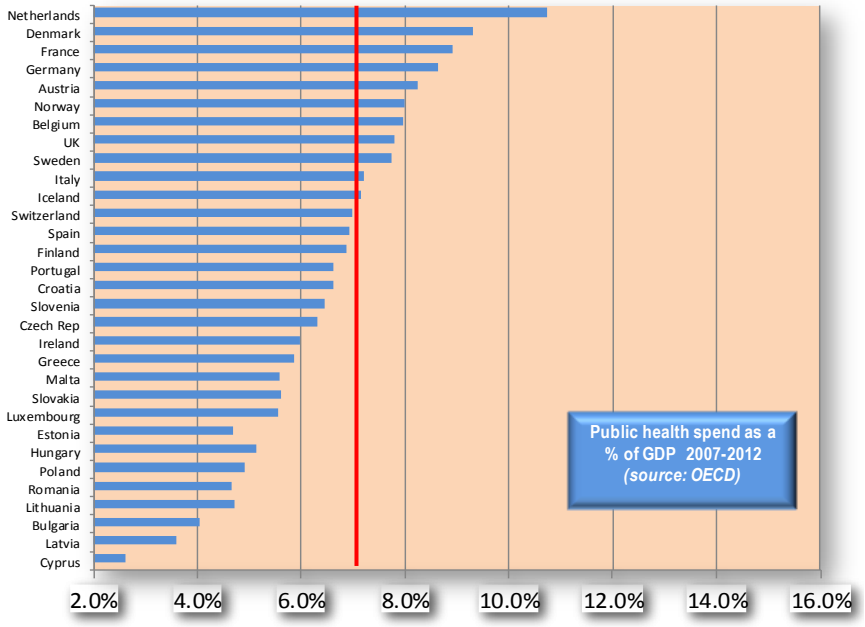


Chart 3 - Percentage of GDP spent on health by each country in 2007-12

Source OECD in 2007-12[22]

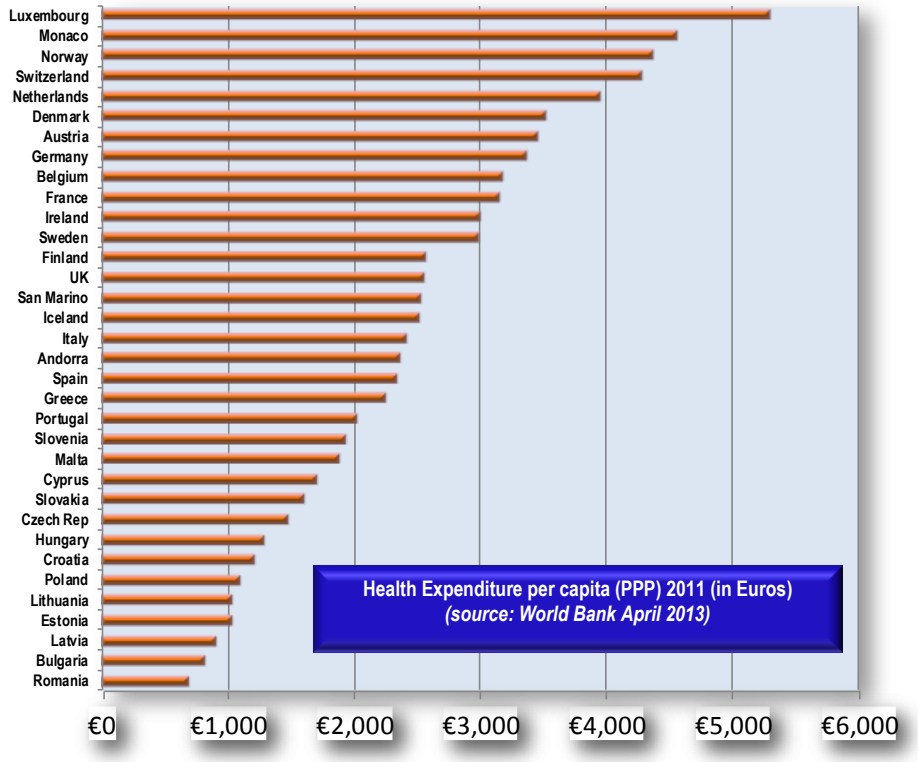
An attempt was made to compare expenditure on overall healthcare in countries, with reported spending on dentistry, but this was not possible as the interpretation of what constitutes spending on dentistry varied significantly. Some countries provided data for state spending only (as there was no data 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 2007-12



[22] nb: the percentages refer to different years recorded for each country, with the oldest at 2007 (Estonia) and the newest at 2012 (several countries); no data for Liechtenstein was supplied

Chart 5 – Spending per capita on health



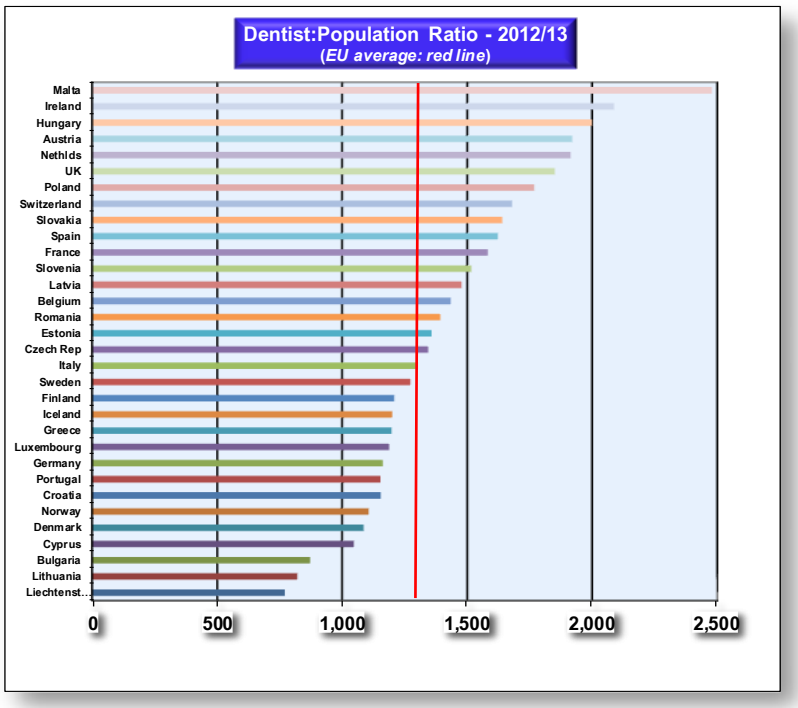
The World Bank has published data about individual spending per capita: this almost matches tables of GDP at PPP in each country.

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.[23]

The population of the areas covered by this Manual was about 518 million in 2013[24]. The dental associations reported that there were about 361,000 ***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 1:1,433. The equivalent figures for 2008 were 345,000 and 1:1,501 respectively, so there has been a small drop in "workload" for dentists. However, there were wide variations from this figure:

Chart 6 - (Active) Dentist to Population ratio



See Part 7 (The Dental Workforce) for numbers.

[23] 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.

[24] Population figures derived from Eurostat – but dates are various in the period 2011-13

Entitlement and access to oral healthcare

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 healthcare

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, which are examined in more detail in Annex 4.

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).

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.

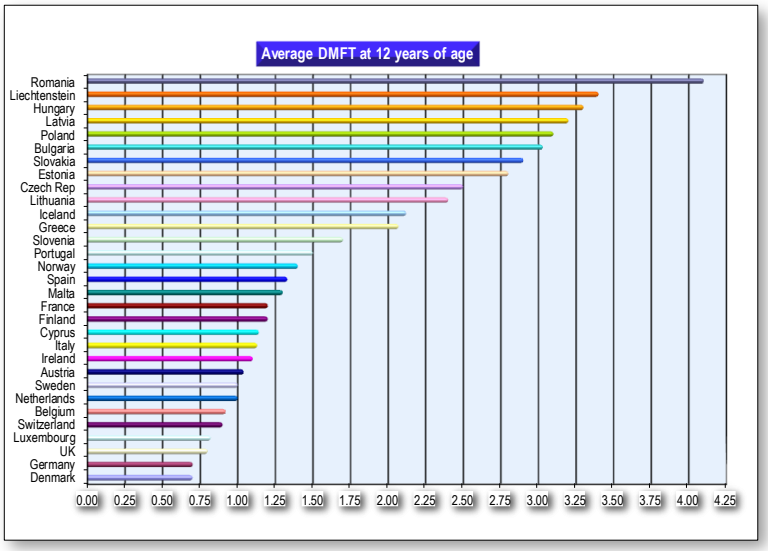
Approximately 6 monthly	The Czech Republic, Malta and Poland
9 to 12 monthly	Denmark, Estonia, the Netherlands, Slovenia and Switzerland
Annual	Austria, Belgium, Cyprus, France, Germany, Hungary, Ireland, Italy, Latvia, Luxembourg, Norway, Romania and the UK
18 months or more	Finland, Iceland, Slovakia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

Table 1 - Patient re-examination periods

Some of these figures actually represent an average where, for example, the country reported that the usual pattern of attendance was "every 12 to 18 months".

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 circumspection.

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 DMFT

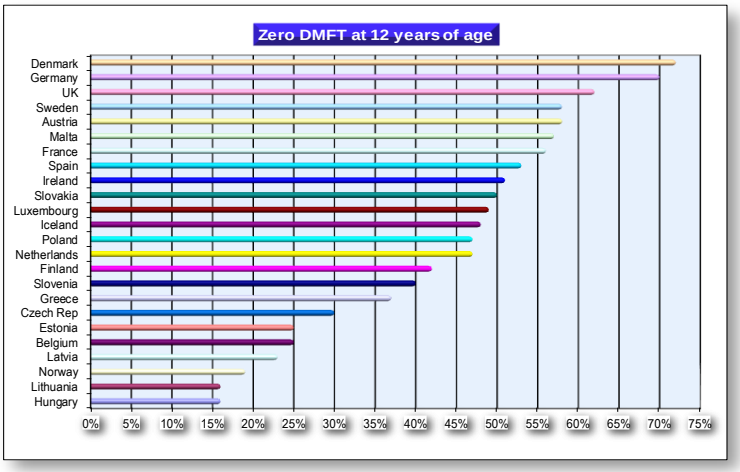
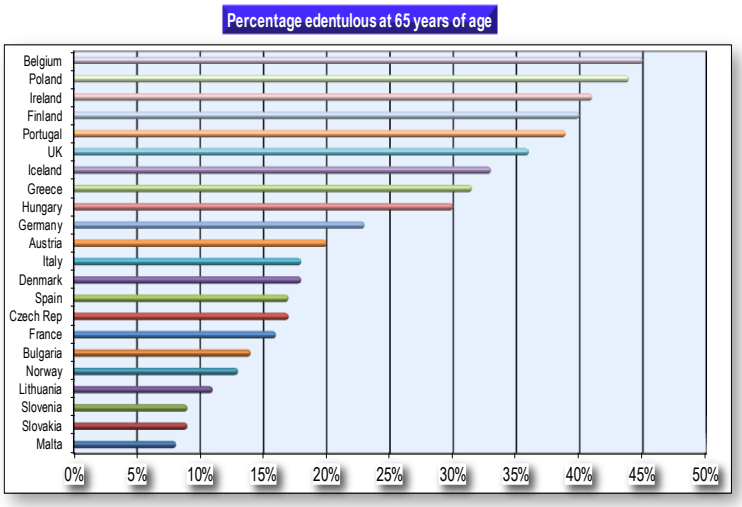


Chart 9 – The proportion of adults 65 years (or older) with no teeth (edentulous)



Fluoridation

Table 2 - Community fluoridation

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 teeth 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, are as described in the PQD.

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 an historical legacy in Austria, France, Italy, Spain and Portugal, and most of the countries which joined in the years after 2004 - but for all of these countries membership of the EU has brought substantial changes in dental education.

Table 3 – Dental schools, numbers of students and gender

	Year	No of schools	Public	Private	Annual intake	Annual graduates	Percentage female	No of females	Course duration
Austria	2013	4	3	1	165	119	65%	77	6 years
Belgium	2012	5	5	0	NK	158	80%	126	5 years
Bulgaria	2012	3	3	0	350	290	50%	145	5.5 yrs
Croatia	2013	3	2	1	148	113	69%	78	6 years
Czech Rep	2012	5	5	0	280	250	38%	95	5 years
Denmark	2012	2	2	0	162	120	76%	91	5 years
Estonia	2013	1	1	0	32	30	87%	26	5.5 yrs
Finland	2013	4	3	1	186	100	68%	68	5 years
France	2011	16	16	0	1,154	917	55%	504	6 years
Germany	2012	30	29	1	2,222	1,813	62%	1,122	5.5 yrs
Greece	2012	2	2	0	250	275	62%	171	5 years
Hungary	2013	4	4	0	310	245	58%	142	5 years
Iceland	2012	1	1	0	7	7	69%	5	5 years
Ireland	2013	2	2	0	86	68	54%	37	5 years
Italy	2013	34	32	2	984	883	47%	415	5 years
Latvia	2012	1	1	0	35	32	87%	28	5 years
Lithuania	2013	2	2	0	161	161	83%	134	5 years
Malta	2013	1	1	0	8	8	38%	3	5 years
Netherlands	2013	3	3	0	243	268	57%	153	6 years
Norway	2013	3	3	0	153	138	75%	104	5 years
Poland	2013	10	10	0	1,231	809	80%	647	5 years
Portugal	2012	7	3	4	716	553	66%	365	5 years
Romania	2013	10	8	2	1,800	1,700	70%	1,190	6 years
Slovakia	2013	4	2	2	117	101	60%	61	6 years
Slovenia	2012	1	1	0	70	50	70%	35	6 years
Spain	2012	17	12	5	1,379	1,379	67%	924	5 years
Sweden	2012	4	4	0	339	200	63%	126	5 years
Switzerland	2013	4	4	0	128	103	60%	62	5 years
UK	2013	16	16	0	1,100	1,052	56%	589	5 years
	2013	**199**	**180**	**19**	**13,816**	**11,942**		**7,522**	
			90%	**10%**			**63%**		
	2008	**196**	**176**	**20**	**14,401**	**11,582**			
			90%	**10%**			**61%**		
	2003	**184**	**174**	**10**	**10,969**	**8,665**			
			95%	**5%**			**53%**		

the secondary school leaving examination or matriculation determine the entry into dental school.

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, all dental undergraduate education and training takes place in universities – usually in Colleges or Faculties of Medicine or Dentistry.

In 2013, there were 200 dental schools in the EU/EEA – up from 184 in 2003. In each of Estonia, Iceland, Latvia, Malta and Slovenia there was only one school, whereas in Italy there were 35 and 30 in Germany. However, although most were publicly funded, many of these dental schools charge course fees to their students.

Additionally, 9% of schools were wholly privately funded – these were in Austria, Croatia, Finland, Germany, Italy, Portugal, Romania and Spain. No public funding supported these institutions.

In 2013, in the dental schools of the EU/EEA, there were over 70,000 dental students in training. Approximately 12,000 graduate each year (63% female – up from 53% in 2003).

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

In France, access to dental faculties is by competitive examination at the end of the first year (common to medicine, dentistry, pharmacy and midwifery) and the subsequent 5-year dental course follows. The UK has three "graduate-entry" dental schools. Entrants must have a primary degree in biological sciences.

Annually, over 13,600 enter into dental schools as undergraduates and across the EU/EEA on average about 84% 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 curriculum.

The duration 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.

Duration

A complete period of undergraduate dental training consists of a minimum 5 year full-time course of theoretical and practical instruction, for a minimum of 5,000 hours, given in a university, in a higher-education institution recognised as having equivalent status or under the supervision of a university. In 10 countries basic dental training is for more than 5 years:

Table 4 – Undergraduate Training greater than 5 years

Austria	Germany
Bulgaria	Netherlands
Croatia	Romania
Estonia	Slovakia
France	Slovenia

Post-qualification education and training

Vocational Training

In the 2009 Manual it was reported that about half of all EU/EEA countries insisted on further post-qualification vocational training (VT) for their new graduates, before they were given full registration, or entitlement to independent practice, or entitlement to participation in the state oral healthcare system as independent clinicians.

Table 5 – Post-Qualification Vocational Training

Belgium	Full	12m
Croatia	Full	12m
Slovenia	Full	12m
Germany	NHS only	24m
Switzerland	NHS only	24m
UK	NHS only	12m

By 2013, only Belgium, Croatia and Slovenia had this as a requirement for full registration for independent practice – all with 12 months' VT programmes. Poland's VT ends with those graduating in 2016. Germany and Switzerland (both 24 months) and the UK (12 months) have this as a requirement only for those working in their state healthcare systems.

The nature of VT means that 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.

The requirement to complete VT is not applicable to dentists from other EU/EEA Member States who hold the evidence of formal qualifications, subject to automatic recognition under the PQD.

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 (see table 4 overleaf).

Table 6 – Continuing Professional Development (Education)

	Mandatory	Partially Mandatory	Requirements	Not mandatory but formal systems	Not mandatory	Comments
Austria					Obligation only	
Belgium	Yes		60 hours in 6 years			Re-registration required after 6 years
Bulgaria	Yes		30 hours in 3 years			
Croatia			7 hours per year			
Cyprus**	Yes		45 hours in 3 years			
Czech Rep	Yes					Certificates of proficiency leads to higher fees from health systems
Denmark**		Yes	10 hours per year			Required only of DDA members
Estonia				Yes		
Finland				Yes		
France**	Yes		1.5 days per year			
Germany		Yes	125 points in 5 years			Required for recertification for sick funds, only (not private)
Greece					Obligation only	
Hungary	Yes		250 hours in 5 years			
Iceland		Yes	75 hours in 3 years			Only mandatory for those treating children in the system
Ireland			250 hours in 5 years	Yes	Obligation only	
Italy	Yes		150 hours in 3 years			Minimum 30 and maximum 70 hours per year
Latvia	Yes		250 hours in 5 years			
Liechtenstein						No information
Lithuania	Yes		120 hours in 5 years			
Luxembourg					Obligation only	
Malta				Yes		
Netherlands					Obligation only	
Norway**		Yes	150 hours in 5 years			Only mandatory for NDA members
Poland	Yes		200 hours in 4 years			
Portugal				Yes		
Romania	Yes		200 hours in 5 years			
Slovakia	Yes		250 hours in 5 years			
Slovenia	Yes		75 hours in 7 years			Followed by an examination
Spain				Yes		
Sweden					Obligation only	
Switzerland	Yes		10 days per year			Failure leads to lower fees.
UK	Yes		250 hours in 5 years			75 hours has to be provable (verifiable)
** changed since 2009 Manual						

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. In 2013, 16 countries had a mandatory requirement, with another 3 having a partial (qualified) requirement. Additionally, 6 countries, whilst not having a mandatory requirement, did have formal systems in place.

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 PQD.

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.

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.

European Dental Education

The EU Directorate General for Education and Culture funded an innovative pan-European project DentEd, to promote a common approach to dental education across Europe. Over six years many dental schools in the EU (including candidates for admission to the EU) received advice and peer support from visiting teams of dental academics, supported by several international conferences on trends and strands in dental curricula. Work on dental education is continuing through the Association for Dental Education in Europe (ADEE).

The Bologna Process

The Bologna Process was launched in 1999 as the "Bologna declaration", when the education ministers of some 40 countries expressed the desire to create a European Higher Education Area (EHEA). The goal was that it should be easy for students to move from one country to another within the Area and that European higher education should be made more attractive to non-European prospective students. The EHEA has been in place since 2010 – and by 2014 it covered 49 higher education systems in 47 countries (both Belgium and the UK are considered to have two systems).

Amongst the proposals was 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. By 2014, some countries had split their programmes, while others have retained them.

The EHEA is not based on an international treaty, but most of the signatory countries have also signed and ratified the Lisbon Recognition Convention covering academic qualifications. The European Commission is a member of the Bologna Follow-Up Group, along with higher education stakeholder organisations operating at European level, as well as the 49 ministers of higher education. The EHEA is based on shared practice in such areas as quality assurance, qualifications frameworks, curriculum design, student and staff mobility. The official EHEA website is at http://www.ehea.info/

Recognition of professional qualifications, however, falls within the scope of EU legislation, at least for the EU/EEA Member States under EU Directive 2013/55/EU. Besides its major innovations (the European Professional Card and the alert mechanism) it is notable for the extent to which it has begun to accommodate the principles and instruments of the EHEA: in particular, the European Credit Transfer and Accumulation System (ECTS), the European Qualifications Framework (EQF), and competence-based curricula.

The European University Association (EUA) has published a briefing on the HE-related aspects of the Directive. It is available at:

http://www.eua.be/eua-work-and-policy-area/building-the-european-higher-education-area/bologna-and-professional-qualifications.aspx

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 practise' 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.

Good character and good repute

For the purposes of temporary provision of services by dentists, in the event of justified doubts, competent authorities of a host Member State may ask the competent authorities of the Member State of establishment to provide information about the good conduct or the absence of any disciplinary or criminal sanctions of a professional nature against the health professional, as well as any information relevant to the legality of his/her establishment.

In the case of an application by a dentist for establishment in another Member State, the host Member State may demand, when deciding on the application documents produced by the competent authorities in the home Member State, other documents: that they are of good character or repute, or that they have not been declared bankrupt, or that they have not been suspended or prohibited from pursuing the profession, in the event of serious professional misconduct or a criminal offence.

Where the competent authorities of the home Member State does not issue such documents, they may be replaced by a declaration on oath or a solemn declaration. The host Member State may also require, in the event of justified doubts from the competent authorities of the home Member State, confirmation that the applicant is not suspended or prohibited from the pursuit of the profession as a result of serious professional misconduct, or conviction of criminal offences relating to the pursuit of any of his/her professional activities.

Language

The December 2013 PQD does give Host Countries the right to conduct language tests, for example, when patient safety is an issue. The survey carried out for this Manual indicates that some countries anticipated this change to the Directive and introduced language testing prior to registration, using Patient Safety as the reason for this.

Thus, 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.

Serious professional misconduct and criminal penalties

The same procedure is followed in the case of serious professional misconduct and conviction for criminal offences. The existing rules (in the 2005 PQD) provided for detailed obligations for Member States to exchange information. So, the Member State of origin or from which the person comes must forward to the host MS all the necessary information about any disciplinary action which has been taken against the practitioner concerned, or criminal penalties imposed on him/her.

The amended PQD reinforces the obligations. From 2014, competent authorities of Member States will have to proactively alert the authorities of other Member States about professionals who are no longer entitled to practise their profession due to a disciplinary action or criminal conviction, through a specific alert mechanism. If the host Member State has detailed knowledge of a serious problem before registration, it must 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 MS must accept a certificate issued by a competent authority in that State, provided that it corresponds to the certificates issued by the host MS.

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.

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 should give its reply within three months.

In the absence of a reply, leading to failure to reach a decision by the host Member State within the three month deadline, the applicant has the right to appeal under national law.

Alternative to taking an oath

Some Member States require their nationals to take an oath or make a solemn declaration in order to practise. 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.

Table 7 - Regulation of dentists (2013)

REGULATION OF DENTISTS IN 2013

	Name of regulator	Cost per annum (2013)
Austria	Austrian Dental Chamber via their regional organisations	% of income
Belgium	Federal Ministry of Health	€ 550
Bulgaria	Bulgarian Dental Association by means of its Regional Colleges.	€ 77
Croatia	Croatian Dental Chamber	No fee
Cyprus	Cyprus Dental Council & Cyprus Dental Association	€35 + €130
Czech Rep	Czech Dental Chamber and the Regional Authority*	Included in annual sub
Denmark	Health and Medicines Authority	No fee
Estonia	Healthcare Board/General Dental Council, within the Commission for Licence	€ 13
Finland	National Authority for Medicolegal Affairs	No annual fee
France	Ordre National	€ 398
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	€ 52
Ireland	Irish Dental Council	€ 200
Italy	Federazione Ordini dei Medici Chirurghi e degli Odontoiatri	Variable according to region
Latvia	Health Inspectorate by order of the Ministry of Health	No fee
Liechtenstein	Amt für Gesundheitsdienste, a public authority	€ 820
Lithuania	The Licensing Committee at the Lithuanian Dental Chamber	€19 + €58
Luxembourg	Ministry of Health	€ 275
Malta	Medical Council. Until 2011 overseas dentists need a work permit.	€ 35
Netherlands	Ministry of Public Health Welfare & Sport - also, the BIG register	€ 80
Norway	Norwegian Registration Authority for Health Personnel (SAK)	€ 200
Poland	The Regional Chamber of Physicians and Dentists (Okręgowa 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	€ 4
Slovenia	The Medical Chamber of Slovenia	No fee
Spain	Regional colegios (central list held at Consejo General in Madrid)	Variable €216 to €600
Sweden	National Board of Health and Welfare unit for Qualification and Education	€ 77
Switzerland	Federal Board but registers kept by each of the 26 Cantonal authorities	No fee
UK	General Dental Council	€ 685

* Dentists qualified outside the CR must register (free) with the Ministry of Health

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 later).

In all countries, whatever classes of dental auxiliaries exist, most oral healthcare is provided by dentists. The description of what a dentist may provide is regulated by Member States. However, in relation to the Freedom of Movement, and the desire of professionals to practise in another Member State, please see Part 3 (the Professional Qualifications Directive) for more information.

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.

	Year of data	Population	Number Registered	Female	Number Active	Female
Austria	2013	8,489,482	4,820	42%	4,421	42%
Belgium	2011	11,153,405	8,879	48%	7,777	48%
Bulgaria	2013	7,282,041	8,350	66%	8,350	66%
Croatia	2007	4,475,611	4,537	65%	3,875	65%
Cyprus	2013	865,878	1,073	49%	827	65%
Czech Rep	2012	10,516,125	9,354	65%	7,821	65%
Denmark	2013	5,605,836	7,989	58%	5,161	83%
Estonia	2013	1,324,814	1,615	87%	1,250	87%
Finland	2013	5,434,357	5,925	69%	4,500	69%
France	2012	65,657,000	41,505	40%	41,505	40%
Germany	2012	80,523,746	88,882	42%	69,236	42%
Greece	2013	10,772,967	14,125	47%	9,000	47%
Hungary	2013	9,906,000	5,500	57%	4,973	57%
Iceland	2012	322,930	351	33%	269	33%
Ireland	2013	4,591,087	2,627	44%	2,200	44%
Italy	2012	59,685,227	58,723	34%	45,896	34%
Latvia	2012	2,178,443	1,724	87%	1,474	87%
Liechenstein	2013	37,009	57		48	
Lithuania	2013	2,962,000	3,660	83%	3,610	83%
Luxembourg	2008	537,000	512	40%	452	40%
Malta	2013	421,364	230	36%	170	36%
Netherlands	2013	16,789,800	10,780	35%	8,773	35%
Norway	2013	5,063,709	5,350	47%	4,576	47%
Poland	2012	38,533,299	33,633	78%	21,800	78%
Portugal	2012	10,487,289	9,097	57%	9,097	57%
Romania	2013	20,057,458	15,500	68%	14,400	68%
Slovakia	2013	5,410,728	3,357	61%	3,298	61%
Slovenia	2013	2,060,253	1,762	63%	1,358	63%
Spain	2012	47,059,533	31,261	52%	29,000	52%
Sweden	2010	9,580,424	14,454	52%	7,528	52%
Switzerland	2013	8,058,100	4,850	28%	4,800	28%
UK	2013	63,887,988	40,156	45%	34,534	45%
EU/EEA Totals		**519,730,903**	**440,638**		**361,979**	**49%**

Table 8 - Numbers of dentists

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 dental practice. 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 in 2013 was about 440,000 (400,000 in 2008).

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 361,000 dentists were active in 2013 (345,000 in 2008). So, whereas the number of registered dentists has increased by 10%, the number "active" has only increased by 4.6%.

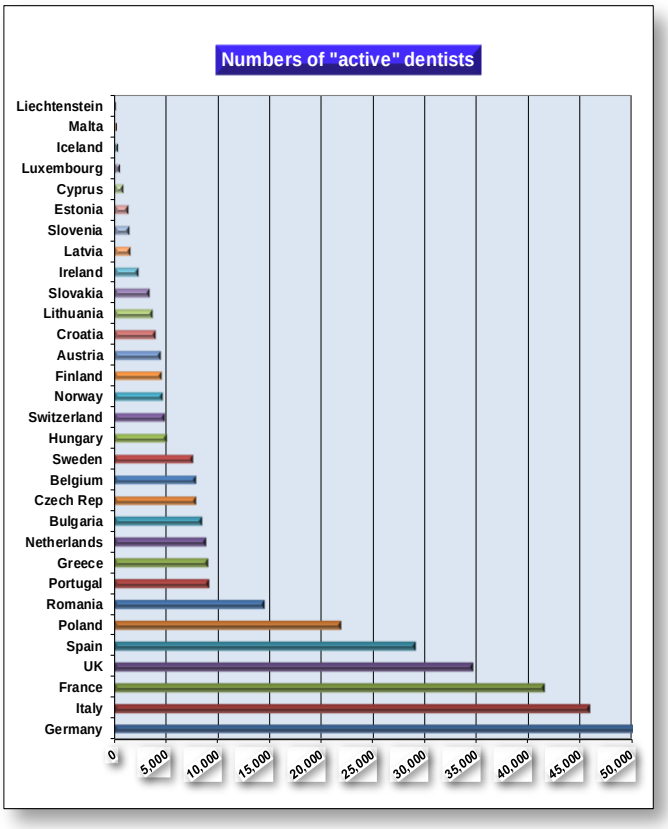


Chart 10 – The number of "active dentists" in each country

Table 9 - Gender of dentists - percentage female

Latvia	87%	Belgium	48%
Estonia	87%	Cyprus	49%
Lithuania	83%	Greece	47%
Poland	78%	Norway	47%
Finland	69%	UK	45%
Romania	68%	Austria	42%
Bulgaria	66%	Germany	42%
Czech Rep	65%	France	40%
Croatia	65%	Iceland	33%
Slovenia	63%	Italy	34%
Slovakia	61%	Ireland	44%
Hungary	57%	Luxembourg	40%
Portugal	57%	Nethlerlands	35%
Spain	52%	Malta	36%
Denmark	58%	Switzerland	28%
Sweden	52%		

The Gender Mix of Practising Dentists

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 49% 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 28% in Switzerland.

However, the trend is very much to an increase of females as a proportion of the dentist population. When the figures were last measured (2008) about 46% of dentists were female. There have been marked increases in several countries. For example, the proportion of females is up from 33% to 52% in Norway, 34% to 45% in the UK and 36% to 40% in France.

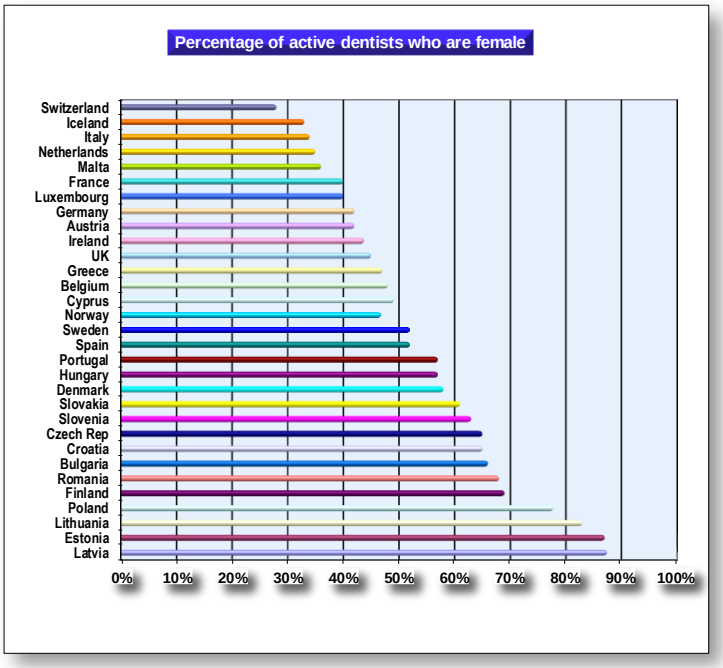


Chart 11 – The gender of "active dentists" in each country

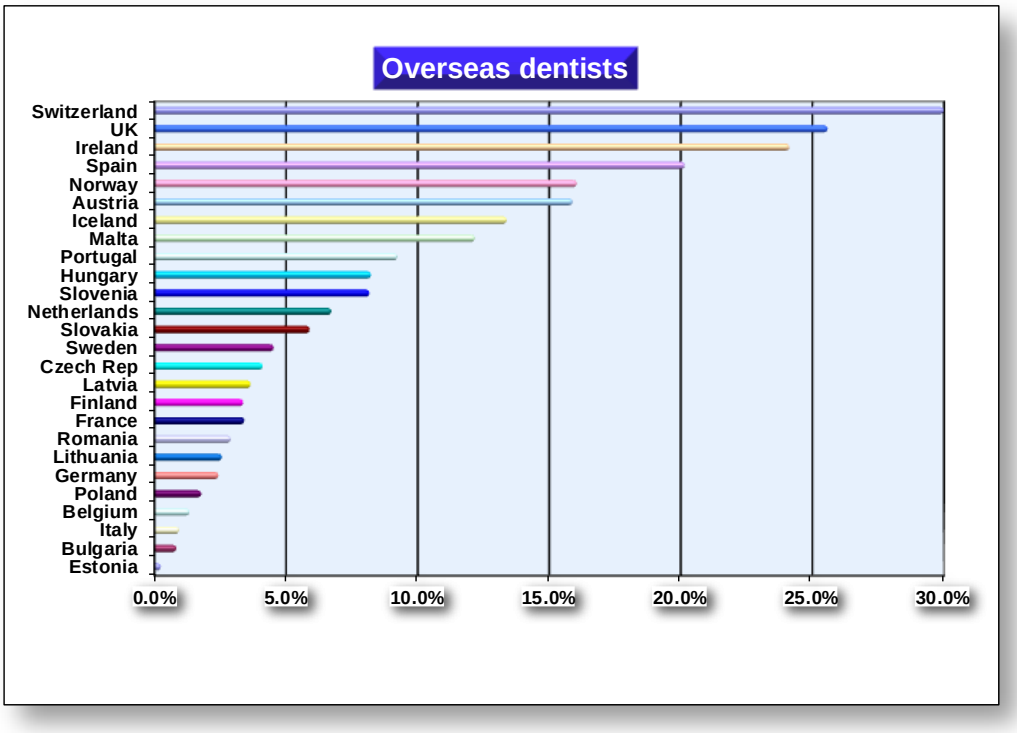
Overseas dentists

This expression refers to dentists who have received their basic 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" have made travel between EU/EEA countries for the purposes of working as a dentist 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, and Greece. Three countries – Cyprus, Liechtenstein and Luxembourg do not have their own dental schools so, by definition, all dentists practising there qualified overseas (abroad), and are not shown. Since 2008, Austria, Malta, Slovenia and the UK had a significant increase in the number of overseas dentists practising – whereas Sweden and Portugal reported a reduced proportion.

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 five by 2008 (Croatia, Finland, Germany, Greece and Italy). In 2013 the number had increased to 11 – as below.

Table 10 – Dentist unemployment in 2013

Austria	**Germany**	**Luxembourg**
Croatia	**Greece**	**Switzerland**
Bulgaria	**Hungary**	**United Kingdom**
Finland	**Italy**	

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	Ortho	OS	OMFS	Endo	Paedo	Perio	Prostho	DPH	Others
Austria	2013	0		167						
Belgium	2011	399		290			139			
Bulgaria	2013	45	226	45	417	580	36	115	17	Yes
Croatia	2013	184	98		97	130	74	156		Yes
Cyprus	2013	46	12							
Czech Rep	2012	337		72						
Denmark	2013	290		98						
Estonia	2013	62		25						Yes
Finland	2013	156		104					90	Yes
France	2012	1,981								
Germany	2012	3,443	2,552				0		460	
Greece	2013	476		174						
Hungary	2013	379	139	157		254	65	924		
Iceland	2012	15	4		2	3	8	5	3	Yes
Ireland	2013	140	49	5						
Italy	2012	1,795		640						
Latvia	2012	24	0	39	10	23	0	19		
Liechtenstein	2013	2	1				1			
Lithuania	2013	93	92	23	44	56	57	270		
Malta	2013	7		1	9	2	3	3	3	Yes
Netherlands	2013	331		265	73	46	81			
Norway	2013	206	68	0	63	20	90	65		Yes
Poland	2012	1,115	805	227	1,561	486	420	1,453	71	
Portugal	2012	51	4	93						
Romania	2008	412	157	234						
Slovakia	2013	193	192	26		39	95	64		
Slovenia	2013	84	24	34	24	36	16	24		
Sweden	2010	265		145	47	83	101	134		Yes
Switzerland	2013	370	185				112	72		
UK	2013	1,343	754		250	246	333	431	117	Yes
		14,244	**5,362**	**2,864**						
Luxembourg and Spain do not recognise specialists										

- 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).
- 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 dentistry. 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 (overleaf) 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 only to dentists, 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)[25] 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.

[25] Romania has reportrd having hygienists and denturists but has not provided any further information

Table 12 - Types of auxiliary recognised in each country

Country	Dental Hygienist	Dental Technician	Clinical Dental Technician	Chairside Assistant DCA	Dental Therapist	Comments
Austria		R		FT		Some DCAs specialise in oral health prevention
Belgium		R		NFT		
Bulgaria		R		NFT		
Croatia		FT		NFT		
Cyprus	N	R**		NFT		
Czech Republic	N	N		FT/N		
Denmark	R	N	R	FT/N		Hygienists may work without supervision.
Estonia	N	R		R		
Finland	R	R	R	R		
France		N		FT/N		
Germany	R	R		R		
Greece		R		R		
Hungary	N	R		R		
Iceland	R	R		R		Formal training must take place overseas
Ireland	R	N	R	FT/N	R	Orthodontic Therapists train in the UK. There are also Oral Health Educators
Italy	N	R		FT/N		
Latvia	R	R		R	R	Training of Therapists ceased in 1976
Liechtenstein	R	R		R		Formal training takes place in Switzerland
Lithuania	R	R		R		There are also Assistant's helpers, who do not need to be registerd
Luxembourg		N		NFT		
Malta	R	R		FT/N		
Netherlands	N	N	R	FT/N*		Hygienists and CDTs are independent professions (and are not auxiliaries)
Norway	R	R		R		
Poland	N	N		NFT		
Portugal	R	R		FT/N		
Romania		R		R		There are Hygienists and CDTs, but there is no further information about them
Slovakia	R	R		R		There are Nurses and Assistants
Slovenia	N	R		NFT		
Spain	R	N		NFT		Technician registration is mandatory in some regions
Sweden	R	R		FT/N		There are also orthodontic operating auxiliaries
Switzerland	R	R	R	FT/N	R	There are Registered Dental Therapists and Denturists in some cantons
United Kingdom	R	R	R	R	R	There are Registered Dental, Orthodontic Therapists, Expanded Duties Dental
						Nurses. There are also Oral Health Educators (who do not need to be registered).

Formal training is always necessary for Hygienists, Clinical Dental Technicians and Therapists – and always available for Dental Technicians. It may be available for Chairside Assistants/Dental Nurses (as shown)

R = Registration with a competent authority necessary (always following formal training and qualification)
N = No registration necessary to work
NFT = No formal training or registration necessary
FT = Formal training available

Blank cell indicates that this class of dental auxiliary is not recognised

Table 13 - Regulators of dental auxiliaries

	REGULATION OF DENTAL AUXILIARIES IN 2013
	Name of regulator
Austria	Local trade federations
Belgium	Registration with the Ministry of Health
Bulgaria	Laboratories must register with the Ministry of Health
Croatia	Techs must pass state exam of Ministry of Health to work
Cyprus	Technicians must register with the Dental Technicians' Council
Czech Rep	No registration
Denmark	Hygienists and denturists only: CDTs must register with the Health and Medicines Authority
Estonia	Registration is with the Healthcare Board
Finland	Registration is with the National Supervisory Authority for Welfare and Health
France	No registration
Germany	Kassenzahnärztliche Vereinigungen (KZV) - dental hygienists and assistants
Greece	Technicians' registration is with the Ministry of Health and Welfare
Hungary	Hygienists and DCAs register with the Ministry of Health, Master technicians by the regional Chambers of Industry*
Iceland	Registration is with the Directorate of Health
Ireland	Hygienists, CDTs and Orthodontic Therapists: Irish Dental Council
Italy	Technicians have to be registered with the *Camera di Commercio* of each Province
Latvia	Registration is with the Centre of Dentistry
Liechtenstein	Hygienists and technicians register with the public *Berufsbildungsamt*
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	Denturists must register with their Federation
Norway	All auxiliaries (including Assistants) - the Registration Authority for Health Personnel (SAK)
Poland	Register planned but none in 2013
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 Chamber of Dental Technicians, register these, respectively.
	DNs are registered with the Chamber of Midwives and Nurses and Assistants with the Chamber of Other Health Professionals
Slovenia	Only technicians must register (with the Economy Chamber)
Spain	Hygienists must hold a Certificate of Proficiency granted by the Ministry of Education and Culture
Sweden	National Board of Health and Welfare (Hygienists and Technicians)
Switzerland	Hygienists: professional education department of the Swiss Red Cross**
UK	General Dental Council
	** 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 Lithuania, Slovakia and the United Kingdom.

Numbers in the dental workforce

Table 14 – The total workforce

Number of dentists	**442,027**
Number of auxiliaries	**681,850**
Workforce total	**1,123,877**

From the figures in Table 14, it can be seen that the recorded total dental workforce is over 1.12 million workers (0.97m in 2008). 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 1.5 million people directly derive their employment from dentistry in the EU/EEA.

Numbers of dental auxiliaries

Table 15 – The numbers of dental auxiliaries

	Hygien-ists	Techs	CDTs	Assist-ants	Thera-pists	Others	F/T equiv at 0.43	Equiv Wrkfrce	Equiv PopRatio	Dents per tech
Austria	0	620	0	10,200	0	0	0	4,421	1,920	7
Belgium	0	2,250	0	1,500	0	0	0	7,777	1,434	3
Bulgaria	0	1,235	0	No data	0	0	0	8,350	872	7
Croatia	0	1,691	0	631	0	0	0	3,875	1,155	2
Cyprus	458	130	0	34	0	0	197	827	1,047	6
Czech Rep	800	4,500	0	8,000	0	0	344	8,165	1,288	2
Denmark	800	1,100	565	4,400	0	0	587	5,748	975	5
Estonia	32	137	0	1,540	0	0	14	1,264	1,048	9
Finland	1,490	450	400	4,800	0	0	813	5,313	1,023	10
France	0	16,500	0	15,350	0	4,786	0	41,505	1,582	3
Germany	550	58,000	0	182,000	0	0	237	69,473	1,159	1
Greece	0	4,500	0	2,000	0	0	0	9,000	1,197	2
Hungary	1,000	3,000	0	4,668	0	0	430	5,403	1,833	2
Iceland	14	101	9	320	0	0	10	279	1,158	3
Ireland	458	350	24	1,262	5	0	209	2,409	1,905	6
Italy	6,000	13,023	0	95,000	0	0	2,580	48,476	1,231	4
Latvia	219	551	0	1,360	87	0	132	1,606	1,357	3
Liechtenstein	8	27	0	105	0	0	3	51	719	2
Lithuania	572	1,114	0	1,904	0	0	246	3,856	768	3
Luxembourg	0	82	0	390	0	0	0	452	1,188	6
Malta	21	53	0	100	0	0	9	179	2,354	3
Netherlands	3,200	5,000	370	19,000	0	0	1,535	10,308	1,629	2
Norway	902	703	0	3,671	0	0	388	4,964	1,020	7
Poland	2,500	7,000	0	9,725	0	0	1,075	22,875	1,685	3
Portugal	520	546	0	No data	0	0	224	9,321	1,125	17
Romania	100	4,500	8	2,000	0	0	46	14,446	1,388	3
Slovakia	187	1,392	0	3,610	0	0	80	3,378	1,602	2
Slovenia	15	251	0	870	0	0	6	1,364	1,510	5
Spain	13,200	11,135	0	37,000	0	0	5,676	34,676	1,357	3
Sweden	3,749	1,500	0	12,000	0	360	1,612	9,140	1,048	5
Switzerland	1,600	1,800	50	6,500	280	0	830	5,630	1,431	3
UK	6,291	6,283	233	48,465	2,194	322	3,749	38,283	1,669	5
EU/EEA Totals	**44,686**	**149,524**	**1,659**	**478,405**	**2,566**	**5,468**		**382,814**	**1,358**	

"Equiv" means Equivalent [Workforce]

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.

Table 16 - Percentage of dentists who are practising in general practice

Active dentists in full or part-time GP			
Finland	44%	Czech Rep	94%
Sweden	46%	Liechtenstein	94%
Slovenia	59%	Portugal	94%
Lithuania	61%	Cyprus	95%
Denmark	66%	Latvia	95%
Ireland	68%	Slovakia	95%
Norway	69%	Germany	96%
Croatia	76%	Bulgaria	96%
Hungary	76%	Estonia	96%
Greece	82%	Belgium	97%
Austria	87%	Romania	88%
France	90%	Malta	98%
Switzerland	90%	Luxembourg	99%
Italy	91%	Spain	99%
UK	92%	Iceland	100%
Poland	96%	Netherlands	100%
Total for the EU/EEA			89%

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

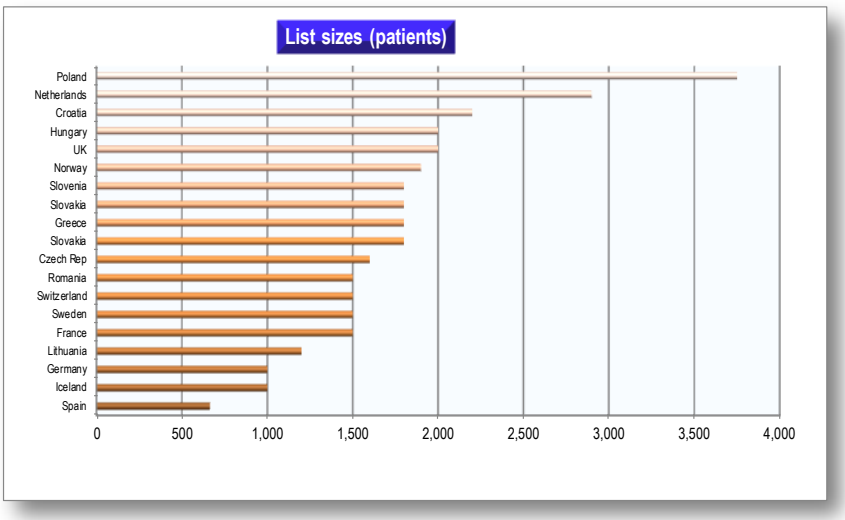
The methods of establishing a liberal or general practice are similar across Europe, with younger dentists employed as associates or assistants before they can afford to buy their own practice. However, in countries where solo private practice dominates (for example, France, Belgium and Norway) starting 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. The importance of dentists as a liberal profession was underlined by the adoption of the EU Charter for Liberal Professions, proposed by the Council of European Dentists and jointly developed and adopted with the representative organisations of European doctors, community pharmacists, engineers and veterinarians. Please see Annex 12 for more information.

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 Part 9 – Professional Matters) and so there are large, multi-dentist group practices – for example in the United Kingdom one company owns over 500 practices, employing several thousand dentists.

Dental associations suggest 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.



Dental Practice 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.

Overall, about 11% of dentists in the EU/EEA work in public dental service clinics. This figure has hardly changed since the last edition of the Manual.

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.

Table 17 –Dentists working in public dental services

PUBLIC CLINIC DENTISTS								
		Population	Active dentists	Public clinics	Univer-sities*	Hospitals	Armed Forces	Others
Austria	2013	8,489,482	4,421	601	206	110	0	
Belgium	2011	11,153,405	7,777	0	200	0	10	
Bulgaria	2013	7,282,041	8,350	0	258	35	46	
Croatia	2007	4,475,611	3,875	446	137	No data	No data	33
Cyprus	2013	865,878	827	39		0	2	0
Czech Rep	2012	10,516,125	7,821	0	295	30	31	
Denmark	2013	5,605,836	5,161	1,215	112	58	15	
Estonia	2013	1,324,814	1,250		18	35	5	0
Finland	2013	5,434,357	4,500	2,165	86	113	72	
France	2012	65,657,000	41,505	2,828	393	219	48	
Germany	2012	80,523,746	69,236	450	2,000	200	450	
Greece	2013	10,772,967	9,000	452	237	452	71	836
Hungary	2013	9,906,000	4,973	20	240	35	40	
Iceland	2012	322,930	269	3	23	5		
Ireland	2013	4,591,087	2,200	333	50	10	5	
Italy	2012	59,685,227	45,896	3,157	400	300	100	
Latvia	2012	2,178,443	1,474	10	31	31	0	
Liechtenstein	2013	37,009	48	0	0	0	0	
Lithuania	2013	2,962,000	3,610	538	80		13	
Luxembourg	2008	537,000	452					
Malta	2013	421,364	170	35	24	31	0	
Netherlands	2013	16,789,800	8,773	250	110	214	30	
Norway	2013	5,063,709	4,576	1,109	234	35	23	
Poland	2012	38,533,299	21,800	500	400	250	300	
Portugal	2012	10,487,289	9,097	43	446	90	16	
Romania	2013	20,057,458	14,400	1,200	950	234	80	
Slovakia	2013	5,410,728	3,298	80	120	29	22	
Slovenia	2013	2,060,253	1,358	523	27	31	0	
Spain	2012	47,059,533	29,000	1,300	864	350	340	
Sweden	2010	9,580,424	7,528	4,065	431	N/R	N/R	
Switzerland	2013	8,058,100	4,800	200	300	50	0	
UK	2013	63,887,988	34,534	1,800	566	2,084	244	250
			361,979	**23,362**	**9,238**	**5,031**	**1,963**	**1,119**
				6.5%	2.6%	1.4%	0.5%	0.3%
Proportion of total workforce:			**11.2%**					

*** For the purpose of this table, this includes private universities**

Bulgaria, Lithuania, Romania and Switzerland: "active" means registered dentists

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 7 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.

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.

Table 18 - Countries without public clinics

Belgium	Iceland
Bulgaria	Liechtenstein
Czech Republic	Luxembourg
Estonia	

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 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.

Clinical Dental Technicians/Denturists may practise legally in Denmark, Finland, the Netherlands, parts of Switzerland and the UK – so the potential for illegal practise is reduced.

However, a continued problem in many EU/EEA countries is the illegal provision of tooth whitening products in the mouth by unqualified persons, even after the introduction of the 2011 Directive. In the UK, despite successful prosecutions in the courts by the General Dental Council, non-qualified persons continue to offer whitening services using >0.01% hydrogen peroxide.

Part 9: Professional Matters

Professional representation

Table 19 - Membership of national dental associations

Membership of dental associations and chambers

Mandatory membership in red

		Numbers		Year	Source
Austria	Österreichische Zahnärztekammer	4,820	100%	2013	Chamber
Belgium	Chambres Syndicales Dentaires	1,016		2012	FDI
Belgium	Société de Médecine Dentaire	1,096		2012	FDI
Belgium	Verbond der Vlaamse Tandartsen	3,500		2012	VVT
Belgium	Vlaamse Beroepsvereniging voor	600		2012	VVT
Bulgaria	Bulgarian Dental Association	8,350	100%	2013	BgDA
Bulgaria	Association Médicale	>150		2013	BgDA
Croatia	Dental Chamber	6,859	100%	2012	Chamber
Croatia	Dental Society	1,748	100%	2012	FDI
Cyprus	Cyprus Dental Association	773	100%	2012	FDI
Czech Rep	Czech Dental Chamber	9,354	100%	2012	Chamber
Denmark	Association of PH Dentists	1,293		2013	DCPA*
Denmark	Danish Dental Association	6,507	81%	2013	DCPA*
Estonia	Estonian Dental Association	799	50%	2012	FDI
Finland	Finnish Dental Association	4,240	98%	2013	FDI
France	ADF	30,053	65%	2012	FDI
Germany	Bundeszahnärztekammer	69,236	100%	2012	BZÄK
Greece	Hellenic Dental Association	9,000	100%	2013	HDA
Hungary	Hungarian Dental Association	718	88%	2012	FDI
Iceland	Icelandic Dental Association	270	90%	2012	FDI
Ireland	Irish Dental Association	1,700	82%	2013	IDA
Italy	ANDI	23,396		2012	ANDI
Italy	AIO	7,053		2012	FDI
Latvia	Latvian Dental Association	1,474	100%	2012	LDA
Liechtenstein	Liechtenstein Dental Association	28		2013	LDA
Lithuania	Lithuanian Dental Chamber	3,660	100%	2013	Chamber
Luxembourg	Association des Médecins	410	90%	2013	AMMD
Malta	Dental Association of Malta	130	76%	2013	DAM
Netherlands	Nederlandsche Maatschappij	6,653	76%	2013	NMT
Norway	Norwegian Dental Association	4,539	90%	2012	FDI
Poland	Polish Dental Association (Society)	5,400		2013	Chamber
Poland	Chamber of Physicians & Dentists	21,800	100%	2013	Chamber
Portugal	Ordem dos Médicos Dentistas	8,568	100%	2012	OMD
Romania	Romanian Dental Association	700	25%	2012	FDI
Romania	Romanian Soc of Stomatology	200		2012	FDI
Slovakia	Slovak Chamber of Dentists	2,906	87%	2013	Chamber
Slovenia	Medical Chamber of Slovenia	1,789	100%	2013	MCS
Spain	Consejo General de Colegios	31,260	100%	2013	Colegios
Sweden	Swedish Dental Association	5,138	95%	2013	SDA
Switzerland	Société Suisse des médecines-	4,130	90%	2013	SSO
UK	British Dental Association	19,736	50%	2012	FDI
	Total	**310,902**			

* The Danish Confederation of Professional Associations

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 Germany, Greece 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.

In about one third of the countries, membership of the dental association or, as is often 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 Latvia 100% of dentists are members of the association, in many countries (Estonia, Italy, Malta and the UK) only about half of dentists are members of the national association.

European dental organisations

The Council of European Dentists (CED)

The Council of European Dentists, which commissioned this Manual, was established in 1961 at the request of the Department of Social Affairs of the European Commission. It is a European not-for-profit association which represents over 340,000 dentists across Europe. It was formerly called the EU Dental Liaison Committee (EUDLC), but its name was changed in May 2006. It is a council of dental associations, with all the member countries of the EU, except for Romania, being members in 2014. Attending as observers are representatives of Iceland, Norway and Switzerland. The associations appoint up to two members each as delegates to the CED's plenary meetings – which are held 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 Board (of Directors) is composed of 8 members who serve for 3 years, being elected by the (plenary) General Meeting. The Board formulates proposals for the CED policy, for approval by the General Meeting. It secures and monitors the proper and efficient administration of the CED.

The Board generally meets four times a year.

Much of the business of the Council is conducted by Working Groups and Task Forces. In 2014 there were 8 WGs, looking after subjects such as Education, Patient Safety and Oral Health (etc).

The CED task forces are active for limited periods of time, and for specific and urgent issues, such as Antibiotic Use, and the Internal Market. They are established by, and accountable to the CED Board of Directors.

The Council's objective is to develop and execute policy and strategy in order to:

- Promote the interests of the dental profession in the EU;
- Promote high standards of oral health;
- Promote high standards of dentistry and dental care;
- Contribute to safeguarding the protection of public health;
- Monitor, analyse and follow up on all the political and legal developments and documents of the EU that involve dentists, dental care and oral health;
- Actively lobby the European Institutions and Parliament, in order to serve the legal and political interests of dentists, including consumer protection issues

To achieve these objectives, the CED:

- Monitors EU political and legislative developments which have an impact on the dental profession
- Issues policy statements and drafts amendments to proposed EU legislation, so as to ensure that the views of European dentists are reflected in all EU decisions affecting them
- Provides expertise for the EU institutions in the areas of health and consumer protection, training, safety at the work place and internal market legislation
- Provides a platform for the exchange of information between national dental associations, and supports them in understanding the effects and implementation of EU legislation, in particular members from the new Member States and EU accession countries
- Cooperates with all major European associations of health professionals and other liberal professions on policy issues of common interest

The Council and member associations have worked closely with the European Institutions in a number of matters and are officially consulted by the European Commission on health matters.

http://www.eudental.eu/

The Association for Dental Education in Europe (ADEE)

The Association for Dental Education in Europe was founded in 1975 as an independent European organisation representing academic dentistry and the community of dental educators. Since then, ADEE has played an important role by enhancing the quality of education, advancing the professional development of dental educators and supporting research in education and training of oral health personnel.

The ADEE brings together a broad-based membership across Europe comprised of dental schools, specialist societies and national associations concerned with dental education.

The ADEE is committed to the advancement of the highest level of health care for all people of Europe through its mission statements:

- To promote the advancement and foster convergence towards high standards of dental education.
- To promote and help to co-ordinate peer review and quality assurance in dental education and training.
- To promote the development of assessment and examination methods
- To promote exchange of staff, students and programmes.
- To disseminate knowledge and understanding on education
- To provide a European link with other bodies concerned with education, particularly dental education.

http://www.adee.org/about/index.html

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. The CED's Code of Ethics can be found in Annex 9.

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 20 – 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.

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. The Guidance to the Directive on Electronic Commerce, developed by the CED, can be found in Annex 10.

Data Protection

All the countries of the EU, Norway and Switzerland have adopted the EU Data Protection Directive into their national legislation. National law in Iceland covers this area of dental practice.

Indemnity Insurance

In all EU/EEA countries, professional Indemnity Insurance, to ensure that proper compensation is available for patients who are harmed in some way. This thereby protects dentists against having to pay damages and legal costs should a claim arise against them. However, in some countries this indemnity insurance is not mandatory (see below):

Table 21 – Indemnity Insurance mandatory

Mandatory Indemnity					
	Mandatory	Overseas		Mandatory	Overseas
Austria	Yes	No	Latvia	Yes	No
Belgium	Yes		Lithuania	Yes	No
Bulgaria	Yes	No	Luxembourg	Yes	No
Croatia	No		Malta	Yes	
Cyprus	No		Netherlands	No	Yes
Czech Rep	Yes	Yes*	Norway	Yes	
Denmark	Yes**		Poland	Yes	
Estonia	No		Portugal	No	
Finland	Yes	No	Romania	Yes	
France	Yes	Yes	Slovakia	Yes	No
Germany	Yes	No	Slovenia	Yes	Yes*
Greece	No	Yes*	Spain	Yes	Yes
Hungary	Yes	No	Sweden	Yes	No
Iceland	Yes	No	Switzerland	No	No
Ireland	Yes	Yes	UK	Yes	Yes
Italy	Yes				
* at additional cost			** included in membership of DDA		

Eight 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 alternatively to any country, but for a limited period (usually measured in months).

Corporate Practice

Most countries permit dentists to set up their practices as limited liability companies (corporate bodies). Only in Germany, Ireland, and Malta is this barred completely. There is no information for Luxembourg.

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

Belgium	Greece	Portugal
Bulgaria**	Hungary	Romania
Croatia	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.

In Austria, 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

The current information about Tooth Whitening can be found in Annex 8.

By 30th October 2012 all countries had complied with the demand to enact regulations putting the Directive into effect.

Most countries have reported that in 2013 there were still many non-dental professionals illegally continuing to undertake tooth whitening using products with greater than 0.1% hydrogen peroxide.

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. There has been little change to this list since 2008.

Table 23 – Inoculation against Hepatitis B mandatory

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

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 just over 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

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

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. Only Denmark has been added to this list since 2008.

Table 25 – Amalgam separators mandatory

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

** 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.

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

Table 26 - Normal (state) retirement ages

This table shows the normal retirement ages for males/females in each country; the first figure is for males, the second for females and 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, are 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.

Table 27 – Tax rates in 2013

	Top rate of tax	Standard rate of VAT		Top rate of tax	Standard rate of VAT
Austria	50.0%	20%	Latvia	24.0%	21%
Belgium	53.5%	21%	Lithuania	20.0%	21%
Bulgaria (1)	10.0%	20%	Luxembourg	49.0%	15%
Croatia	40.0%	25%	Malta (6)	35.0%	18%
Cyprus	35.0%	18%	Netherlands (7)	52.0%	21%
Czech Republic (2)	22.0%	21%	Norway	54.3%	25%
Denmark	51.5%	25%	Poland	32.0%	23%
Estonia (1)	21.0%	20%	Portugal	45.0%	23%
Finland	31.75%	24%	Romania (1)	12.0%	24%
France	49.0%	20%	Slovakia	25.0%	20%
Germany	45.0%	19%	Slovenia	50.0%	22%
Greece (3)	42.0%	23%	Spain (8)	30.5%	21%
Hungary (1)(4)	16.0%	27%	Sweden	57.0%	25%
Iceland	46.22%	25.5%	Switzerland	42.0%	8%
Ireland (5)	41.0%	23%	United Kingdom	45.0%	20%
Italy	43.0%	22%			

Source: various

(1) Flat rate
(2)) Dental consummables VAT is 15%. Tooth whitening 21%
(3) VAT is 13% for intra-oral materials
(4) VAT 5% for medicaments, 15% for materials
(5) VAT 21% on dental equipment and materials
(6) Some dental materials are charged at a lower VAT rate
(7) A lower VAT rate of 6% is applied to dental materials
(8) Lower VAT rate of 10% on dental equipment

Income Tax rates

In all but a handful of countries, tax rates are progressive with increasing incomes, but all countries do allow a certain amount of income before tax is applied. The highest rate reported was in Sweden, with a top rate of 57%. However, in 2014, France was introducing a rate of 75% on earnings over €1M. The lowest rate is in Bulgaria (10% flat rate on all earnings).

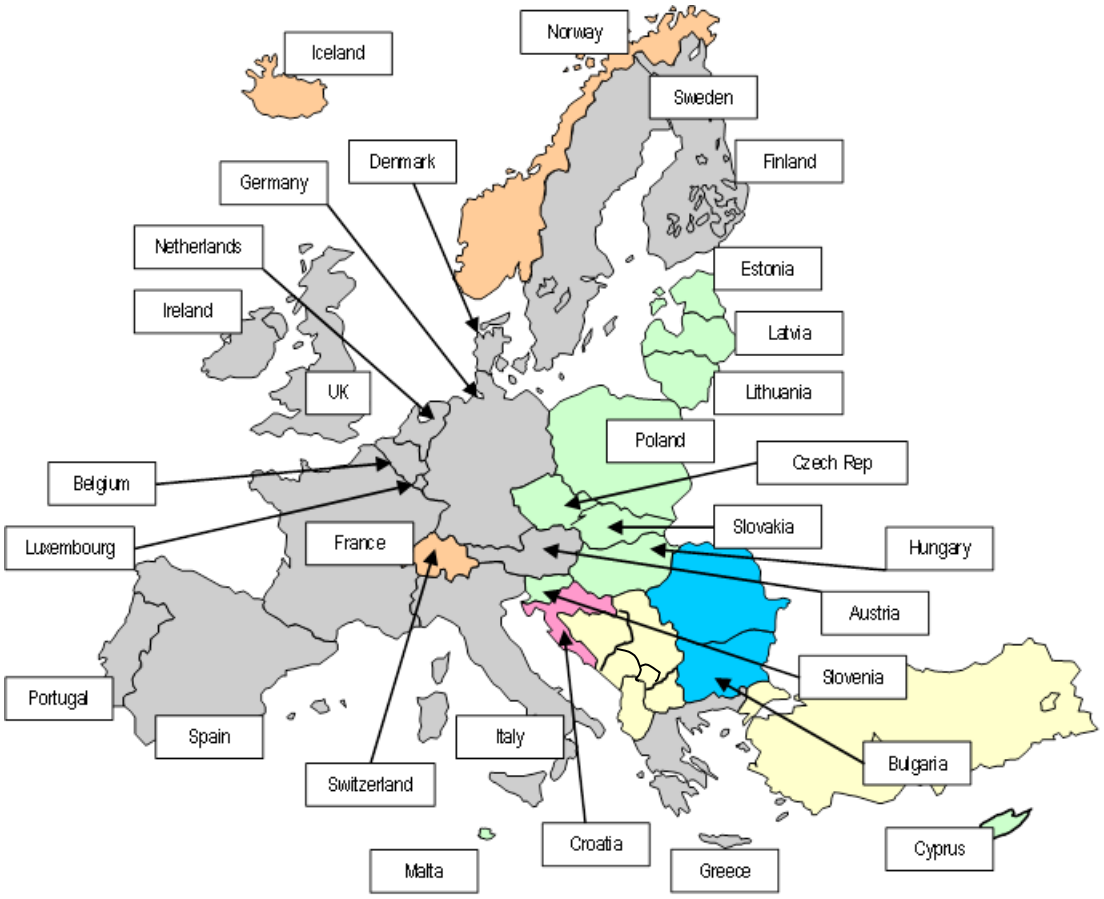
VAT

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.

Most countries charge VAT for dental consumables and equipment at their standard rate, but several countries (marked in the table) do offer some lower VAT rates. Again, the levels of VAT levied across the different countries, are very complex. The highest rate charged is 25.5% (Iceland), but the average is about 20 to 23%.

Individual Country Sections



EU joined 2004

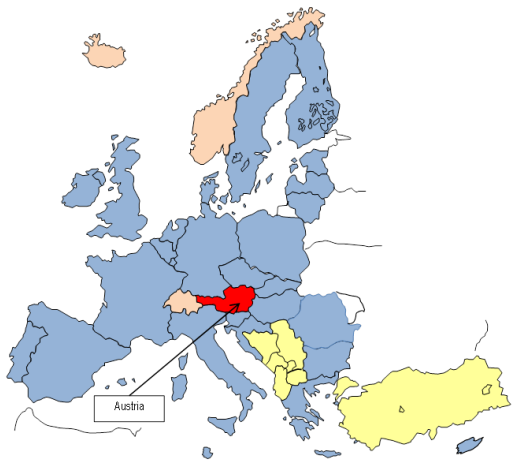
EU joined 2007

EU joined 2013

EEA & Switz

Non-EU/EEA

Austria



In the EU/EEA since	1995
Population (2013)	8,489,482
GDP PPP per capita (2012)	€32,269
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:	4,820
Population to (active) dentist ratio:	1,920
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 mandatory.

Date of last revision: 7th January 2014

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%).

		Year	Source
% GDP spent on all health	10.8%	2011	OECD
% of this spent by government	75.6%	2011	World Bank

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.

Oral healthcare

		Year	Source
% GDP spent on oral health	0.65%	2007	CECDO*
% of OH expenditure private	40%	2007	CECDO

*estimated

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 some 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 introduced a countrywide system of quality assurance in 2009. This system is organised by the Austrian Dental Chamber. Evaluations have to be done every 5 years, and are done via self-evaluation based on a questionnaire formulated by the quality assurance company, which is authorised by the Austrian Dental Chamber.

The answers to the questionnaire are verified in a randomised process.

Health Data

		Year	Source
DMFT at age 12	1.40	2007	WHO
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 then 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.

Year of data:	2013
Number of schools	4
Student intake	165
Number of graduates (2012)	119
Percentage female	65%
Length of course	6 yrs
VT mandatory?	No

Graduation takes place at the three public (university) dental schools in Graz, Innsbruck and Vienna and a new private university dental school in Krems, which started in 2008, and the first graduates from there are expected in 2014.

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.

There is no annual cost of the registration, but every registered dentist has to be a member of the Austrian Dental Chamber, with annual fees dependent on the income of the dentist.

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 there is no minimum number of hours that have to be undertaken 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 public 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:	2013
Total Registered	4,820
In active practice	4,421
Dentist to population ratio*	1,920
Percentage female	42%
Qualified overseas	766

* 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 16% 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 within the data for dental specialists for 2013).

OMFS (2013)	167

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:	2013
Hygienists	0
Technicians	620
Denturists	0
Assistants (estimate)	10,200
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 Austrian Dental Law and 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 health 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 - about 19% of dentists work solely in the private sector.

Year of data:	2013
General (private) practice	3,866
Public dental service	601
University	206
Hospital	110
Armed Forces	
General Practice as a proportion is	87%

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 87% 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 23% 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 there is a political intention of the Austrian Dental Chamber 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 82 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 mostly 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	4,820	2013	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 normally convened before court action can be considered. The examining committee consists of dentists and of delegates of associations for patient interests. 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 Dental Chamber. Limitations refer, for example, to the form of the advertisement in print media and it is not permitted to include a dentist´s fees in any advertisement. 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 Dental Chamber, which is more restrictive than the guidance of the Council of European Dentists.

Insurance and professional Indemnity

Liability insurance is compulsory for dentists. 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.

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 the European Cosmetics Directive so there is a legal limit on the concentration of peroxide.

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.

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 a mandatory continuing education and training requirement of at least 4 hours every five years.

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.

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

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"

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

Income tax for individuals is set up at up to 50% on a four-bracket progressive schedule: 20.4% (on taxable income from €11,000 to €25,000; 33.7% (€25,001 to €60,000); and 50% above €60,000. Married people are taxed separately.

Taxes are levied on corporations (25% on distributed and undistributed profits), trade income, real estate, inheritance, dividends, gifts, and several miscellaneous services and properties. Capital gains and dividend income are also taxed.

VAT

Standard VAT rate is 20% (since January 1984). Reduced VAT rates are 10% on foodstuffs, books, pharmaceuticals, passenger transport, newspapers, admission to cultural and amusement events, hotels. Most dental equipment and consumables are charged at the standard rate.

Various Financial Comparators

Vienna ***Zurich = 100***	**2003**	**2013**
Prices (including rent)	85.2	70.2
Wage levels (net of taxes)	52.3	53.5
Domestic Purchasing Power*	57.3	67.7

(* relative to net income)

Source: UBS August 2003 and November 2012

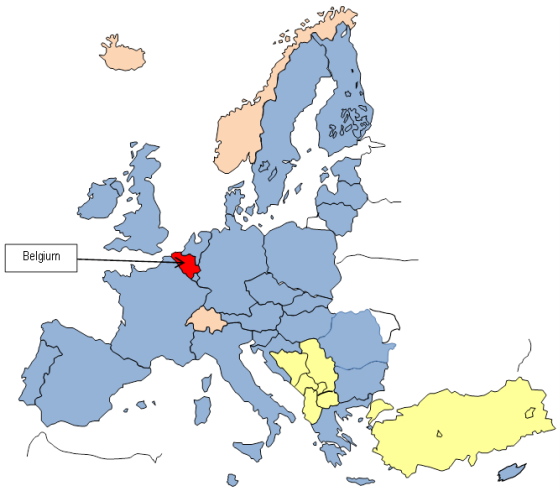
Other Useful Information

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: office-zmk@meduniwien.ac.at Website: www.unizahnklinik-wien.at Dentists graduated 2012: 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: michael.rasse@i-med.ac.at Website: www.zmk-innsbruck.at Dentists graduated 2012: 25 Number of students: 150
Graz	**Krems (New)**
Universitätsklinik fur ZMK Graz Auenbruggerplatz 12 A-8036 Graz Tel: +43 316 385 – 22 48 Fax: + 43 316 385 – 33 76 E-mail: zahnklinik@medunigraz.at Website: www.medunigraz.ac.at/zahnklinik Dentists graduated 2012: 24 Number of students: 150	Danube Private University Steiner Landstrasse 124, A-3500 Krems Tel: +43 676 842 419 305 Fax: +43 2732 70478 7060 E-mail: info@dp-uni.ac.at Website: www.danube-private-university.at Dentists graduated 2012: None Number of students: 250

Belgium



In the EU/EC since	1957
Population (2013)	11,153,405
GDP PPP per capita (2012)	€29,170
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:	8,879
Population to (active) dentist ratio:	1,434
Members of Dental Association:	Varies

Dentists may belong to one of 4 dental associations, depending upon their language. In 2013 membership was about 74%. The use of dental specialists is widespread but there has been no development of clinical dental auxiliaries. Continuing education for dentists is mandatory.

Date of last revision: 31st January 2014

Government and healthcare in Belgium

Belgium is an independent parliamentary monarchy, founded in 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 Federal Parliament consists of a Senate or *Senaat* in Dutch, *Senat* in French. There are 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'Iinvalidité* (INAMI)/*Rijksinstituut voor Ziekte en Invaliditeits Verzekering* (RIZIV) is the Federal 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. Prevention is a regional responsibilty.

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 six months, the budget of all of the sectors are examined to determine what measures must be taken to control any expected overspend.

The health budget in 2013 was €26.7 billion. There is a legally approved increase of 3% per year in health care expenditure, with amounts above this having to be justified separately, for example by lobbying from the dental profession.

		Year	Source
% GDP spent on health	10.6%	2011	World Bank
% of this spent by government	75.6%	2010	OECD

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

1. Minister of Social Affairs decides treatment tariffs and oversees relations with sick funds
2. Minister of Health decides registration, and how many dentists are required
3. 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.
Almost all dental care is provided in private practice together with a very small amount in hospitals and universities.

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

		Year	Source
% GDP spent on oral health	0.19%	2007	CECDO
% of OH expenditure private	40%	2007	CECDO

Public compulsory health insurance

There is an agreed scale of fees for dental treatments, called the *convention*. This is jointly agreed by the dental associations and the sick funds working as a commission within the *Institut*. Dentists generally charge patients for each item of treatment, and 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.

Just over than two thirds of dentists (68%) were signed up to provide care within the Convention, in 2013. They may also provide care outside the Convention, provided this is during published hours.When a dentist breaks the rules of the Convention, the patient has a right to demand an indemnity payment of 300% of the excess of the feescale.

Almost the whole population is within a 15 minute bus access of a dentist. However, only approximately half of the population attend a dentist regularly.

The average number of patients on a dentist's list is not known.

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, 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 five stages of construction at a minimum of four visits. As part of the convention a voluntary quality assurance accreditation system has been organised since 1998.

Dentists working ouside the Convention (approximately 32%) self-regulate for quality assurance, based on the possibility of claims for liability by patients.

Since 2002 there has been a mandatory system of 10 hours continuing education per year (60 hours over 6 years), to preserve a dentist's registration.

Health data

		Year	Source
DMFT at age 12	0.90	2010	WHO
DMFT zero at age 12	40%	2007	CECDO
Edentulous at age 65	45%	2007	CECDO

"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.

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:	2012
Number of schools	5
Student intake*	1,025
Number of graduates	158
Percentage female	80%
Length of course	5 yrs
* 920 in French schools and 105 in Dutch schools	

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:

1 Flemish *Master in de tandheelkunde*
2 French *Licencie en sciences dentaires*

Vocational Training (VT)

To register to work in the INAMI/RIZIV as general dentists, graduates have to follow a 1-year vocational training (3 years for periodontology and 4 years for orthodontics.as specialist training)

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 170.

The current situation (in 2013) relating to the need for VT by overseas graduates depends on the situation in the homeland (country of qualification). Sometimes a supplementary academic learning is mandatory.

VT in general practice includes a specific academic learning, with a specific input from the dental associations.

The VT dentist is paid by the dentist supervisor.

Registration

Before being able to practise a dentist must register with the Federal Ministry of Health. There is no fee payable.

Re-registration is mandatory after 6 years.

Language requirements

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.

Postgraduate and Specialist Training

Continuing education

Continuing education spread over all aspects of the profession (general medicine, radiology, prevention, practice management, conservative dentistry, orthodontics, prosthodontics, …) is mandatory to preserve registration. The requirement is 60 hours over 6 years.

Specialist Training

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

1 Algemeen Tandarts, Dentiste Généraliste
2 tandarts specialist in de Orthodontie Dentiste Spécialiste en orthodontie
3 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 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:	2011
Total Registered	8,879
In active practice	7,777
Dentist to population ratio*	1,434
Percentage female (2007)**	48%
Qualified overseas**	118

*active dentists only
**CECDO estimate (2007)

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:	2011
Orthodontics	399
Endodontics	
Paedodontics	
Periodontics	139
Prosthodontics	
OMFS (2007)	290
Dental Public Health	
Stomatology	286

These data are all for active specialists only.

Stomatologists, who are reducing in number, are usually undertaking general dentistry. They train for 6 years in medicine, then 2 years as master in dentistry, finally 2 years specialisation in stomatology.

OMFS do two years supplementary training in addition to that. They are registered under the Medical Directives.

Auxiliaries

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

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

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 undergo one year's formal training, in Flanders, but no registration. In 2013 about 120 a year were training. In 2000, FDI reported that there were 800 chairside assistants.

Training in the French speaking part of Belgium had just begun in 2013.

Practice in Belgium

Almost all patient care is undertaken in General Practice.

Year of data:	2011
General (private) practice	7,567
Public dental service	
University	200
Hospital	
Armed Forces	10
General Practice as a proportion is	97%

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. Removeable dentures may be reimbursed.

Orthodontics is only included if treatment starts before the age of 15 years. Private fees can be set for all of these excluded 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.

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 has to inform a patient whether or not he/she is in the *convention*. The benefit to the dentist of being in the *convention* is related to pension rights on retirement.

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.

To overcome the above restrictions, the sick funds and some private insurers offer supplementary insurances 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 ivest their own money.

A practice must be registered at a specific address. Some sick funds own polyclinics.

There are no specific contractual requirements between practitioners working in the same practice.

No domiciliary care is offered in Belgium. There are some isolated personal initiatives, but there is no organised care. In 2013, VVT was conducting a pilot study, on behalf of RIZIV/INAMI, on special needs,

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

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. 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 4 national dental associations recognised by the social security system (RIZIV-IMAMI):

	Number	Year	Source
Chambres Syndicales Dentaires	1,016	2012	FDI
Société de Médecine Dentaire	1,096	2012	FDI
Verbond der Vlaamse Tandartsen	3,500	2012	VVT
Vlaamse Beroepsvereniging voor Tandheelkunde (VBT)	600	2012	VVT

1. the *Chambres Syndicales Dentaires* (CSD) for French-speaking dentists
2. the *Société de Médecine Dentaire* (SMD) also fo French-speaking dentists and
3. the *Verbond der Vlaamse Tandartsen* (VVT) for Flemish speaking dentists.
4. The *Vlaamse Beroepsvereniging voor Tandheelkunde* (VBT) for Flemish speaking dentists.

Membership of a dental association is not compulsory.

Ethics and Regulation

Ethical Code

There is no federal ethical code. The ethical codes of the dental associations cover relationships and behaviour between dentists, the contract with the patient, consent and confidentiality, continuing education and advertising.

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 are ethical commissions which also consider complaints.

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 re-approved by the European Court in 2008 and 2012 as not being in contradiction to 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.

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

Belgium has adopted the 2011 Cosmetics Directive. Nevertheless, some illegal practice, with so called "no—peroxide products " does take place.

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 on radioprotection of at least 3 hours each 5 years.

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..

Amalgam separators have been required by law since 2002.

Financial Matters

Retirement pensions and Healthcare

Social security must be paid on earned income. For employees, part of the social security is paid by the employer, and a smaller part by the employee. The employer's social security contribution amounts to approximately 35%, while the employee's social security amounts to 13.07%, both uncapped.

The social security tax for the self-employed is capped at approximately €15,905.32 per year (2013 figure).

The state old age pension is called Rustpensioen/Pension de retraite. The standard pension age is 65, but it can be received from an earlier age if pension rights have built up for a sufficient number of years (career condition). This includes any years in which rights to a pension in a country other than Belgium have been built up.

The amount of the Belgian old age pension depends on:

- the number of years worked in Belgium, and
- the salary earned each year.

Taxes

National income tax:

Employees and self-employed individuals pay progressive income tax. The top rate is approximately 53.5% (including communal tax) and starts at a salary level of €37,330 (2013 income and 2014 tax year figure).

VAT/sales tax

There is value added tax, payable at a standard rate of 21% on purchases, including dental equipment and materials. There are reduced rates of 12% for restaurants and 6% for foodstuffs, books, water, pharmaceuticals, medical, books, newspapers, cultural and entertainment events, hotels.

Dental services are not included in VAT.

Financial Comparators

Brussels ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	75.7	67.0
Wage levels (net)	56.0	44.9
Domestic Purchasing Power @PPP	64.5	59.6

Source: UBS August 2003 and November 2012

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: aurelie.somer@health.fgov.be
Website: www.health.fgov.be

Dental Associations:

Flemish (Dutch) language:

Vlaamse Beroepsvereniging Tandartsen (VBT)
Franklin Rooseveltlaan 348
9000 Gent
BELGIUM
Tel: +32 9 265 02 33
Fax: +32 2 414 87 27
Email: vragen@vbt.be
Website: www.tandarts.be

Flemish (Dutch) language:

Verbond der Vlaamse Tandartsen (VVT)
Vrijheidslaan 61,
1080 Brussel,
BELGIUM
Tel: +32 2 413 00 13
Fax: +32 2 414 87 27
Email: verbond@vvt.be
Website: www.tandarts.be

French language

Chambres Syndicales Dentaires (CSD)
Siège social : avenue de la Renaissance, 1
1000 Bruxelles
Boulevard Tirou 25 bte 9
6000 Charleroi
BELGIUM
Tel: +32 71 31 05 42
Fax: +32 71 32 04 13
Email: 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:

VBT: Consultand (3-Monthly)
Editor: Guido Lysens
Franklin Rooseveltlaan 348
9000 Gent
BELGIUM
Tel: +32 9 265 02 33
Fax:
Email: guido.lysens@tandarts.be
Website: vragen@vbt.be

CSD: *L'Incisif*
Boulevard Tirou 25 bte 9
6000 Charleroi
BELGIUM
Tel: +32 71 31 05 42
Fax: +32 71 32 04 13
Email: csd@incisif.org
Website: www.incisif.org

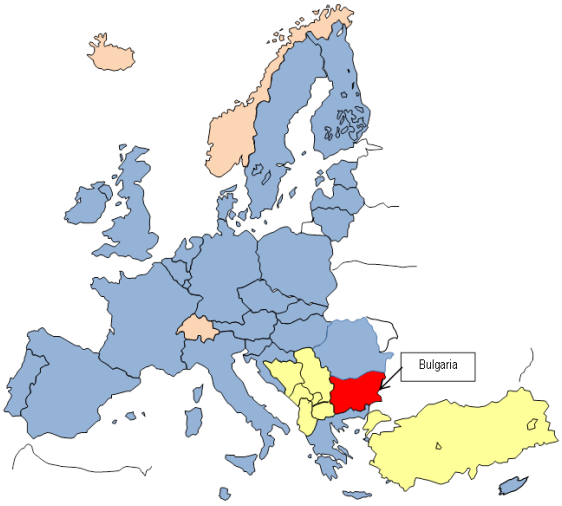
VVT: *Vvtmagazine (Monthly)*
Editor: Guy Kefel
Vvtnieuws (Monthly)
Editor: Dirk Barbier
Vrijheidslaan 61
1081 Brussel
BELGIUM
Tel: +32 2 413 00 13
Fax:
Email: redactie@vvt.be

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 (French) Université Catholique de Louvain Avenue Hippocrate, 10, B 2.5721 1200 Bruxelles BELGIUM Tel: +32 2 7645752 Fax: +32 2 7645722 Email: website: http://www.uclouvain.be Dentists graduating each year: 37 (2011/12) Number of students:	**Brussels (French)** Univerisité Libre de Bruxelles Hôpital Universitaire Erasme Route de Lennik 808 1070 Bruxelles BELGIUM Tel: +32 2 555 6118 Fax: +32 2 555 6798 Email: Website: www.ulb.be Dentists graduating each year: 21/ (2012) Number of students:
Liège (French) Université de Liège Faculté de Médecine, Avenue de l'Hopital, 1, CHU du Sart Timan B-4000 Liège BELGIUM Tel: +32 4 343 43 3 Fax: Email: Website: http://www.ulg.ac.be Dentists graduating each year : 10 (2012) 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: 40 Number of students:	**Leuven (Flemish)** KU Leuven School voor Tandheelkunde 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: 50 Number of students:

Bulgaria



In the EU/EEA since	2007
Population (2013)	7,282,041
GDP PPP per capita (2012)	€10,859
Currency	Bulgarian Leva (BGN) 1.95 BGN = €1.00 (2013)
Main languages	Bulgarian

General health care is mainly funded by deductions from salaries.
The system is designed as a state monopoly. It operates through the National Health Insurance Fund.

Number of dentists:	8,350
Population to (active) dentist ratio:	872
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.

Date of last revision: 13th January 2014

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 sqkm.The capital is Sofia. The country is divided into 28 districts.

The people's ethnic origins are Bulgarian 84.8%, Turk 8.8%%, Roma 4.9%, other 1.4%. The religion is predominantly Eastern Orthodox (76%) and Muslim 8%.
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 NarodnoSybranie (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 voluntary health insurance. 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 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 by the Minister of Health. The contracted annual package of activities

		Year	Source
% GDP spent on health	7.3%	2011	World Bank
% of this spent by government	55.3%	2011	World Bank

in dental medicine varies according to the age.

The Bulgarian Dental Association (BgDA) reports that in 2012, the proportion of public resources spent on general healthcare, including dental medicine, was 4.3% of GDP (3.2 billion BGN or €1.6 billion).

The total budget for the mandatory health insurance system for 2013, adopted by the Parliament, amounted to 2.71 billion BGN (€1.39 billion).

Oral healthcare

The proportion of the total budget for the mandatory health insurance that was spent on dental medicine in 2013 was 4.47%.

		Year	Source
% GDP spent on oral health	0.16%	2012	BgDA
% OH expenditure private	No data		

In April 2009 the Bulgarian Council of Ministers adopted the proposed by BgDA National Oral Health Preventive Programme for Children of 0 to18 years (NOHPPC).
This is the link to the official website of the NOHPPC:
http://www.oralnaprofilaktika.bg/

About 96% 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 6,100 had contracts with the NHIF in 2013.

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

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 Ministry of Health, through its Medical Audit Agency, audits the quality of dental care according to its Dental Medicine Standards.

The quality of dental care in private practice is not actively monitored. Some control is being carried out by the BgDA on the basis of the Ethical Code.

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

Health Data

		Year	Source
DMFT at age 12 *	3.03	2008	NOHPPC
DMFT zero at age 12	21%	2011	NOHPPC
Edentulous at age 65	14%	2013	BgDA

"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 systemic fluoridation in Bulgaria.

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 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:	2012
Number of schools	3
Student intake*	350
Number of graduates	290
Percentage female	50%
Length of course	5.5 yrs
* estimated	

All the schools are public, and there are no private schools.

Students, studying in the faculties of dental medicine, who have properly entered schools according to all the rules, do not payany fees.

However, from the data supplied by the BgDA it seems that a large number of students are fee-paying from outside of Bulgaria, as the numbers graduating appear to be much in excess of the government funded student intake.

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

Qualification and Vocational Training

Primary dental qualification

The primary degree in Bulgaria is *Physician of Dental Medicine with a Master Degree*
(Лекар по денталн амедицина 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.

Diplomas from other Member States are recognised without the need for any vocational training.

Registration

The prerequisite for registration is a primary degree in dental medicine. The registration of a *Physician of Dental Medicine*is is administered by the Bulgarian Dental Association (BgDA) by means of its Regional Colleges.

Cost of registration (2013)	€ 77

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 (CE) is mandatory. A credit system has been introduced and administered by the BgDA. A minimum of 30 credits is to be covered in no more than 3 years. The CE is delivered by the BgDA, or by other institutions, accredited by the BgDA. CE is also delivered by the Medical Universities, Military Medical Institute, Red Cross.

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 concludeswith 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- this is a specialty, which includes prevention and treatment of the pathology of all clinical cases in the mouth caused by allergenic reactions towards drugs and dental materials.

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:	2013
Total Registered	8,350
In active practice	8,350
Dentist to population ratio*	872
Percentage female	66%
Qualified overseas	70

The Total Registered and the Total Active are the same because (for example) those who are going on maternity leave apply to not pay the annual fee, but still remain in the Register. However, others who do not pay their annual fees are removed from the Register.

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 pressure from theBgDA, the National Framework Contract with NHIF now 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 distinctmovement into Bulgaria by overseas dentists. In 2008, 85% of the overseas dentists working in Bulgaria were citizens of non-EU countries.

Since the beginning of 2007,over 800 Certificates of Good Standing have been issued to dentists by the BgDA (these are for registration with other EU and Non-EU regulatory bodies).

Specialists

Patients have free access to specialists.

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 have a contract with NHIF. The law has now been amended to abolish this duty. The data for these dentists remains at the 2008 level.

General Dental Medicine (2008)	2,264

Year of data:	2013
Orthodontics	45
Oral Surgery	226
Endo & Restorative	417
Paedodontics	580
Periodontics	36
Prosthodontics	115
Oral Radilogy	5
OMFS	45
Dental Public Health	17
Dental Clinical Allergology	7

Auxiliaries

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

Year of data:	2013
Hygienists	0
Technicians	1,235
Denturists	0
Assistants	No data
Therapists	0
Other	0

Dental technicians

Dental technicians graduate from a 3 years' special education programme with the degree of *Professional Bachelor*. The training is 3,240 hours, including 1,275 hours of 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 construction 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). In 2013, general care nurses were 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 2013 – the number in dental clinics is small.

Practice in Bulgaria

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

The data, except for general practice, remains the same as in 2008.

Year of data:	2013
General (private) practice	8,011
Public dental service	0
University	258
Hospital	35
Armed Forces	46
General Practice as a proportion is	96%

Working in General Practice

Virtually all Bulgarian dentists are working in the private sector on a self-employment basis in general (liberal) practice; most of them are in individual practices for primary care. The registration of the dental practices as medical institutions is administered by the Ministry of Health by means of its regional bodies – the Regional Healthcare Inspectorates. 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 6,100 (2013) 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 2013, the annual scope for children and adolescents (up to age 18) comprised1 extensive check + 4 curative procedures (including fillings, endodontics and extractions). The annual scope for adults comprises 1 extensive check + 2 curative procedures (including fillings and extractions).

There is a small co-payment for children for endodontic treatment only – approximately 20%. Orthodontic treatment for children is not covered by the NHIF.

Endodontics, removable appliances, crowns and bridges for adolescents are not covered by the NHIF. If a patient needs more than the annual scope of treatment then he/she has to pay the full dentist's fee.

The 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 Healthcare Inspectorates – 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.

Whilst dentists usually work on a self-employed basis, rarely they 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 oral surgical treatments.

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.

Professional Matters

Professional associations

The members of the ABD and AMSRS are also members of the BgDA

	Number	Year	Source
Bulgarian Dental Association	8,350	2013	BgDA
Association of Bulgarian Dentists	>150	2013	BgDA
Association Médicale Scientifique Républicaine de Stomatologie	>150	2013	BgDA

The Bulgarian Dental Association (BgDA) 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 11th1990 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 (2007), 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 ethical principles of the profession and penalise 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: www.bzs.bg

The Association of Bulgarian Dentists (ABD) was established in 1997. It unites a group of dentists with common ideas regarding the problematic issues of the modern dental medicine.

Main purposes of the organization are:

- promotion of the prestige of the dental profession;
- implementation of the modern European and worldwide experience in the field of treatment of the dental illnesses of the Bulgarian citizens;
- continuous improvement of the professional skills of the Bulgarian dentists;
- establishment of a system for postgraduate training and qualification; participation in the work of the FDI;
- active steps for solution of concrete issues related to the European integration of the Bulgarian dentists;
- organisation of annual completions for students - dentists and awarding of scholarships for excellent achievements and active work in programs related to the dental science; active participation in the Bulgarian scientific activity..

Ethics and Regulation

Ethical Code

Bulgarian dental practitioners are subject to the *"Code of professional ethicsof the physicians in dental medicinein 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:
www.bzs.bg

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 dental practices.

Tooth whitening

Tooth whitening is being practiced only by physicians in dental medicine.

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.

With a change in the *Law of the Safe Use of Nuclear Energy* in 2012 the regulations for dental x-ray equipment was changed from a licensing regime to a regime of information only.

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 mandatory.

Financial Matters

Retirement pensions and Healthcare

The retirement ages in Bulgaria are 63 for men and 60 for women. Up until the new pension reform was approved in December 2011, Bulgaria's retirement age was 63 years for men and 60 years for women. Plans are for these to be increased gradually so that by 2020 it will be 65 years for men and the same for women soon after 2020.

Taxes and Insurance

National income tax

Since 2008, there has been a flat income tax of 10% of income.Tax is 0% for capital gains from disposal of shares on a regulated Bulgarian / EU / EEA market by EU / EEA residents, 5% for dividends and liquidation quotas and 7% for income from voluntary life insurance received after the termination of the insurance policy.

Mandatory insurance contributions

Health care in the mandatory health insurance system is funded by mandatory health insurance payments amounting to 8% of the income due by all Bulgarian citizens.

The total is between 30.7% and 31.4%, paid by both the employer and the employee. This includes 12.8% - for the pensions fund, 5% for the universal pensions fund

0.4% - 1.1% for occupational accident and professional disease fund (rate depending on the field of activity), 3.5% for general illness and maternity fund 1% for the unemployment fund and 8% for the health insurance fund

Payments are capped at BGN 200 (€100) a month

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. There is a reduced rate of 9% for hotel services.

Various Financial Comparators

Sofia ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	No data	35.5
Wage levels (net)	No data	10.3
Domestic Purchasing Power at PPP	No data	26.3

Source: UBS January 2003 and November 2012

Other Useful Information

Important Contacts::

Bulgarian Dental Association (BgDA)
49, Kniaz Dondukov Blvd.
1000 Sofia, Bulgaria
Tel.: +35929874797
Fax: +35929888724
Gateway: +359888407226
Email: office@bzs.bg
Website: www.bzs.bg

Ministry of Health:
5, SvetaNedelya Square
1000 Sofia, Bulgaria
Tel.: +35929301152
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: +35929659130
Tel./Fax: +35929659124
EU integration: +35929659130
Email: jvatkova@nhif.bg
Website: www.nhif.bg

Association Medicale Scientifique Republicalne Stomatologie
1, St. Georgi Sofiiski Blvd.
1431 Sofia, Bulgaria
Tel.: +35929522818
Fax:
Mobile: +359887300550
Email: toppir@abv.bg
Website:

Dental Schools: The numbers of annual intake of government funded Bulgarian citizens as students is the same each year, and is recorded here. However, data for fee-paying foreign students varies annually.

Sofia

Medical University
Faculty of Dental Medicine
1, Sveti G. Sofiiski Blvd.
1432 Sofia, Bulgaria
Tel: +35929522818;
+35929541247;
+35929523548
E-mail: info@stomfac.org
E-mail: fdent@abv.bg

Numbers of annual intake: 80
Dentists graduating (2012): 140

Plovdiv

Medical University
Faculty of Dental Medicine
3, Hristo Botev Blvd.
4002 Plovdiv, Bulgaria
Tel: +359896610286
E-mail: doc.todorov@yahoo.com
E-mail: doz_kukleva@abv.bg

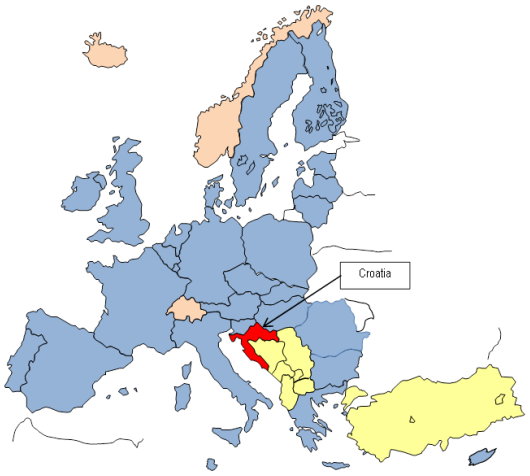
Numbers of annual intake: 60
Dentists graduating (2012): 90

Varna (established in 2005)

Medical University
Faculty of Dental Medicine
55, Marin Drinov Str.
9002 Varna, Bulgaria
Tel: +359888226863
E-mail: svechtarov@yahoo.co.uk

Numbers of annual intake: 30
Dentists graduating (2012): 60

Croatia



In the EU/EEA since	July 1st 2013
Population (2013)	4,475,611
GDP PPP per capita (2012)	€13,566
Currency	Croatian Kuna (HRK) 7.50 HRK = €1.00 (2013)
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:	4,537
Population to (active) dentist ratio:	1,155
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.

Date of last revision: 2nd January 2014

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.

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.

HNB is the Croatian National Bank

		Year	Source
% GDP spent on health	7.8%	2012	HNB
% of this spent by governm't	85.0%	2012	HNB

Oral healthcare

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

		Year	Source
% GDP spent on oral health	No data	2012	Chamber
% OH expenditure private	No data	2012	Chamber

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).
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.

Routine oral examinations would normally be undertaken annually for patients and a dentist would be looking after about 2,200 patients on a regular basis.

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	4.00	2011	Croatia Med
DMFT zero at age 12	55%	2011	Croatia Med
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.

Croatia Med is the Croatian Health Insurance Fund

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:	2013
Number of publicly funded schools	2
Number of privately funded schools	1
Student intake (2013-14)	148
Number of graduates (2012)	113
Percentage female	69%
Length of course	6 yrs

The oldest dental school is in Zagreb, which was founded in 1962; the school in Rijeka was founded 1973. The dental school of Split was founded in 2006 and is privately funded. All curricula are tailored according to the *Bologna Declaration*.

In the 2013-14 academic year there was a total of 926 undergraduate students.

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 post-qualification VT for Croatian graduates.

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 €7,000 (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.

Dentists who have qualified from outside of Croatia do not need to undertake vocational training if are they from EU countries. Dentists from countries outside the EU/EEA need to pass written exam, as a confirmation of their qualifications.

There is no fee for registration in Croatia.

Language Requirements

There is a formal need to understand and speak the Croatian language to a basic level, 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:	2013
Total Registered	4,537
In active practice	3,875
Dentist to population ratio*	1,155
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" (132 unemployed and registered at the Croatian employment service in July 2013). There are some overseas qualified dentists working in Croatia. In 2013 there were 5 with a proper licence.

Movement of dentists across borders

The Chamber has suggesed that there is an increased interest to work in Croatia as a dentist.

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:	2013
Orthodontics	184
Oral Surgery	98
Endo & Restorative	97
Paedodontics	130
Periodontics	74
Prosthodontics	156
Oral Medicine	95
OMFS	45
Family Dental Medicine	4

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

Year of data:	2013
Hygienists	0
Technicians*	1691
Denturists	0
Assistants	631
Therapists	0
Other	0
* there are an unknown number of unregistered technicians	

There is no system of use of dental auxiliaries in Croatia other than dental technicians and dental assistants.

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. In 2010 the "Chamber of Dental Technicians" was established and became a part of Croatian Dental Chamber. In 2013, the Chamber of Dental Technicinas had 1,691 members.

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 the 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.

Dental Assistants

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, so above is an estimate.

Many are members of the Croatian Dental Chamber.

Practice in Croatia

Oral health services are provided mainly in General Practice, both in the public and private sectors..

Year of data:	2013
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:	76%

"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.

Just over half of general practitioners are in purely private practice and just under half are 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

	Number	Year	Source
Dental Chamber	6,859	2012	Chamber
Dental Society	1,748	2012	FDI

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.

Total number of dentists in Croatia is 4,537 but dental technicians and dental assistants are also the members of Dental Chamber – hence the increased number shown.

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Membership of the Chamber is obligatory by Statute for dentists. 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 34 complaints made against dentists in 2012.

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.

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 official retirement age in Croatia in 2013 was 65 – male, 60 – female.

There are three main insurancebased schemes: **Pension insurance** – covers risks of old age, invalidity, employment injury and occupational disease, and death. **Health insurance** – covers the risk of temporary incapacity for work due to sickness or maternity and health care. **Unemployment insurance** – covers the risk of unemployment and also promotes employment and the rehabilitation process of unemployed persons disabled at work.

The main principles of these social security branches are that these are public, general and compulsory. They cover the insured persons and are based on contributions paid by employees, employers, self-employed persons, and are partly financed by the State budget. They are based upon solidarity of members, except for the second pillar of funded pension insurance.

a) I pillar : Pay as you go (PAYGO) system fi nanced by contributions and state budget revenues - 15% of gross earnings
b) II pillar: Compulsory pension insurance based on individual capitalized savings - 5% of gross earnings.
c) III pillar: Voluntary pension insurance based on individual capitalized savings.

Retirement pensions in Croatia are from 40% to 60% of regular working salary.

Taxes

Residents are taxed on worldwide income, while nonresidents are taxed only on Croatian source income. Spouses are separate persons for tax purposes.

Taxable income is based on total income from employment, self-employment, property and proprietary rights, capital, insurance and other income less personal allowances. Gross income is reduced by the employee's pension contribution payments (20% of gross income). Each individual is entitled to a personal allowance of HRK 2,200 per month (2013). The deduction may be further increased for each dependent family member.

Rates are 12% to 40%, depending on gross income.

VAT/sales tax

The standard rate of VAT has been 25% since March 2012. There is a lower rate of 10% on hotels and newspapers. Dental and medical services are excluded.

Various Financial Comparators:

No data published by UBS

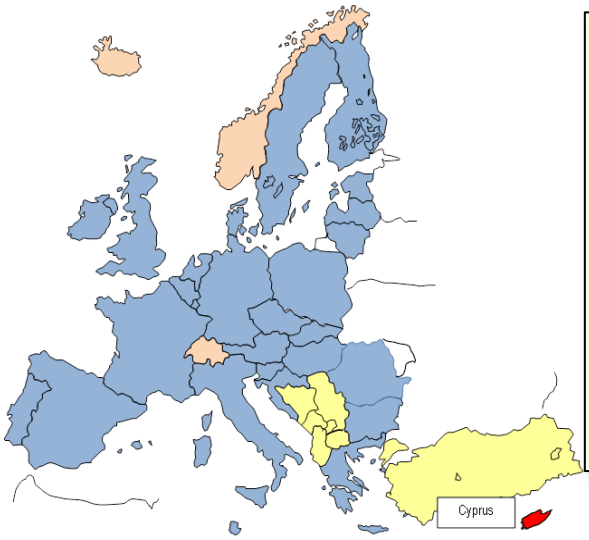
Other Useful Information

Main national associations and Information Centre:	
Hrvatska komora dentalne medicine Croatian Dental Chamber Kurelčeva 3, 10000 Zagreb Tel: +385 1488 6710 Fax: +385 1481 6540 Website: www.hkdm.hr E-mail: hkdm@hkdm.hr	*Specialist associations and societies:* Dentists' scientific organisation: Hrvatsko stomatološko društvo Hrvatski liječnički zbor, Šubićeva 9, 10000 Zagreb Avenija Gojka Šuška 6, 10040 Zagreb Tel: +385 1290 3067 Fax: +385 1286 4250 Website: hsd@kbd.hr
Competent Authority:	***Publications:***
Ministry of Health Ksaver 200a, 10 000 Zagreb Prisavlje 14, 10 000 Zagreb Tel: +385 1460 7555 Tel: +385 1467 7005 Tel: +385 1469 8300 Tel: +385 1616 9111 Web : http://www.zdravlje.hr	Vjesnik dentalne medicine Dental Design Smile

Dental Schools:

Zagreb	**Rijeka**	**Split**
University of Zagreb Stomatološki fakultet Sveučilišta u Zagrebu Gundulićeva 5, 10000 Zagreb Tel: +385 1 480 2111 Fax: +385 1 480 2158 Web: sfzg@sfzg.hr Student intake 2013-14: 85	University of Rijeka Stomatološki fakultet Sveučilišta u Rijeci Braće Branchetta 20, 51 000 Rijeka Tel: + 385 51 65 1111 Fax: + 385 51 67 5806 Web: www.medri.hr/studiji/stomatologija Student intake 2013-14: 33	University of Split Stomatološki fakultet u Splitu Šoltanska 2, 21000 Split Tel: + 385 21 557903 Fax: +385 21 557895 Website: www.mefst.hr Student intake 2013-14: 30

Cyprus



In the EU/EEA since	2004
Population (2012)	862,000
GDP PPP per capita (2012)	€20,856
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:	1,073
Population to (active) dentist ratio:	1,042
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 mandatory.

Date of last revision: 10th October 2013

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 *AcquisCommunautaire* 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-Cypriot (including about 9,000 Maronites, Armenians and Latins), 11.0% are Turkish-Cypriot and 8% foreign residents and workers.

A National Health System had not yet been established by 2013. 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.

		Year	Source
% GDP spent on health	6.0%	2010	CSS
% of this spent by governm't	41.5%	2010	CSS

The introduction of a General Health Insurance Scheme (GHIS) is scheduled for 2015. 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 and 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 stipulates that financial criteria must be taken into account to define eligibility for receiving health care by the public sector.

The CSS is the Cyprus Statistical Service.

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%	2010	CSS
% of OH expenditure private	97%	2010	CSS

A comprehensive spectrum of services is provided from the Public Dental Services including conservative and surgical treatment, as well as removable dentures. 83% of the population has almost free access to public oral healthcare (they pay only €3 regardless of the offered care and €75 for a denture). Primary school children receive free treatment from the public sector. For orthodontic care from the public sector only children up to the age of 18 receiving welfare assistance are eligible.

In the private sector, patients pay directly and the price is not regulated. Where there is insurance company involve-ment, the fees are agreed between the dentist and the company.

With the implementation of the General Health Insurance System (GHIS), the Ministry of Health has recommended the following adjustments related to Public 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. Around 20 patients a day would normally be seen.

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

There are no routine checks and there is reliance on patients making complaints. The Cyprus Dental Association in collaboration with the Ministry of Health, were in 2013 preparing a new legal Act that will regulate the operation of dental clinics.

Health data

		Year	Source
DMFT at age 12	1.14	2010	Min of Health
DMFT zero at age 12	54%	2010	Min of Health
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. About 75% of dentists practising 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 are 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 MemberState.
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 practise dentistry in Cyprus, registration with the Cyprus Dental Council is mandatory first, for recognition of his/her title. Then, in order to practise the profession, he/she has to be registered with the Cyprus Dental Association (the 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 have been imposed with the new amended legislation (harmonisation with the EU Directive 2005/36) as regards the license to practice. The CDC requires basic knowledge of the Greek language, verified by a personal interview.

Cost of registration CDC (2013)	€ 35
Cost of registration CDA (2013)	€ 130

Further Postgraduate and Specialist Training

Continuing education

Since 2012, the Cyprus Dental Association (CDA) has implemented a programme of Continuing Professional Development of Dentists (CPDD). This programme is mandatory for all dentists (private and public sectors) in order to obtain the Certificate of the Clinical Competence (CCCA).

This is obtained by accumulating a minimum of 45 Modules of Education (ME) in a period of 3 years. In a next step, and after the implementation of the Dental legislation, the Certificate of Clinical Competence Act, this will be connected to the renewal of the licence to practise dentistry in Cyprus, from the CDA.

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:	2013
Total Registered	1,073
In active practice	827
Dentist to population ratio*	1,042
Percentage female	49%
Qualified overseas	1,073

Of the 1,073 registered (in 2013), 136 were working outside Cyprus, 63 were not active and 47 were retired.

There was no reported unemployment amongst dentists in 2013.

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 theUK) 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
- Dento-alveolar surgery, after basic dental training plus at least 4 years' training, and.
- Oral Surgery, after basic dental training plus at least 3 years' specialist training, and
- Oral Maxillo-facial surgeons, after basic medical and dental training plus at least 4 years' specialist training.

Year of data:	2013
Orthodontics	46
Dento-alveolar Surgery	11
Oral Surgery	1
OMFS	8

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

Year of data:	2013
Hygienists	0
Technicians	130
Denturists	0
Assistants in public sector	34
Therapists	0

Dental Hygienists

There were 7 hygienists reported as working in Cyprus in 2008, but there is no data now (in 2013), as this is not a recognised profession.

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 are not qualified and in most cases are trained by their employers. There is no formal education programme.

The CDA reported that they had no information about how many are employed in the private sector.

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 practise 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:	2013
General (private) practice	787
Public dental service	39
University	
Hospital	
Armed Forces	2
General Practice as a proportion is	95%

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 suggested minimum price, in a 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.

Working in Hospitals (the Public Dental Service)

Public Dental Services run 56 clinics in 5 district hospitals, 8 urban, 23 rural health centres and 2 foundations. Dentists working at the public sector are all salaried and are not permitted to undertake private practice. Primary and secondary dental care is provided at all the public clinics, while tertiary care is provided only at the district hospitals.

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 just a couple of dentists working full time for the Armed Forces.

Professional Matters

Professional associations

	Number	Year	Source
Cyprus Dental Association	773	2012	FDI

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.

Insurance and professional indemnity

There is no mandatory professional indemnity cover in Cyprus. However, discussions have been held in the Parliament and in the CDA on this topic, but by 2013 it was still not mandatory by law.

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

Cyprus has been harmonised with EU Directive since October 2012.

The CDA reported that there have been a few instances of illegal practice, which have been reported to the police.

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. Dentistscan attend seminars organised on this issue by the Ministry of Labour andMinistry of Health.

Hazardous waste

Cyprus adopted the European legislation on waste disposal in 2005. The disposal of clinical and hazardous waste is collected and managed by a licenced company. The Public Dental Service and all private practices have a contract with a private company for the safe disposal of clinical and hazardous waste.

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

National normal pension age is 65 (63 if disabled).Pensions for dentists in the public sector are monitored through the Pensions Law of the civil servants. 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.

Since 2011, for dentists working in the private sector, it has been mandatory to contribute to the "Dentists and Doctors Pension Fund".

Taxes

National income tax:

Cyprus has a progressive tax rate, commencing at 20% on incomes over €19,500 to 35% on earnings over €60,000. There are various allowances and exemptions.

In addition to income tax, social insurance premiums are paid as a percentage of salary. Employers pay a 6.8% contribution plus various funds and employees pay 6.8% also. Self employed persons pay 12.6% of income.

VAT/sales tax

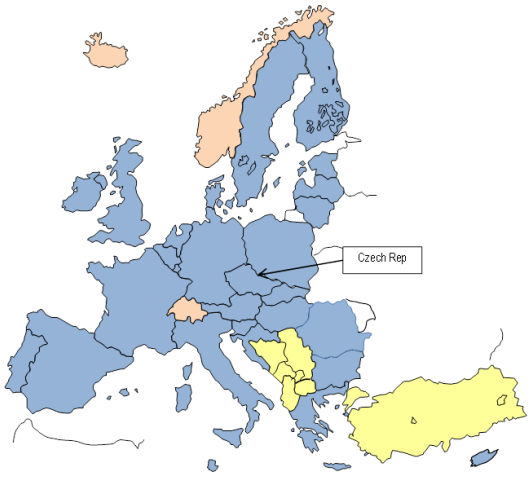
The Standard rate of VAT is 18% (since January 2013). The rate will be raised to 19% in 2014. There are two reduced rates: 8% (hotels, restaurants) and 5% on foodstuffs, books, pharmaceuticals, medical, passenger transport, news-papers, admission to cultural entertainment and sporting events. Medical and dental services are not subject to VAT.

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 27898 2434 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 GeneralHospital 1450 Nicosia Cyprus Tel;+357 22801620 Fax +357 22669148 Email: director@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 27898 2434 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.Box2434 2434 Nicosia, CYPRUS Tel: +357 22 819 819 Fax: +357 22 819 815 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 (2013)	10,516,125
GDP PPP per capita (2010)	€20,790
Currency	Czech Crown (CZK)
	27.56 CZK = €1.00 (2013)
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:	9,354
Population to (active) dentist ratio:	1,345
Members of Dental Chamber:	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: 5th January 2014

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 7 (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% (employee) and 9% (employer) 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.

		Year	Source
% GDP spent on health	7.5%	2011	OECD
% of this spent by government	84.2%	2011	OECD

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.

Oral healthcare

The healthcare budget is annually estimated according to the expected amount of money in the insurance fund. About 5% of the public healthcare budget is spent on dentistry.

		Year	Source
% GDP spent on oral health	0.36%	2006	Chamber
% OH expenditure private	60%	2007	CECDO

Oral healthcare is coordinated by the Czech Dental Chamber (Česká 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 2012, 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% is paid from sick fund, 80-85% by patient,
- partial dentures with casting framework = 30-60% is paid from sick fund, 40-70% by 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 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 about 1,600 patients regularly attending. Oral re-examinations are covered by the health insurance fund and normally would be carried out for most adult patients every 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 (CSK) 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
- to the Regional authority

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	2.60	2007	WHO
DMFT zero at age 12	29.0%	2007	CECDO
Edentulous at age 65	17.0%	2007	CECDO

"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:	2012
Number of schools	5
Student intake	280
Number of graduates	250
Percentage female	38%
Length of course	5 yrs
VT mandatory?	No

Dental schools are known as *Stomatologická klinika Lékařské fakulty*, of a university (Stomatological Clinic of the Faculty of Medicine of the University).

Following the Czech Republic's accression to the EU in 2004, dental studies have been under a new a curriculum, compliant with to the Directive of the EU.

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 ukončení studia ve studijním programmeu zubní lékařství (doktor zubního lékařství, MDDr.* This change of title is in relation to the newly formed study of dentistry has been from the year 2004.

Vocational Training (VT)

There is no post qualification vocational training. *MDDr* graduates are able to work in the Czech Republic, and in other EU countries, immediately upon qualification.

Vocational training is not mandatory for graduates of other Member States'' dental schools, also.

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.

Certificates of Proficiency	
Year of data:	**2012**
Paedodontics	20
Periodontics	500
Prosthodontics	
Oral Surgery	513
Dental Public Health	

Specialist training

There is specialist training in two EU 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 in orthodontics it takes 3 years and in oral-maxillo-facial surgery 6 years; on completion there is an examination.

There is also specialist training in clinical dentistry for of the university dental clinic employees.

All specialist 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 maxilofaciální chirurgie)*
- Clinical dentistry: attestation in complete dentistry *Diplom - klinická stomatologie*

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:	2012
Total Registered	9,354
In active practice	7,821
Dentist to population ratio*	1,345
Percentage female	65%
Qualified outside the CR or Slovakia	385

* The "dentist to population ratio" means the figure of active dentists including specialists to the figure of population.

The difference between the total registered and those who are "active" is from those who are retired, on maternity leave or other similar reasons.

The Chamber has advised that there were no reports of unemployed dentists in 2013.

Movement of dentists across borders

There is no significant movement of dentists from the CR to its neighbouring countries. Approximately 30 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:	2012
Orthodontics	337
OMFS	72
Clinical Dentistry	

*In 2012, 30% of orthodontists were male, and 87% of OMFSs were male.

Additionally, about 75% of dentists hold a Certificate of Proficiency, which entitles them to apply to the Health insurance company for higher fees – see previous section. This includes practitioners with a General Dental proficiency.

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:	2012
Hygienists	800
Technicians	4,500
Denturists	0
Assistants	8,000
Therapists	0
Other	0
all figures approximate	

There is no obligatory registration of dental hygienists, dental technicians and dental assistants in the 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. Since 2008 there has been a Bachelor degree (BSc) available, following study of 3 years, for dental hygienists. Both methods of qualification of dental hygienists are acceptable in the Czech Republic.

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 was also started. Both methods of qualification of dental technicians are acceptable in the Czech Republic.

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 an 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:	2012
General (private) practice	6,500
Public dental service	0
University	295
Hospital	30
Armed Forces	31
General Practice as a proportion is	94%

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. So, for example, the common range of prices for metallo-ceramic crown in 2013 was between 2,500 and 4,500 Czech Crowns, (about €100 - €180). 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.

For those items partially covered by the scheme, the insurance element is taken out of the calculated price. 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. New prices are scheduled as a result of negotiations between the health insurances and 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 or by e-mail) – 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 2012. 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.

In 2013, about 5,926 dentists were self-employed in their **own practices** (or as partners within corporate bodies) and about 1,600 dentists were **employees** in these 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. – associate professor), 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 50% of dentists serving in the Armed Forces are female.

Professional Matters

Professional associations

The **Czech Dental Chamber** (Česká 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	9,354	2012	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 Executive 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 €250 per year (in 2013) for this insurance. For work abroad it 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

The Czech Republic has implemented the EU Directive 2011/84/EU concerning cosmetic products. Whitening procedures are under Cosmetic rules and are not covered within the health insurance system.

Agents with a peroxide concentration higher than 6% are not permited for use in dental practice. The Czech Dental Chamber has no official verification about any iillegal practise of tooth whitening but it probably exists.

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 have been obligatory since 2004, as part of a 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 in 2013 (it will increase in the future), although dentists and staff can work past then. Those working in hospitals and universities can also work after 63 years of age.

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

Residents are taxed on their worldwide income; nonresidents are taxed only on Czech source income. For taxable income, there are five basic sources of income: employment, entrepreneurial activity, capital, leased assets and "other." General taxable income is
defined as the difference between actual gross income and allowable expenses. Domestic sources - dividends and interest – are taxed separately under a lump sum withholding system.

Deductions are granted for mortgage interest, life and supplementary pension insurance and gifts. Personal allowances are also available.

The tax rate is 15%, with a 7% increase in the rate for income from employment and entrepreneurship exceeding 48 times the average salary within the calendar year. Capital gains generally are taxed at 15%, but may be exempt if certain conditions are satisfied.

VAT

Standard VAT rate is 21% (since Jan 2013). There is reduced rate of 15% foodstuffs, books, medical, pharmaceutical, passenger transport, newspapers, admission to cultural sporting and entertainment events, hotels.

All dental services (including prostheses are exempt from VAT, except for cosmetic tooth whitening (21%). Purchase of dental materials (filling materials, impression materials, instruments) has a 15% VAT rate.

Various Financial Comparators

Prague ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	41.8	46.8
Wage levels (net)	12.4	19.0
Domestic Purchasing Power*	32.0	36.9

(* relative to net income)

Source: UBS August 2003 & November 2012

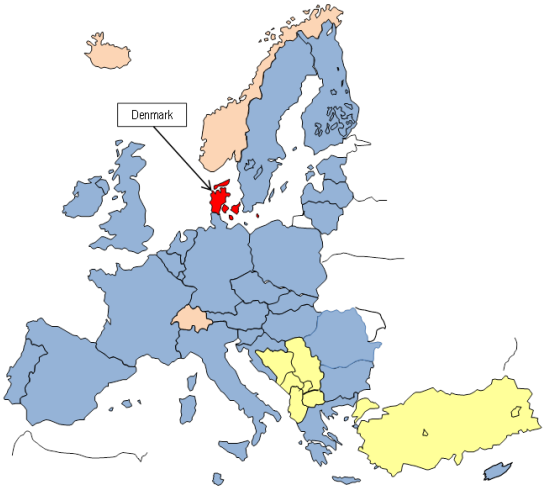
Other Useful Information

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. Jiří 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 ČR Tel: +42 022 497 2243 Fax: +42 022 491 5982 E-mail: sekretariat@uzis.cz Website: www.uzis.cz	Name: Ministerstvo zdravotnictví ČR (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: Česká pojišťovna, a.s. Tel: +420 800 133 666 Fax: E-mail: info@cpoj.cz Website: www.cpoj.cz

Dental Schools:

City: Plzeň Name of University: Lékařská fakulta Karlovy univerzity v Plzni Tel: +42 377 593 400 Fax: +42 377 593 449 E-mail: marie.kleckova@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. lékařská 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: Lékařská 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: Lékařská fakulta univerzity Palackého Tel: +42 585 632 010 Fax: +42 585 223 907 E-mail: jiri.pridal@upol.cz Website: www.upol.cz Dentists graduating each year: 50 - 60 Number of students: cca 290
City: Brno Name of University: Lékařská 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



In the EU/EEA since	1973
Population (2013)	5,605,836
GDP PPP per capita (2012)	€28,996
Currency	Kroner (DKK)
	7.46 DKK = €1 (2013)
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:	7,989
Population to (active) dentist ratio:	1,086
Members of Danish Dental Association:	81%

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

Date of last revision: 30th January 2014

Government and healthcare in Denmark

Denmark is geographically small country of 43,094 sq km.

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.

Denmark has a national health service funded by general taxation. There are few additional special taxes and very few private insurance contributions involved. Dental care for adults is only partly subsidised by the government (approximately 17.5%). The amount paid by the patients is dependent on the treatment —but in general the patients pay the majority of the treatment costs.

The management of health care is highly decentralised, with the individual regions running most services and the municipalities responsible for some public health commitments.

The Danish Health and Medicines Authority is responsible for the administration of the legislation concerning dentistry.

		Year	Source
% GDP spent on health	11.1%	2010	OECD
% of this spent by governm't	85.1%	2010	OECD

Oral healthcare

Oral healthcare is provided in one of two ways. For children under 18, 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

These are the latest figures supplied by the Danish Dental Association (DDA) in 2013. The actual governmental spending on healthcare was:

	€11,213M
The public dental service (children 0-18):	€253M
Spending on adult care:	€160M

Spending on oral healthcare represented 3.7% of the total public healthcare spend.

Dental services for children

Dental services for those aged 0 to 18 are organised by the municipalities and is free of charge. In 2013 there were 98 muncipalities in Denmark 91 of them employed their own dentists and had their own premises for examining and treating children.

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 a few rural areas, there are municipality 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 and the Danish Dental Association. 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 82.5% of costs and the public about 17.5%. In general the subsidy is higher for preventive care and essential treatments, and lower for expensive treatments such as oral surgery. Subsidies for the 18 to 25 year-olds are higher.

The main treatments for which subsidies are paid include examination & 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.

Several groups may receive extraordinary subsidies towards their dental treatment, for example, patients with cancer and Sjögren and patients with a poor economic status.

Dental care for elderly living in nursing homes and for mentally and physically handicapped living in their own homes but unable to use the normal dental care system is part of the municipalities dental care service

Free dental care may be available for adults, for example, if the treatment needs to be carried out in a hospital.

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 Quality of Care

The regional councils monitor standards and spending 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.

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 programme comprises 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	0.60	2011	OECD
DMFT zero at age 12	72%	2007	NBH
Edentulous at age 65	27%	2007	OECD

Danish Health and Medicines Authority

"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 scheme in Denmark. Some parts of the country have naturally occurring fluoridated water.

Education, Training and Registration

Undergraduate Education and Training

The general admission requirement to dental school is a secondary school education. For specific admission requirement prospective students are advised to contact the universities. Foreign applicants must be skilled in Danish.

Year of data:	2012
Number of schools	2
Student intake	162
Number of graduates	120
Percentage female	76%
Length of course	5 yrs

The dental education is 100% government funded and there is no tuition fee. Students do have to pay for books etc. The education is a 2-cycle curriculum (3+2) with a bachelor degree (after the first cycle) and a master after the second.

The education is accredited by the Danish Accreditation Institution.

Qualification and Vocational Training

Primary dental qualification

Having completed dental education, candidates receive an authorisation from the Danish Health and Medicines Authority.The authorisation gives the right to work as a dentist under supervision.

Dentists educated outside Denmark (including dentists from the Nordic countries and the EU/EEA countries) must hold a Danish authorisation in order to use the title "dentist" in Denmark.

As a result of international agreements, different rules govern the recognition of qualifications obtained abroad, depending on the applicant's nationality, and where the education took place. The Danish Health and Medicines Authority (Sundhedsstyrelsen) issues the certificate. Please see more on www.sst.dk

Diplomas from EU countries are recognised according to the EU Professional Qualifications Directive.

Vocational Training

There is no formal post-qualification vocational training.

If a dentist wishes to own a practice or become a chief dental officer in the municipal dental care system, a permission from the Danish Health and Medicines Authority to practise independently must be obtained. To obtain this the dentist needs to have worked for a minimum of 12 months with a minimum of 1,440 hours. In that period the dentist must have treated both adult patients and children – each group for a minimum of 360 hours. To receive this permission the dentist must pay approximately €160 (in 2013) to the The Danish Health and Medicines Authority.

EU qualified dentists wishing to own a practice need a permission to practise independently, from the Danish Health and Medicines Authority, as mentioned above.

Registration

Dentists are registered at the Danish Health and Medicines Authority (see more at www.sst.dk). There is no annual registration fee.

Dentists working in Denmark are s advised to hold a membership of the Danish Dental Association, even though this is not mandatory. Contact info@tdl.dk.

Language requirements

Foreign dentists have to be skilled in Danish as all records must be written in Danish and dentists must be able to communicate with patients, relatives, 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.

Continuing Education and Specialist Training requirements

Continuing education

Continuing education (CE) is not mandatory (by the Danish Health and Medicines Authority) to retain authorisation as a dentist.

However, the Danish Dental Association has a compulsory requirement for CE to all its members. Practising dentists who are members of the DDA must complete a minimum of 25 hours of CE annually. Within the first three years after graduation this is reduced to 10 hours.

Specialist Training requirements (Acknowledgement)

Denmark and The Danish Health and Medicines Authority only provide and recognise two types of specialists' acknowledgments.

- Orthodontics (Ortho) (3 years)
- Oral Maxilla Facial Surgery (OMFS) (5 years)

A third speciality is planned in paediatric dentistry.

The requirements for applying to undertake specialist training are at least two years working experience. Trainees are paid by the hospital (OMFS) or dental school (Ortho). There is no tuition fee.

For a specialist's degree in OMFS, 5 years of specialist training is required. The experience must be gained in departments of Oral Surgery, Oral Pathology and Medicine, Ear, Nose and Throat, and Anaesthetics. There are no requirements for both DDS and MD for this degree.

For specialists in Orthodontics, 3 years of specialist training is required. The experience must be gained within a Department of Orthodontics.

Workforce

Dentists

Year of data:	2013
Total Registered	7,989
In active practice*	5,161
Active dentist to population ratio	1,086
Percentage female	58%
Qualified overseas	No data
* active dentists: 2010 data	

The Danish Dental Association estimated that after 2013 there would be a slight decrease of the workforce, due to fewer dentists being educated than those dentists retiring.

Movement of dentists across borders

There is little movement of dentists in and out of Denmark.

Specialists

As written above, only orthodontics and Oral Maxilla-Facial Surgery are recognised specialties in Denmark.

Year of data:	2013
Orthodontics	290
OMFS	98

OMF surgeons and orthodontists may run their own practices but most specialists in Oral Maxilla Facial Surgery work in hospitals. 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.

Many societies which represent special interests in dentistry exist. The Danish Dental Association can establish contact with these societies.

Auxiliaries

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	

There are 3 classes of dental auxiliaries, besides dental assistants – hygienists, technicians and clinical dental technicians:

Dental Hygienists

Dental hygienists undertake 3 years training, obtaining a non-universital bachelor diploma. Upon qualification they are authorised by the Health and Medicines Authority.

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 infiltration analgesia.

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 Health and Medicines Authority 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.

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, or in Technical Schools in several municipalities.

Practice in Denmark

Year of data:	2013
General (private) practice	3,431
Public dental service	1,215
University	112
Hospital	58
Armed Forces	15
General Practice as a proportion is	66%
Number of general practices	2,208

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.

Payments to dentists (Fee scales)

All payments to dentists are by way of "item of service" fees. 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 DDA 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 (the amount is half of normal pay) 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 4 employees strict rules on occupational security apply.

Monitoring the standards of private dental practice is the responsibility of the Society of the 5 regional bodies with the DDA. The monitoring consists of statistical checks and official procedures for dealing with patient complaints.

Working in the Public Dental Health Service

Of the 98 municipalities in Denmark, 91 employ dentists. These dentists are working in universities, the armed forces, hospitals and public dental health 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 employed by the university. Whilst they all have teaching responsibilities, they may have additional responsibilities to treat patients in university clinics (*Clinical teacher*), or have a mixture of management, research and student supervisory responsibilities (*Professor*, or *Assistant Professor/ Associate professor*). There are also external lecturers who provide teaching in specialties.

Clinical teachers usually work part-time at dental schools and part-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

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

	Number	Year	Source
Association of PH Dentists	1,293	2013	DCPA*
Danish Dental Association	6,507	2013	DCPA*

* The Danish Confederation of Professional Associations

The Danish Dental Association (DDA) organises dentists of all categories, for example dentists in general (private) practice, municipally employed dentists or dentist employed at universities. Approximately 81% of all active dentists hold membership of the DDA.

The main goals of the DDA 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

The Association of Public Health Dentists (APHD) organises primarily municipally employed dentists. It was founded in 1985 and works for better pay and employment conditions and the Association has declared health care policy goals.

Many members of the APHD are also members of the DDA

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 (Patientombuddet).

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 brought to the Dental Appeal Comittee.

The system under *Tandlægeoverenskomsten* also deals with the money issue, but it is a compulsory patient insurance that gives the patients compensation when entitled.

The *Patientombuddet* deals with complaints about other dentists and auxiliaries.

Protection of Data and information

The rules for data protection follow the EU Directives.

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 live footage is not permitted.

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).

Dental Patient Insurance

People being treated in the public or private healthcare system are covered by the Danish Act on the Right to Complain and Receive Compensation within the Health Service.

Patients may be able to receive compensation for injuries caused by treatment and examinations, or by drugs. This right to compensation is not based on whether a dentist has assumed responsibility for the injury due to an error on the dentist's part.

The Dental Patient Insurance does not consider whether an error has been made, but only whether there is an injury which should be covered. The insurance is therefore a "no fault" compensation scheme.

Indemnity Insurance

Liability insurance and insurance for industrial injury for staff are compulsory for all private dental practitioners. As a member of The DDA, a private dental practitioner will have such insurances, as well as legal expenses insurance and industrial injury for owners.

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

Denmark has adopted the 2011 Cosmetics Directive. There is no record of illegal activities, and no way of knowing that for sure. It is possible that it is happening on a small scale.

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 Danish Health and Medicines Authority.

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 generally mandatory.

Regulations for Health and Safety

For	***administered by***
Ionising radiation	Radiation Institute, Danish Health and Medicines Authority
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

Financial Matters

Retirement pensions and Healthcare

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.

National pension insurance premiums are paid at about 10% of earnings (an average of approximately 8,000 DKK to 10,000 DKK per year per employee (€1,070 to €1,340).

Denmark's pensions system was described by the Mercer Index, in 2013, as "the best in the world". It consists of a public basic pension scheme, a means-tested supplementary pension benefit and fully funded, mandatory private schemes, run by large funds rather than individual companies. The Index classified the system as the first in the world to be an A grade and awarded it an overall index value of 82.9. The unique A grade ranking was described as being "awarded in recognition of the country's well-funded pension system, its high level of assets and contributions, the provision of adequate benefits and a private pension system with well-developed regulations".

Final salary pensions are run by employers who contribute to a central pot of money and take on the risk of investing it. The payout is guaranteed, linked to salary. With defined contribution schemes an individual invests in his own pot, with the employer usually contributing, and retirement income depends on investment returns and the rates being offered in the annuity market.

Taxes

National income tax:

Individuals are entitled to an annual personal allowanceof 42,900 DKK (€5,750) before income tax is payable. Most personal income is subject to AM tax of 8%. This tax is deducted from the income before the other taxes are calculated. The income tax rates are progressive and comprise state, municipality and church taxes. The lowest tax rate is approximately 36% up to a marginal income tax rate of 51.5% (on incomes over about €65,000 per year).exclusive of church tax.

VAT/sales tax

VAT is generally applied at one rate, and with few exceptions. The current standard rate of VAT (in 2013) is 25%. That makes Denmark one of the countries with the highest value added tax. A number of services have reduced VAT at 0%, for example, publishing newspapers and rent of premises (the lessor can, though, voluntarily register as VAT payer, except for residential premises), and travel agency operations.

Dental treatment is excluded from VAT, as are insurance, financial services, postal, medical, education and passenger transport. . However, costs related to purchase of dental equipment, instruments and materials are subject to VAT at 25% and will be reflected in the prices.

Various Financial Comparators

Copenhagen *Zurich = 100*	2003	2012
Prices (including rent)	97.9	86.6
Wage levels (net)	74.8	70.5
Domestic Purchasing Power at PPP	68.3	68.1

Source: UBS August 2003 & November 2012

Other Useful Information

Main national associations and information entre:	***Competent Authority:***
The Danish Dental Association Tandlægeforeningen Amaliegade 17 Postboks 143 DK 1004 Copenhagen K, Tel: +45 70 25 77 11 Fax: E-mail: info@tandlaegeforeningen.dk. Website: www.tandlaegeforeningen.dk Association of Public Health Dentists in Denmark Peter Bangs Vej 36.3. DK 2000 Frederiksberg DENMARK Tel: +45 33 14 00 65 Fax: Email: info@deoffentligetandlæger.dk or info@doft.dk	Danish Health and Medicines Authority Axel Heides Gade 1 DK 2300 Copenhagen S Tel: +45 72 22 74 00 Fax: 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*

Dental Schools:

Copenhagen	**Åarhus**
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: odont@ sund.ku.dk Website: www.odont.ku.dk Dentists graduating each year: 70 Number of students:	School of Dentistry 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: 357

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.

Estonia

In the EU/EEA since	2004
Population (2013)	1,324,814
GDP PPP per capita (2012)	€16,720
Currency	Euro
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:	1,615
Population to (active) dentist ratio:	1,208
Members of Estonian Dental Association:	50%

There are three specialisms – oral maxillo-facial surgery, orthodontics and clinical dentistry. The use of auxiliaries is limited to a few hygienists. Continuing education is not mandatory, but there is a general requirement to keep skills updated.

Date of last revision: 30th January 2014

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 21% between 1990 and 2013, 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.

On 1 January 2010, three Estonian governmental health authorities (i.e. the Health Protection Inspectorate, the Health Care Board and the Chemicals Notification Centre) were united into one joint Health Board. The Health Board is a government agency within the Ministry of Social Affairs. Its main fields of activity are:

- medical devices;
- healthcare;
- communicable diseases and control;
- environmental health;
- chemical safety.

Total health expenditure in 2011 was €944.6M, an increase of 4% over 2010. Public health expenditure was 4.7% of GDP, so private expenditure was 1.3% of GDP. In other words, about 80% of health expenditure was public and about 20% private.

		Year	Source
% GDP spent on health	6.0%	2011	OECD
% of this spent by government	78.3%	2011	OECD

Oral healthcare

		Year	Source
% of GDP spent on oral health	0.30%	2011	Ministry
% of OH expenditure private	66%	2006	Ministry

"Ministry" refers to the Ministry for Social Affairs

It has not proved possible to obtain meaningful up to date figures for what percentage of the total expenditure on oral health is paid for by patients directly (ie private) and what percentage is paid for by government (ie public). The Estonian Dental Association has reported that the public proportion is reducing.

Public dental care

Almost all adult 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 do not receive reimbursement exept pensioners – in 2013, €19 for a checkup and €255 for prosthetic work once during a 3-year period.. 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 €28.76.

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

As stated previously, most 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	2.40	2012	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:	2013
Number of schools	1
Student intake	32
Number of graduates	30
Percentage female	87%
Length of course	5 yrs

Until 2003 the student intake was higher (40).

The dental school is situated within the Faculty of Medicine in the University of Tartu. It is publicly funded. 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 (2013)	€ 13

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. Specialists in Restorative (Clinical) Dentistry were recognised from 2004, and need to be registered as such.

Workforce

Dentists

Year of data:	2013
Total Registered	1,615
In active practice	1,250
Dentist to population ratio*	1,358
Percentage female	87%
Qualified overseas	4

* active dentists only

The majority of dentists are self-employed and there is no reported unemployment amongst dentists in Estonia.

Some dentists practise 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:	2013
Orthodontics	62
Paedodontics	
Clinical dentistry	19
includes Periodontics,	
Prosthodontics & Endo	
Oral Surgery	
Dental Public Health	
OMFS	25

Auxiliaries

The system of use of dental auxiliaries is developing in Estonia.

Year of data:	2013
Hygienists	32
Technicians	137
Denturists	0
Assistants	1,540
Therapists	0

Hygienists

In 2012, it was reported that there were 2 hygienists in Estonia, who had been trained outside the country, and 32 who had trained in Estonia. They are permitted to work under the supervision of a dentist.

The 32 hygienists are not registered because their education is thought to be too short and there is no such dental auxiliary specified as "hygienist". However, in 2013 work was being done by the dental association to recommend a professional standard for them, so that in the near future they can be formally recognised.

All hygienists are salaried. The Insurance Fund does not pay for their service.

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 earlier years it was reported that there were dental therapists in Estonia (26 in 2008), but by 2013, none were practising.

Practice in Estonia

Year of data:	2013
General (private) practice	1,200
Public dental service	
University	18
Hospital	35
Armed Forces	5
General Practice as a proportion is	96%

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. Some private dentists provide some publicly funded or assisted oral healthcare, mainly for children.

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 reclaims a partial or full reimbursement from the local office of the sick fund.

Fee scales

Since September 1998, 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 public foundations. 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 around 5 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	799	2012	FDI

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%..Only dentists may use this on patients. In 2013 there was some illegal practice but the Health Board was focussed on stopping this.

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

State pensions are financed by a social tax paid by all employers on behalf of their employees and by the self-employed. The rate of social tax is 33% of the gross payroll. The share of social tax allocated for pensions is 20% of the gross payroll (13% is allocated for health insurance). The state pension is based on the principle of redistribution, ie the social tax paid by today's employees covers the pensions of today's pensioners.

Men have the right to old age pension at the age of 63 and women at the age of 60.5. The pension age for men and women will be equal by 2016 with the women's qualifying age gradually rising to 63. People working after reaching the pension age are entitled to a full pension, regardless of their work income. The pension can be up to €336 a month. Liberal dental practitioners may work until any age.

There are two supplementary schemes. To encourage participation in the supplementary pension schemes, there are tax incentives.

Taxes

National income tax:

The rate of income tax is a flat rate of 21% (2013).

VAT/sales tax

The standard VAT rate is 20%. A reduced rate of 9% is available on such items as books, newspapers, medicines and accommodation. Medical and dental services are not included in VAT.

Various Financial Comparators

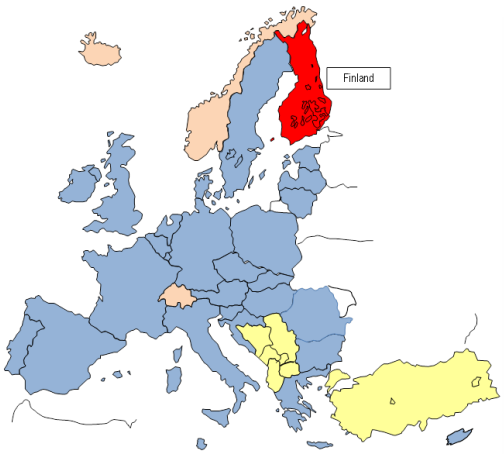
Tallin ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	46.1	48.9
Wage levels (net)	11.9	21.4
Domestic Purchasing Power at PPP	15.6	37.0

Source: UBS August 2003 & November 2012

Other Useful Information

Dental associations and information centres:		
Estonian Dental Association: 1) Narva mnt 5-76 10117 Tallinn ESTONIA Tel: +372 64 59 001 Fax: +372 64 59 001 2) Lille 12-5 51003 Tartu ESTONIA Tel: +372 7319 855 Fax: +372 7428 608 Email: tallinn@ehl.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:***
Health Board Gonsiori 29 Tallinn 15157 Estonia Tel: +372 650 9840 Fax: +372 650 9844 Email: info@terviseamet.ee Website: www.terviseamet.ee	The General Dental Council 29 Gonsiori Str, Tallinn 15157 Estonia Tel: +372 6509840 Fax: +372 6509844 Email: info@terviseamet.ee Website: www.terviseamet.ee	The Dean Prof.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



In the EU/EEA since	1995
Population (2013)	5,434,357
GDP PPP per capita (2012)	€27,544
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:	5,925
Population to (active) dentist ratio:	1,208
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.

Date of last revision: 31st January 2014

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 2013 there were 19 ministers in the Cabinet.

Regional government is organised through 6 provinces, and 320 municipalities.

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.

For more information please consult http://www.stm.fi/c/document_library/get_file?folderId=6511570&name=DLFE-26813.pdf

		Year	Source
% GDP spent on health	8.8%	2011	OECD
% of this spent by governm't	74.8%	2011	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 6,000 persons took part in the study, which included clinical and radiological oral examination. The results are published by the National Public Health Institute in pdf-form:

http://www.terveys2000.fi/julkaisut/oral_health.pdf

New results from year 2011 will be published in due course, see http://www.thl.fi/en_US/web/en

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 and has its own budget. 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	0.40%	2007	CECDO
% of OH expenditure private	60%	2007	CECDO

About three quarters of the population receive oral healthcare regularly (in any 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.

Municipalities 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 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. In connection with the Cross-border Health Directive, the Ministry will publish information in 2014 about what care will be reimbursed from other Member States.

Private Care

Private care is available to Finnish residents, but as of 2013 there were no private insurance schemes offering to finance this.

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 Supervisory Authority for Welfare and Health 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. In addition, X-rays are actively monitored by the authorities.

Health Data

		Year	Source
DMFT at age 12	0.70	2009	WHO
DMFT zero at age 12	42%	2007	CECDO
Edentulous at age 65	40%	2007	CECDO

"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 5.5 years.

There are four dental schools: the University of Eastern Finland, University of Helsinki, University of Oulu and University of Turku. Dental schools are part of the Colleges of Medicine.

Year of data:	2013
Number of schools	4
Student intake	186
Number of graduates	100
Percentage female	68%
Length of course	5.5 yrs

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)

From 2014, a vocational training period of six months is part of the undergraduate training, which will be extended to 5.5 years. The vocational training will be done in salaried positions, in community health centres, with a monthly salary of approximately €3,000.

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. The register is administered by National Authority for Medicolegal Affairs (the competent authority).

A "decision" fee on licensing for Finnish qualified dentists is €100 (2013). Where a dentist's qualification was in another EU/EEA country this is €400.

For those from outside the EU/EEA this is €600. For these dentists the education of the applicant will be evaluated by a Finnish university (usually the dental school in the University of Turku) and there are usually clinical and theoretical tests, paid for by the applicant.

There is no annual re-registration fee.

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, an employer can require that the dentist speaks Finnish and/or Swedish.

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 (except in radiation protection), but under Finnish legislation there is a general requirement to keep skills updated. Continuing education is delivered mostly through the Finnish Dental Society Apollonia.

Specialist Training

Specialists are trained 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 led also to a degree, eg specialist in orthodontics. However, from 2014, a university degree is no longer awarded for medical and dental post-graduate studies.

Oral Surgery was combined in 1999 with Oral maxillo-facial surgery, as a medical specialty. There are about 100 post-graduate positions in the country, so there is a limit to how many can train. Trainees are paid approximately €44,000 a year (2013).

There is training in 5 main specialties:

- Orthodontics
- Dental Public Health
- Oral Maxillo-Facial Surgery
- Clinical Dentistry
- Oral Diagnostics

Clinical Dentistry is a specialty with 4 subgroups. These are:

- cariology
- periodontology
- prosthodontics
- paedodontics

Oral Diagnostics is a specialty with 3 subgroups. These are:

- oral radiology
- oral pathology
- microbiology

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

- Erikoishammaslääkärin tutkinto, hampaiston oikomishoito / Specialtandläkarexamen, tandreglering

  (Certificate of ompletion of specialist training in orthodontics)

- Erikoishammaslääkärin tutkinto, suu ja leukakirurgia / Specialtandläkarexamen, oral och maxillofacial kirurgi

  (Certificate of completion of specialist training in oral surgery)

Workforce

Dentists

Year of data:	2013
Total Registered	5,925
In active practice (estimated)	4,500
Dentist to population ratio*	1,208
Percentage female	69%
Qualified overseas	200

** active dentists only*

The register does not distinguish between working or retired persons.

Of the 4,500 working-age dentists described as “active” the FDA estimates that 180 were not actually working in 2013.

Many dentists practice in more than one sphere of practice.

The annual intake of dental students has been increased since 2003 and also more dentists from outside Finland have been licensed. According to the workforce prognostics the number of working age dentists will remain quite stable until the 10 years from then. There were sufficient numbers of dentists in 2013 to service the population with oral healthcare - the problem is an unequal geographical distribution of them.

Again in 2013, there was some small reported unemployment amongst dentists - about 20-30 dentists, 0.5%. Unemployment benefits for salaried dentists are described by the FDA as “being good”.

Movement of dentists across borders

About 80% of the foreign dentists working in Finland qualified in the EU/EEA and 20% outside the EU/EEA.

In 2013, about 160 Finnish qualified dentists were working abroad.

Specialists

There are 5 dental specialities that are recognised under the National Supervisory Authority for Welfare and Health:

- Orthodontics
- Oral Maxillo-Facial Surgery
- Dental Public Health
- Clinical Dentistry
- Oral Diagnostics

Patients can normally consult a private specialist without referral, but in public care other routines may be necessary.

In the following table, the specialty of "Clinical Dentistry" has not been broken down into the known sub-specialties

Year of data:	2013
Orthodontists	156
Clinical Dentistry	291
OMFS	104
Dental Public Health	90
Oral Diagnostics	31

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:	2013
Hygienists	1,490
Technicians	450
Denturists	400
Assistants	4,800
Therapists	0
Other	0

All data estimated by the FDA

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 Supervisory Authority for Welfare and Health.

Dental hygienists work usually as part of the dental team, although they can work independently. The examination, diagnosis and treatment planning is, by Health Care Professionals Act of 1994, restricted to physicians and dentists.

However, dental hygienists can undertake "health checks". This is described by the FDA as a "grey area". Treatment planning can cover a two years' time span and the hygienist works then under the directions given by the dentist. In KELA, the organisation subsidies the dentist´s examination and for referral it is a prerequisite that the patient gets a reimbursement from the hygienist doing the work.

Hygienists may undertake infiltration local anaesthesia. They take legal responsibility for their work and may accept payment from patients, if they have a practice of their own. However, this is very rare – in 2013 only about 20 hygienists operated this way

Otherwise, 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 Supervisory Authority for Welfare and Health. 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 Supervisory Authority for Welfare and Health.

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 Supervisory Authority for Welfare and Health 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:	2013
General (private) practice	1,994
Public dental service	2,165
University	86
Hospital	113
Student Health Service	72
Other settings	70
General Practice as a proportion is	44%

Working in General 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.* In 2011, dentists who worked in this way, provided approximately 50% of the care for the adult population. In 2013, about 30% of private practitioners worked in single dentist practices.

Despite the emergence of companies, most dentists in private practice remian self-employed and earn their living through charging fees for treatments. The patient pays the dentist in full and and all citzens are entitled to reclaim partial reimbursement from the local office of the *KELA*. However, usually now the reimbursement is taken into account when paying the dentist´s bill, so called "immediate-reimbursement". For example:

The dentist´s fee is €100, KELA´s subsidy is €35, the patient thus pays €65 to the dentist, and the dentist claims the remaining €35 from KELA after treatment.

http://www.kela.fi/web/en/reimbursements-of-the-costs-of-private-medical-treatment gives further information.

Fee scales

The compensation from the public health insurance (KELA) is 30-35% 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 (as a 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.

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 law.

Municipalities obtain their 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. Treatment is free of charge to people under 18 years of age.

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 approximately 20% lower than those 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 other settings

A small number of dentists work in the Student Health Service (YTHS), and for companies which hire a dental workforce. The Armed Forces, public administration and associations are also employers of a few dozen dentists.

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	4,240	2013	FDI

The Finnish Dental Association looks after 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 maintain strong professional cohesion.
The Association promotes treatment of oral and dental diseases in Finland and sponsors oral healthcare. 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 2013 there were 20 people working, led by the Executive Director. About 95% 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 Supervisory Authority for Welfare and Health, with about 15 complaints being made against dentists each year. Another avenue for complaint can be the provincial government. There is also a Consumer Complaints 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 2012 the Patient Insurance Centre received 675 claims from dental patients, 60% from private sector and 40% from public sector. More than a third 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 € 3,300.

Fees for the insurance do not vary according to the type of treatments undertaken by dentists. In 2014, a general dental practitioner would pay €525 annually for this. Failure to insure by a dentist leads to an eventual increased insurance premium.

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. Oral Hammaslääkärit Plc is a company for dental care services, which is listed on the NASDAQ OMX Helsinki. There are other companies as well.

Tooth Whitening

In Finland, Council Directive 2011/84/EU on tooth whitening products has been implemented into legislation. However, national competent authorities have considered tooth whitening products also as medical devices and the legal situation is unclear in 2014.

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	The National Institute for Health and Welfare
Medical devices	National Supervisory Authority for Health and Welfare
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 (5,2% 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 was 60.5 in 2013. 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

National income tax:

Income tax on earned income is paid to the local town or city (15% to 20%), paid to the church (1% to 2% - although voluntary) and is paid to the State on a progressive scale of 6.5% to 31.75% for incomes over €100,000.

In addition, there is a social security charge called 'the health insurance contribution of the insured' paid by individuals (2%).

VAT/sales tax

There are 3 levels of value added tax, at the following rates (from January 2013):

- standard rate (24%),
- reduced rate (14%): This reduced rate is for the supply of foodstuffs, animal feed and restaurant and catering services
- lowest rate (10%): This rate is for the supply of books, pharmaceutical products, and a number of other items.

Medical and dental services are not subject to VAT. Cosmetic procedures, such as cosmetic surgery, are subjected to VAT tax from 2014.

Various Financial Comparators (*Source: UBS August 2003 & November 2012)*

Helsinki *Zurich = 100*	2003	2012
Prices (including rent)	84.5	80.3
Wage levels (net)	56.6	56.0
Domestic Purchasing Power at PPP	61.5	64.0

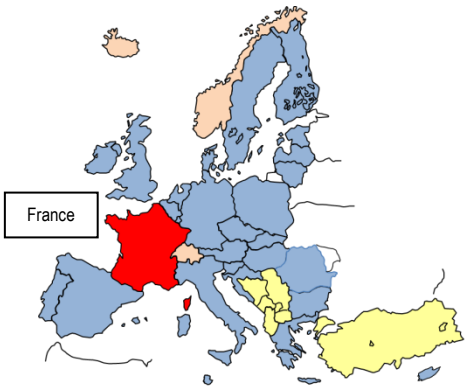
Other Useful Information

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: toimisto@hammaslaakariliitto.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 Institute for Health and Welfare (THL) P.O. Box 30, 00271 Helsinki, Finland Tel. +358 29 524 6000 E-mail: info@thl.fi Website: www.thl.fi
Competent Authority:	***Publications:***	
National Authority for Medicolegal Affairs PO Box 265 00531 Helsinki Finland Tel: +358 295 209 111 Fax: +358 295 209 700 Email: kirjaamo@valvira.fi Website: http://www.valvira.fi/en/	The Finnish Dental Journal (*Suomen Hammaslääkärilehti-Finlands Tandläkartidning*- ~~Finnish Dental Journal~~) Fabianinkatu 9 B, 00130 Helsinki, FINLAND Email: toimisto@hammaslaakariliitto.fi Homepage: www.hammaslaakarilehti.fi	

Dental Schools:

Helsinki	**Turku**
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: hanna.thoren@helsinki.fi Website: www.helsinki.fi/hammas/eng/index.html Dentists graduating each year: 35 Number of students: 200	University of Turku Department of Dentistry Lemminkäisenkatu, 2 20520 Turku, Finland Tel: +358 2 333 81 Fax: +358 2 333 8413 E-mail: juha.varrela@utu.fi Website: www.med.utu.fi/dent/en/ Dentists graduating each year: 25 Number of students: 100
Oulu	**Kuopio**
University of Oulu Department of Dentistry Aapistie 3 90220 Oulu, Finland Tel: +358 8 537 5011 Fax: +358 8 537 5560 E-mail: pertti.pirttiniemi@oulu.fi Website: www.oulu.fi/hammaslaaketiede/ Dentists graduating each year: 35 Number of students: 220	University of Eastern Finland Institute of Dentistry Kuopio campus P.O.Box 1627 FI-70211 KUOPIO Tel: +358 290 4450 1111 E-mail: jari.kellokoski@uef.fi Website: www.uef.fi/en/hammas/etusivu The school was reopened in 2010

France



In the EU/EEA since	1957
Population (2013)	65,657,000
GDP PPP per capita (2012)	€27,177
Currency	Euro
Main language	French

The social insurance system is established by law and is divided into 3 major branches, the Sickness Funds, Pensions and Family. These are managed independently of the state. Most oral healthcare is provided by 'liberal practitioners' according to an agreement called the Convention. Almost all dentists practise within the Convention.

Number of dentists:	41,505
Population to (active) dentist ratio:	1,582
Members of CNSD:	36%
Members of ADF	65%

The use of recognised specialists was limited to orthodontics but since 2011 oral surgery and oral medicine has been recognised. There are no clinical dental auxiliaries.
Continuing education has been mandatory since 2004.

Date of last revision: 26th January 2015

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 (348 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, Social et Environnemental*, the Economic, Social and Environmental Council, with an advisory function, composed of representatives of the associations and the professional world.

Although the organisation of government is centralised, two political and administrative structures exist below the national level where there are 22 regions and 101 departments (including 5 overseas: French Guyana, Martinique, Guadeloupe, Reunion, Mayotte). Most French institutions exhibit strong liberal traditions and this is mainly reflected in the medical and dental professions.

The Overseas Territories, (Polynésie Française, Wallis-et-Futuna, Terres Australes et Antarctiques Françaises) 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, as a result of the last health reform, and 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 the text, including the new annual budgets of the sickness funds. Then the Caisse controls the application of the bill.

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 RSI (Régime social des Indépendants), for independent professionals; and the MSA (*Mutualité Sociale 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 for themselves and their dependants.

		Year	Source
% GDP spent on health	11.6%	2011	OECD
% of this spent by governm't	77.0%	2010	OECD

Generally, hospital expenses, as well as primary care costs, are partially or totally paid by *securité sociale* and complemented by additional individual insurance (private).

In 2011, the part of Social Security (sickness funds) in the funding of the "consumption of medical care and goods" was 75.5%. Hospital expenses represent more than half of the expenses of Social security and ambulatory care represent 21.1%.

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). 98% of dental surgeons in France practise 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 following necessary care (conservative treatment and sealants) is totally covered as well.

For conservative and surgical treatments the practitioner must charge fees according to the Convention 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 for orthodontic treatments), 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, who then transmits electronically this information to Social Security to enable the refunding to the patient.

		Year	Source
% GDP spent on oral health	0.94%	2007	CECDO
% of OH expenditure private	95.0%	2007	CECDO

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 and prosthetics are set by the Government. Only conservative and surgical care fees have been reviewed since – last in 2006.

About two-thirds of the population visits a dentist at least once a year.

Private insurance for dental care

In 2013, approximately 90% of people used 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.

A law passed in June 2013, provides for the generalisation of complementary health insurance and collective agreements to all employees and all enterprises in 2016, regardless of their size. This law will also apply to dentists and their employees.

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. No law provides for however a "guarantee of result".

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	2007	OECD
DMFT zero at age 12	56%	2007	CECDO
Edentulous at age 65	16%	2007	CECDO

"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 25 years. Fluoride toothpastes are sometimes freely given to children in the framework of education campaign, although these goods are largely available over the counter.

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 (common to medicine, dentistry, pharmacy and midwifery). 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 is necessary to obtain the title of doctor in dental surgery and is required to practise. It has to be presented within 18 months after the 6th year of dental curricula.

Year of data:	2011
Number of schools	16
Student intake	1,154
Number of graduates	917
Percentage female (2004 data)	55%
Length of course	6 yrs

NB: the number of graduates does not include Lille and Nice

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 a diploma that is legally required. 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.

Practitioners have to pay an annual charge in order to remain on the register.

Cost of registration (2013)	€ 398

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.

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.

In 2011, new arrangements were made introducing "*Developpement Professionnel Continu*" (different from the EU CPD), for a duration of 1.5 days per year, per dentist. It is controlled by the Ministry of health and organised by different dental societies or associations.

Specialist Training

Since 2011, France has recognised three dental specialties: orthodontics, oral surgery and oral medicine.

- Orthodontics - Training lasts for 6 semesters, part-time and takes place in university clinics. A national specialist diploma is then awarded by the authority recognised competent for this purpose: "*diplôme d'études specialisées d'orthopédie dento-faciale".* The professional title is*: "chirurgien-dentiste spécialiste qualifié en orthopédie dento-faciale".*
- Oral Surgery: training lasts for 8 semesters, part-time and takes place in university clinics. It is a specialty common to medicine and dentistry. A national specialist diploma is then awarded by the authority recognized competent for this purpose: *"diplôme d'études spécialisées en chirurgie orale".* The professional title is: "*chirurgien-dentiste specialiste qualifié en chirurgie orale*".
- Oral Medicine: training lasts for 6 semesters, part-time and takes place in university clinics. A national specialist diploma is then awarded by the authority recognized competent for this purpose: "*diplôme d'études spécialisées en médecine bucco-dentaire*". The professional title is: "*chirurgien-dentiste specialiste qualifié en médecine bucco-dentaire* ".

Stomatologists

NB: Stomatologists are doctors specialised in stomatological sciences (medical specialty). In 2013, only a few of them were still being trained. This speciality has now been replaced with a 4-year training, common to dentists and doctors, and the title is: médecin spécialiste en chirurgie orale.

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:	2012
Total Registered	46,104
In active practice	41,505
Dentist to population ratio*	1,582
Percentage female	40%
Qualified overseas	1,420

It was reported by the CNSD that there were no unemployed dental surgeons in 2013.

Movement of dentists

In 2012, about 3% of dentists practising in France had qualified abroad. There were 283 such new registrations that year.

Year of data:	2012
Total	1,420
EU graduates	776
EEA graduates	7
Convention d'établissement*	474
Others (Minister's discretion)	163

*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

As stated above, since 2011 there have been three dental specialties recognised in France – orthodontics, oral surgery and oral medicine. Those last two started two years ago.

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 dental specialists – patients may go directly to them.

Year of data:	2012
Orthodontics	1,981

In 2013, the first specialists in oral medicine and oral surgery were still being trained.

There are also specialists in maxillo-facial surgery but, as stated earlier, this is a medical 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:	2010
Hygienists	0
Technicians	16,500
Denturists	0
Assistants	15,350
Therapists	0
Receptionists	4,786

Dental Assistants

Dental assistants qualify after 18 months alternative training in dental practice. This training representing 590 hours is mainly governed by a "parity" body: the Commission paritaire nationale de l'emploi et de la formation professionnelle, CPNEFP. They do not have to register.

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 only under the prescription of the dental surgeon.

Most dental surgeons use independent laboratories and there were 4827 craft or industrial laboratories employing salaried workers in 2012. Some practitioners employ technicians directly in their own private laboratories.

There are still some cases of illegal denturists/clinical dental technicians in 2013 – a few prosecutions are mounted each year by the CNSD and on each occasion the technician has been found guilty of illegal practice.

Practice in France

Year of data:	2012
General (private) practice	36,994
Salaried private practice	522
Public dental service	2,828
University	393
Hospital	219
Armed Forces	48
Stomatologists	1132
General Practice	90%

Working in Liberal (General) Practice

More than 90% of 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 the Employment Code (Code du Travail) which regulates in France 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 usually 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 practice cost of the technical plateform, which complies with regulatory and societal demands.

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 refundable 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.

However many items of treatment are not covered by health insurance. In 2014, a new fee scale/nomenclature (CCAM, *classification commune des actes médicaux*) will be implemented to be more in tune with the current practice.

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-dentist.

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. 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, depending on professional demography.

Standards/settlement

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. Since 2003, patients present to every health professional (including dentists) a personal electronic card (*Carte Vitale*), which enables direct transmission of the treatment provided by the professional to the Health Insurance. This proves that the dentist has been paid by the patient and enables direct reimbursement to the patient. Some dentists employed by the Health Insurance (Advisors) 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 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

Most University Hospital Centres (CHU) have 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 Universitaire*s 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 Master's degree in biological and medical sciences.

Maîtres 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 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 (they do not teach), who are recruited through national competitive examinations, and are usually less than 55 years old. They work full-time and have spent at least three years as a *Maître 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 to work as dental surgeons within their own practice.

Working in the Armed Forces

There were 48 full-time dental surgeons serving in the Armed Forces in 2012 – but the number of females is not recorded.

Professional Matters

Professional associations

	Number	Year	Source
ADF	30,053	2012	FDI
CNSD	15,000	2012	CNSD

The main professional union for dental surgeons is the *Confédération Nationale des Syndicats Dentaires* (CNSD) founded in 1935, encapsulating 100 departmental unions, and representing about 36% 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. 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.

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 objective 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 that are 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. Il is included in the Public Health Code (Code de la santé publique).

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 R4127-215 of the Code of Ethics, which states that dental surgeons are "notably forbidden any form of direct or indirect advertising".

Article R4127-217 defines information that a dental surgeon is allowed to put in the telephone book as: "surname, first names, postal and electronic addresses, telephone and fax numbers, opening hours, speciality". Any entry that is charged for is considered as advertising and is thus forbidden.

Article R4127-218: also defines information that a dental surgeon is allowed to mention on a professional plaque at the entrance of a building, or practice: "surname, first names, speciality and diplomas recognized by the Conseil de l'Ordre". The dental surgeon may add the name and origin of his diploma, and the opening hours as well as the floor and telephone number of the practice. Practitioners who do not hold French diplomas must add references to origins.

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 his working life. There are different prices for different types of practice.

For example, a liberal practitioner who is a *CNSD* member will pay €260 annually, plus a €225 implant supplement, (plus €92 for private legal assistance, €72 for professional legal assistance, and €531 for sinus filling), while non- members will be charged €350 for civil and professional liability, or €990 with implantology or €1,098 with sinus filling. (All these are 2013 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).

In 2012, professional liability insurance was reformed for all liberal health professionals including dentists: a new tax has been implemented to pool insurance risks for all professionals. This new contribution from €15 to €25 (€20 for dentists) serves to create a special fund to support the
major claims/accidents exceeding €8 million (or €3 million for an historical claim).

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

By decision of 9 July 2013, the National Security Agency for Drug (ANSM) suspended the sale, distribution and use of dental whitening or bleaching products with hydrogen peroxide concentration higher than 6%.

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	Directions Regionales des Affaires Sanitaires et Sociales (DRASS)
Medical devices	Health General Direction
Infection control	Health General Direction

Ionising Radiation

Training in radiation protection since 2007 is part of the undergraduate curriculum, as an additional compulsory module to be validated in the 5th year. Since 2004, this training in radiation protection of patients (continuing education) has been mandatory for all existing practitioners and every dentist should have been qualified by June 2009. This qualification must be renewed every 10 years.

Since 2009, the equipment must be declared with the IRSN (see above) and the declaration signed by a PCR (Person

Competent in Radioprotection), is valid for the lifetime of the radiation tube -25 years. A PCR must be designated by each dentist. Moreover, technical inspections of sources must be performed externally.

Since 2011, quality controls of the radiological chain must be carried out internally and externally.

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 CARCDSF (*Caisse Autonome de Retraite des Chirurgiens-Dentistes et des Sages-Femmes)* 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" in 1955. The CARCDSF is administered by a board whose members are elected jointly by contributors and 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 C*ontribution destinée au Remboursement de la Dette Sociale* (RDS) which was initially 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.

Income tax is progressive, commencing at 5.5% with earnings from €5,964 then in bands taxed at 14%, 30%, 41% (from earnings above €70,831) and 45% on earnings over €150,000.

There is a tax called the *contribution exceptionnelle sur les hauts revenus* introduced in 2012. It is collected and paid alongside income tax.

This rate of the tax is 3% on income between €250,001 and €500,000, while those with an income above €500,000 pay at the rate of 4% on any income above the threshold.

VAT

From January 1st 2014, new VAT rates applied:

- the normal rate was increased from 19.6% to 20% (alcohol, tobacco etc, and the rate charged to dental surgeons for equipment, materials and instruments)
- the middle rate was increased from 7% to 10% (transportion and restaurants..)
- the reduced rate was reduced from 5.5% to 5% (food)
- the super-reduced rate remains at 2.2% (refundable drugs).

Various Financial Comparators

Paris ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	75.7	75.6
Wage levels (net)	56.0	55.6
Domestic Purchasing Power at PPP	64.5	58.9

Source: UBS August 2003 and November 2012

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://www.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 Tel: +377 932 56666 Fax: +377 931 50954
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 47 Fax: +33 1 56 79 20 25 Email: cdf@cnsd.fr Website : www.cnsd.fr/	MACSF, Service Assurance Dentaire 10 cours du Triangle de l'Arche 92919 LA DEFENSE CEDEX Tel: +33 1 71 23 80 92 Fax: +33 1 71 23 88 92 E-mail: Website: www.macsf.fr

Dental Schools:

	No of 2nd year Undergrads 2010-11		Annual Graduates 2011
Paris 5	194		111
Paris 7	94		89
Bordeaux	93		73
Brest	26		25
Clermont Ferrand	62		55
Lille	108		NK
Lyon	91		84
Marseille	70		56
Montpellier	59		60
Nancy	79		64
Nantes	73		66
Nice	39		NK
Reims	72		48
Rennes	64		55
Strasbourg	68		59
Toulouse	70		72
Total	**1,262**		**917**
Number of graduates does not include Lille & Nice			

Number of students: this is the number in the 2nd year of the curricula, since the 1st year is common to medicine, dentistry, pharmacy and mid-wives. The number of graduates refers to the calendar year 2011, the number of students to the academic year 2010-2011.

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 00
Fax: +33 1 58 07 68 99
Email: louis.maman@parisdescartes.fr
Website: http://www.odontologie.univ-paris5.fr

Dentists graduate: 111
Number of students: 194

Paris 7

Université Paris 7 (Denis Diderot)
UFR d'Odontologie
5, rue Garancière
75006 Paris
Tel: +33 1 57 27 87 12
Fax : 33 1 57 27 87 01
Email: jgregory.aupiais@univ-paris-diderot.fr
Website: http://www.univ-paris-diderot.fr/formation/ListeMED.php

Dentists graduate: 89
Number of students: 94

Bordeaux

Université Victor Segalen Bordeaux II UFR d'Odontologie
16, cours de la Marne
33082 Bordeaux Cedex
Tel: +33 5 57 57 30 00
Fax: +33 5 57 57 30 10
Email: admin.odonto@u-bordeaux2.fr
Website: http://www.u-bordeaux2.fr

Dentists graduate: 73
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
29238 Brest Cedex 3
Tel: +33 2 98 01 6489
Fax: +33 2 98 01 6932
http://www.univ-brest.fr/ODONTOLOGIE/Welcome.html

Dentists graduate: 26
Number of students: 25

Clermont Ferrand

UFR d'Odontologie
11 boulevard Charles de Gaulle
63000 Clermont Ferrand
Tel: +33 4 73 17 73 00
Fax: +33 4 73 17 73 09
Email: ufr-odontologie@u-clermont1.fr
Website: http://webodonto.u-clermont1.fr

Dentists graduate: 55
Number of students: 62

Lille

Université de Lille 2 – Droit et Santé
Faculté d'Odontologie
Place de Verdun, 59000 Lille
Tel: +33 3 20 16 79 50
Fax : +33 (0)3 20 16 79 51
Email: phdupas@univ-lille2.fr
Website: http://chirdent.univ-lille2.fr

Dentists graduate:
Number of students: 108

Lyon

Université Claude Bernard Lyon 1
Faculté d'Odontologie
Rue Guillaume Paradin
69372 Lyon Cedex 08
Tel: +33 4 78 77 86 80
Fax: +33 4 78 77 86 96
Email: claire.guichard@univ-lyon1.fr
Website : http://www.univ-lyon1.fr

Dentists graduate: 91
Number of students: 84

Marseille

Faculté d'Odontologie
27 Boulevard Jean Moulin
13355 Marseille Cedex 5
Tel: +33 4 86 13 68 68
Fax: +33 4 86 13 68 40
Contact: http://www.univmed.fr/public/contact/mail.asp
Website: http://www.univmed.fr/odontologie/

Dentists graduate: 56
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: 60
Number of students: 59

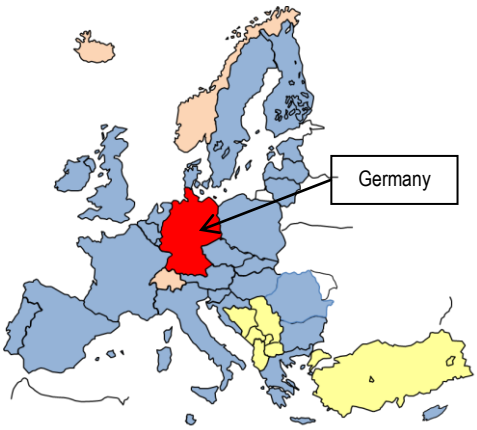
Nancy

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: 64
Number of students: 79

Nantes Faculté de Chirurgie Dentaire–UFR d'Odontologie 1 Place Alexis Ricordeau, BP84215,44042 Nantes Cedex 1 Tel: +33 2 40 41 29 01 Fax: +33 2 40 20 18 67 Contact: accueil.odontologie@univ-nantes.fr Website: http://www.odontologie.univ-nantes.fr/ Dentists graduate: 66 Number of students: 73	**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 Fax: + 33 4 92 00 12 63 Contact : scolarite-odonto@unice.fr Website : http://portail.unice.fr/jahia/page19.html Dentists graduate: Number of students: 39
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: 48 Number of students: 72	**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: 55 Number of students: 64
Strasbourg Faculté de Chirurgie Dentaire Université Louis Pasteur – Strasbourg 1 1 place de l'Hôpital, 67000 Strasbourg Tel: +33 3 68 85 39 02 Fax: +33 3 68 85 39 00 Contact : doyen.dentaire@unistra.fr Website : http://facdentaire.u-strasbg.fr/faculte/ Dentists graduate: 59 Number of students: 68	**Toulouse** Faculté de Chirurgie Dentaire UFR d'Odontologie Toulouse III – Université Paul Sabatier 3 chemin des Maraichers 31062 Toulouse Cedex 9 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: 72 Number of students: 70

Germany



In the EU/EEA since	1957
Population (2013)	80,523,746
GDP PPP per capita (2012)	€29,773
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 134 funds. There is also wide use of private insurance. In 2013, were 43 private health insurance funds plus a rising number of insurance companies offering supplementary health insurance outside of their core business. Dental fees, both inside and outside sick funds and insurance based care, are regulated.

Number of dentists:	88,882
Population to (active) dentist ratio:	1,163
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 for all dentists practising in the health fund system.

Date of last revision: 27th January 2015

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,* with approximately 600 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 the representatives of each state 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- 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. In 2013 there were 134 in the country. There are also private insurance organisations (43 in 2013).

Approximately 90% of the population are members of a state-approved sick fund, which provides a legally prescribed standard package of healthcare.

The sick funds are "not for profit" organisations. Membership is mandatory for all employees with an income of less than €4.350 gross/month. As of January 1st, 2009, premiums are the same across all statutory sick funds (15.5%) and are split fairly equally between employers (47%) and employees (53%). Individuals whose monthly gross income exceeds a certain amount (€4,462.50 in 2014) may opt out of the state-approved insurance system and join a private insurance scheme. For self-employed persons and certain groups of professionals (e.g. civil servants) membership of a private insurance scheme is mandatory.

Private insurance schemes 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 in contrast to state-approved sick funds dependants cannot be co-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 legislation, responsibilities are split between the federal level and the regional level of the *Länder*.

		Year	Source
% GDP spent on health	11.3%	2011	OECD
% of this spent by government	76.5%	2011	OECD

Oral healthcare

Public health care

The key organisations in oral healthcare delivery are:

Sick funds	In January 2013, there were 134 state-approved sick funds in Germany, organised broadly into five main groups. The number of state-approved sick funds has decreased considerably over the last years, due to changed regulation regarding minimum number of members etc., but also due to an increasing consolidation of the market (mergers or closures of sick funds). They are self-governing not-for-profit insurance bodies, jointly managed by employers' and employees' representatives. They generally insure employees whose incomes exceed a specified amount. Their dependants (non-working spouses and children) are usually co-insured under the same contract.
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 17 self-governing regional authorities, which every dentist has to be a member of in order to give dental treatment to patients within the framework of the social security system. The KZVs are the key partners of the sick funds, holding budgets and paying dentists.
KZBV	This is the national legal entity of KZVs, which together with the sick funds defines the standard package of care benefits within the legal framework. It also provides support services to the regional KZVs.
Dental Chambers	The 17 Dental Chambers (*Zahnärztekammern)* at the Länder level are the traditional professional associations (legal entities). It is their responsibility to represent the interests of the profession, but also 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 statutory 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*, (one for each state, with two for North Rhine-Westphalia, the largest state). They represent all dentists who are entitled to give treatment to patients within the framework of the statutory health insurance system.

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 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 maintain 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. The sick funds offer full compensation for all medically necessary conservative and surgical dental treatment as well as necessary orthodontist care for persons aged less than 18. Persons under 18 are also entitled to receive certain prophylactic treatments free of charge. Dental treatments exceeding the pre-defined scope of necessary care as well as dental protheses are subject to co-payments of the insured person. Those co-payments can be reduced if the patient takes measures to maintain healthy teeth. In a typical year approximately 75% of adults and children use the system.

		Year	Source
% GDP spent on oral health	0.11%	2011	OECD
% OH expenditure private	No data	2007	CECDO

Before seeking general care from the statutory health system, the patient must have a voucher from the sick fund. This voucher is both a certificate to demonstrate entitlement to care, and also the dentist's claim form for reimbursement of the care provided. The patient hands the voucher to the dentist at the first visit. The dentist then treats the patient and quarterly forwards the completed vouchers 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.

For prosthetic treatment, all legally insured persons may choose between a private health insurance and the statutory scheme – but it is mandatory to be insured in one or the other.

Usually, most adults have their oral health checked on an annual basis.

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, this applies to freelance workers and members of the liberal professions, civil servants and employees with incomes above the limit for compulsory insurance. The scope of coverage is subject to individual agreements between the insurance company and the patient. This implies that coverage can be flexibly adjusted to each individual's needs.

By the end of 2012, about 9.8 million people were covered by comprehensive private health insurance policies. As of June 2013, there were 43 private insurers exclusively offering health care coverage, with the legal form either of public limited liability companies or of mutual insurance funds, organised on a cooperative basis. In addition, there is a growing number of insurers offering health care coverage outside of their core business. The private health insurance companies differ appreciably in economic significance and size - the four largest companies, with some 4.5 million comprehensively insured persons, account for more than 50% of the total.

Less than 2% of all dentists in active practice treat only patients with private insurance schemes, that is to say they have no contract with the statutory sick funds.

The Quality of Care

The standards of dental care are monitored by a federal committee on guidelines for dental care (the *Gemeinsame 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 determine the range of medically necessary treatments which are to be covered by the statutory sick fund system. This includes the approval of 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. Dentists providing substantially more or less than the average of particular treatments are required to explain the anomaly. Other measures of quality assurance 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 to 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 payment. The threat of patient complaints has a direct effect on the quality of care for most dentists.

Domiciliary (home) care is provided both by self-employed dentists for their respective patients, or by those contracted with a residential home for the elderly or another institution.

Health data

		Year	Source
DMFT at age 12	0.70	2009	WHO
DMFT zero at age 12	70.1%	2007	CECDO
Edentulous at age 65	23.0%	2007	CECDO

"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, Cologne 2006

Fluoridation

There is no water or milk fluoridation, but extensive salt fluoridation. In 2010, 68.3% of all consumed table salt contained 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 achieved a successful result in a Medical Courses Qualifying Test.

Year of data:	2012
Number of schools	30
Student intake	2,222
Number of graduates	1,813
Percentage female	61.9%

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 offering undergraduate training, in Witten-Herdecke. The undergraduate course lasts 5 years and 6 months.

In 2012, there were about 2,100 places at the publicly funded dental schools, for entry (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 who pass the entrance examinations (*Numerus Clausus*). So, the real number of undergraduate students entering dental schools was over 2,200, and the estimated number of all dental under-graduates was over 13,000.

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 to 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 statutory sick fund system, a German dentist with a German state exam pass must have two years of approved supervised experience, in addition to the five and a half years of dental training at university. 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, of manage-ment, 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 are offered on a voluntary basis by most of the dental chambers providing a broad and systematic knowledge in all aspects of running a practice. There is no leaving examination – proof of participation in two years (full-time) assistant training is sufficient.

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 2012, there were 1, 195 new admissions, while in the same year 1,561 approved dentists stopped being active in their own practice, due to retirement, change of employment status or for other reasons.

The cost of registration is included in the subscription fee payable to the KZV (€100 in 2013).

Language requirements

There are no national regulations regarding the necessity for German language skills for non-German dentists who want to practice in Germany. Those matters are usually decided at *Länder* level and a number of states have introduced compulsory language tests over the last few years. In 2013, however, it was decided to introduce uniform regulations on language requirements nationwide in the near future.

Further Postgraduate and Specialist Training

Continuing education (CE)

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 for all dentists providing care in the statutory sick fund system. The content and amount of the compulsory CE was defined by the KZBV, in agreement with BZÄK, in June 2004. There is a great variety of different training offers and participation is rewarded with a predefined number of CE credit points, depending on the scope and type of the course. In principle, the dentist is free to choose among the training offers, but has to gain at least 125 CE credit points over a five years period. Non-compliance will lead to payment cuts on the part of the KZVs, or even withdrawal of the right to practise, in the statutory health care system.

For dentists exclusively providing care outside of the statutory system, there are no formal regulations as to the extent of continuing education.

Postgraduate Master's programmes

In recent years, postgraduate Master's 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 equals 25 to 30 hours workload) and the final examination is for a Master's degree (MSc).

Specialist Training

Three dental specialties are recognised throughout Germany

- Oral Surgery
- Orthodontics
- Dental Public Health

The speciality "Periodontology" is only recognised by the dental chamber in the region Westfalen-Lippe.

Training for all specialties lasts four years and takes place in university clinics or recognised training practices, except Dental Public Health, which is trained 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 equivalent to the certificate 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* (Public Health Dentist), if he has passed an examination at an 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, the fact that all dentists who want to specialise have to attend university for one year limits access to specialist training. The trainee has the status of an employee and gets a salary from his or her employer (ie a dentist in free practice with the special permission to train specialising dentists, a university or a hospital).

After completion of the specialised training the trainee has to pass an examination organized under the responsibility of the dental chamber. He or she is then approved as a specialist and registered with the dental chamber as such.

Workforce

Dentists

During recent years, between 1,500 and 2,100 dentists a year received their dental approbation. Consequently, the number of active dentists is increasing. A change of legislation, effective from 2007, has led to an increase in the number of dentists employed in a practice rather than running their own practice.

Year of data:	2012
Total Registered	88,882
In active practice	69,236
Dentist to population ratio*	1,163
Percentage female	42%
Qualified outside Germany**	2,164

* active dentists only
** excl. State of Schleswig-Jolstein

There is some small reported dentist unemployment.

Movement of dentists across borders

In 2012, there were 2,164 dentists who qualified abroad active in Germany. There are no figures on how many German qualified dentists are practising outside Germany.

Specialists

Specialists work mainly in private practice, hospitals and universities while 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:	2012
Orthodontics	3,443
Endodontics	
Paedodontics	
Periodontics	
Prosthodontics	
Oral Surgery	2,552
Dental Public Health (estimated)	460

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

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 Dental Chairside Assistant (*Zahnmedizinische Fachangestellte*) to Dental Hygienist (*Dentalhygieniker*). Registered *Zahnmedizinische Fachangestellte* may qualify as *Zahnmedizinische Fachassistentin (Specialised Chairside Assistant, ZMF), Zahnmedizinische Verwaltungsassistentin (Dental Administration Assistant, ZMV), Zahnmedizinische Prophylaxeassistentin (Dental Prophylaxis Assistant, ZMP)* or *Dentalhygieniker* (Dental Hygienist). These registerable qualifications do exist in almost all *Länder* and are co-ordinated by the *Bundeszahnärztekammer* (BZÄK).

Year of data:	2011
Hygienists	550
Technicians	58,000
Denturists	0
Assistants	182,000
Therapists	0
Other	0
All figures estimated	

Dental Chairside Assistants (Zahnmedizinische Fachangestellte)

The main type of dental auxiliary is *Zahnmedizinische Fachangestellte.* After 3 years training in a dental practice, attendance of a vocational school and a successful examination conducted by the Dental Chamber, they are awarded a registerable qualification.

Specialisations of Dental Chairside Assistants

There are 3 types of specialisations of Dental Chairside Assistants (*Zahnmedizinische Fachangestellte):* ZMF, ZMP and ZMV.

- *Zahnmedizinische Fachassistentin (Specialised Dental Assistant, 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 (Dental Prophylaxis Assistant, ZMP)*: requires a minimum 400 hours training at a Dental Chamber, and their duties include support in prevention/prophylaxis, motivation of patients and oral health information.
- *Zahnmedizinische Verwaltungsassistentin (Dental Administative Assistant, 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 (Dentalhygieniker)

To become a hygienist a student needs to undergo 3 years training, pass an examination as a dental chairside assistant, 300 - 700 hours training and an examination as ZMP or ZMF first, followed by a further 800 hours training and an examination conducted 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 are trained for 3 years, 40% in a vocational school and 60% in the dental laboratory. After a successful examination conducted 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* directly in his practice, 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 Germany

Numbers of dentists

Year of data:	2012
General (private) practice	66,157
General Practice as a proportion is	96%
Number of general practices	44,600
Year of data:	**2008**
Public dental service	450
University	2000
Hospital	200
Armed Forces	450
All figures estimated	

Working in Free (Liberal or General) Practice

The figures above for dentists in general practice comprise both self-employed dentists (53,767) and dentists employed in general practices (12,390).

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 this way, which represents about 96% 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 standardised. 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, the levels of private fees payable are regulated by federal law and set out in the *Gebührenordnung für Zahnärzte – GOZ.* In this fee scale, the different types of treatment are described and a number of reference points are allotted to each of those. In order to calculate the price for any dental service, the respective reference points have to be multiplied by the so-called "point value", a fixed factor set at 5.62421 Euro cents (in 2013). Depending on the difficulty of the treatment required, the dentist may multiply the result with a factor of up to 3.5. A factor of 2.3 should indicate a treatment of average difficulty. If a factor higher than 2.3 is applied, the invoice must include evidence to justify the increase. An invoice with a factor higher than 3.5 requuires a written agreement by 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 accordingly, if they accept the justification of the factor increase.

As of January 1st, 2012, the GOZ was reviewed for the first time since 1988. Certain newer forms of treatment were included in the fee scale while the prices for a few others were adjusted. Much to the regret of the dentists and their professional organisations, however, the point value was not changed. Hence, the vast majority of prices remain at the level of 1988.

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 2012, 12% of all new establishments were new solo practices, 61% were acquisitions of an existing solo practice and 27% were practice partnerships, either establishing a new practice partnership or joining an existing one. When existing practices are acquired, the predecessor's patient list is usually part of the deal.

Establishing a new practice means to acquire totally new patients. In 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 wherever he or she chooses, with only financial considerations being a limiting factor. There are still planning provisions necessary but no limitations of provision. Earlier regulations regarding the maximum retirement age for dentists active under the statutory insurance system (68 years) have been abolished in the meantime.

Practices are usually located in offices or private houses or apartments, rather than in shops or malls.

The number of patients on a "list" of an average full-time dentist has been estimated at about 1,000. However, there are no reliable data available on this matter,

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.

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 most of the 16 *Länder*.

The quality of dentistry in the public dental service is assured through dentists working in 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. 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. Dentists with this speciality are permitted to work in liberal practice as well as in public health.

Working in Hospitals

A relatively small number of dentists work in hospitals, mostly as 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. 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.

The main academic title in a German dental faculty is that of university professor. Other titles include university assistants, Oberarzt (senior physician), and academic dentists.

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.

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 and a record of original research. Dentists teaching at universities have to earn the “right to teach” by giving a special lecture at 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.

Salaries differ considerably from assistant to professor. Since professors have the right to treat patients privately, their private incomes will exceed the normal salary paid by the university.

Working in the Armed Forces

There are few dentists working full time for the Armed Forces, an unreported (but increasing) number female.

Professional Matters

Professional associations

***Zahnärztekammern* (*Dental Chambers*)**

Zahnärztekammern (or Dental Chambers) are the traditional bodies which represent the interests of dentists whether active under the statutory insurance system or not. Every dentist has to be a member of a Dental Chamber. The Chambers are also responsible for other defined legal tasks.

	Number	Year	Source
Bundeszahnärztekammer	69,236	2012	BZÄK

There are 17 Dental Chambers in the 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 making 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. Its supreme mission is to strive for a liberal future-orientated health care system, with the patient at the centre, 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

The magazine *Zahnärztliche Mitteilungen (zm)* is published twice a month. It is a communication means of both the German Dental Association and Federal Dental Authority. 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 (ZZO) The Agency for Quality in Dentistry gives advice and support to BZÄK and KZBV in all matters of dental quality.

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 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 fulfill 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 fulfill 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.

Ethical Code

Dentists in Germany must work according to an ethical code which covers 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 rare.

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, (*Bundesverfassungs-gericht*).

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 due 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 for short-term treatments - but not for permanent activity.

Corporate Dentistry

Companies or non-dentists are not allowed to be the sole 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 for 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 the establishment of mega-dental surgeries and practice chains with international investors was facilitated.

Tooth whitening

The EU Directive 2011/84/EU of September 2011, amending Directive 76/768/EEC, concerning cosmetic products, regulates the use of hydrogen peroxide and other compounds or mixtures that release hydrogen peroxide in tooth whitening or bleaching products. It establishes a new legal framework for products containing between 0.1% and 6% of hydrogen peroxide and prohibits the marketing of products containing over 6%. This means that only a dentist (or a qualified auxiliary under supervision of the dentist) may apply the whitening products. There are no reports of (continued) illegal practise.

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 radiation protection - the *Röntgenverordnung* (2003). Training in radio protection is mandatory for undergraduate dentists. The dentist must undergo regular mandatory continuing training in radiographic protection (every 5 years). 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 every 5 years, but extra controls are due every time major changes in the equipment are made (for example, if newer equipment is bought).

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 62 to 68, depending upon individual circumstances and preferences.

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:

In 2013, there was a basic tax-free allowance (*Steuerfreibetrag*) of €8,131 for singles and twice as much for a married couple.

In addition to a basic allowance for low-income earners, there are numerous deductibles for taxes, such as deductions for raising children, commuting to work, paying for work uniforms, being a single parent, joining a trade union, contributing to private pension funds, selected insurance premiums, donating to charity, etc.

The starting rate for the lowest taxable income is 14%. The tax rate then rises progressively: so that for annual gross incomes between €8,131 and €13,469, the rise is steep, followed by a more gradual rise for incomes of up to €52,881. Incomes higher than this are subject to a tax rate of 42%. For top incomes of over €250,730 (€500,000 for married persons) the highest tax rate of 45% applies.

In addition, there is a so-called solidarity surcharge (5.5% of the income tax).

VAT/sales tax

The value added tax rate of 19% on purchases has applied since 2007. There is a reduced rate of 7% on certain items and services (including foodstuffs, books, medical, passenger transport, newspapers, admission to cultural and entertainment events, hotels and the costs of production of a dental prosthesis).

Various Financial Comparators

Berlin ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	71.9	62.5
Wage levels (net)	54.5	52.9
Domestic Purchasing Power	65.0	74.2

Source: UBS August 2003 and November 2012

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 B-1000 Brussels Belgium Phone: +32 2 7 32 84 15 Fax: +32 2 7 35 56 79 E-mail: info@bzaek.eu
Competent Authority:	
(For articles 2 & 3) Bundesministerium für Gesundheit Rochusstr. 1 53123 Bonn Tel: +49 228 308 3515 Fax: +49 228 930 2221 Email: info@bmg.bund.de Website: www.bmg.bund.de	(For specialist diplomas contact the dental chambers of the relevant "Länder") Lists available from the Bundeszahnärztekammer
Publications:	***Employment bureaux, and other bodies or publications with information on vacancies for dentists:***
Zahnärzliche Mitteilungen, and regional dental journals (each *Zahnärztekammer* and *Kassenzahnärztliche Vereinigung* publishes its own dental journal)	*Employment bureaux:* Bundesagentur für Arbeit Regensburger Str. 104 90478 Nürnberg Email: zentrale@arbeitsagentur.de Website: www.arbeitsagentur.de

Dental Schools:

The figures refer to places at the dental school available for entry each year, due to Numerus Clausus. The actual number of students may exceed these figures, because there are usually an excess of applicants over places. Consequently, dental schools are forced to accept some more students.

Aachen

Medizinische Fakultät an der
Rhein – Westf. Techn. Hochschule
Aachen
Universitätsklinikum
Pauwelsstrasse 30, 52074 Aachen
Tel: +49 241 800
Fax: +49 241 8888 100
Email: info@ukaachen.de
Website: www.ukaachen,de

Number of students: 60

Berlin

Charité-Universitätsmedizin
Campus Benjamin Franklin
Centrum für Zahn-, Mund- und Kieferheilkunde
Assmannshauser Strasse 4-6,
14197 Berlin
Tel: +49 30 450-5620
Fax: +49 30 450-562922
Website: www.charite.de

Number of students: 80

Bonn

Zentrum für Zahn-, Mund- und Kieferheilkunde der Universität Bonn
Welschnonnenstr. 17
53111 Bonn
Tel: +49 228 287-22413
Fax: +49 228 287 22588
Email: mkg@uni-bonn.de
Website: www.zmk.uni-bonn.de/

Number of students: 69

Dresden

Universitätsklinikum Carl Gustav
Carus der Technischen
Universität Dresden
Zentrum für
Zahn-, Mund-, und Kieferheilkunde
Fetscherstrasse 74, 01307 Dresden
Tel: +49 351 458 2713
Fax: +49 351 458 5381
Email: uzm@uniklinikum-dresden.de
Website: www.uniklinikum-dresden.de

Number of students: 57

Düsseldorf

Zentrum für Zahn-, Mund- und Kieferheilkunde
der Heinrich-Heine-Universität
Westdeutsche Kieferklinik
Moorenstr. 5
40225 Düsseldorf
Tel: +49 211 811 8819
Fax: +49 211 811 6280
Website: www.zmk.uni-duesseldorf.de

Number of students: 54

Erlangen

Mund-,Kiefer- und Gesichtschirurgische Klinik
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: 108

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
Website: www.med.uni-frankfurt.de/zahnklinik/

Number of students: 119

Freiburg

Universitätsklinik für Zahn-, Mund- und
Kieferheilkunde der Universität Freiburg
Hugstetter Str. 55
79106 Freiburg i.Br.
Tel: +49 761/270 4700
Fax: +49 761/270 20200
Email: info@uniklinik-freiburg.de
Website: www.uniklinik-freiburg.de

Number of students: 86

Giessen

Med. Zentrum für Zahn-, Mund- und Kieferheilkunde
an der Justus-Liebig-Universität Gießen
Schlangenzahl 14
35392 Gießen
Tel: +49 641 99 46 100
Fax: +49 641 99 46 209
Email:
Website: www.ukgm.de

Number of students: 71

Göttingen

Zentrum für Zahn-, Mund- und Kieferheilkunde
der Universität Göttingen
Robert-Koch-Str. 40
37075 Göttingen
Tel: +49 551 39 0
Fax: +49 551 39 12 653
Email:
Website: www.zmk.med.uni-goettingen.de
Number of students: 82

Greifswald

Ernst-Moritz-Arndt-Universität Greifswald
Zentrum für Zahn-, Mund- und Kieferheilkunde
Walter-Rathenau-Str. 42
17489 Greifswald
Tel: +49 3834 86 19600
Fax: +49 3834 86 50 10
Website: www.dental.uni-greifswald.de

Number of students: 45

Halle/Saale

Martin-Luther-Universität Halle-Wittenberg
Universitätspoliklinik für Zahnerhaltungskunde und Parodontologie
Grosse Steinstrasse 19
06108 Halle/Saale
Tel: +49 345 557 37 62
Fax: +49 345 557 37 73
Website: www.medizin.uni-halle.de

Number of students: 40

Hamburg

Universitätsklinikum Hamburg-Eppendorf
Zentrum fur Zahn Mund-und Kieferheilkunde
Martinistr. 52
20246 Hamburg
Tel: +49 40 74 10 0
Fax: +49 40 74 10 40236
Email: info@uke.uni-hamburg.de
Website: www.uke.uni-hamburg.de

Number of students: 68

Hannover

Medizinische Hochschule Hannover
Zentrum Zahn-, Mund- und Kieferheilkunde
Carl-Neuberg-Straße 1
30625 Hannover
Tel: +49 511 532 -4763
Fax: +49 511 532-4740
Email: MKG-Chirurgie@mh-hannover.de
Website: www.mh-hannover.de

Number of students: 79

Heidelberg

Universitätsklinik für Mund-, Zahn- und Kieferkrankheiten
Im Neuenheimer-Feld 400
69120 Heidelberg
Tel: +49 6221 56-0
Fax: +49 6221 56 5999
Email: contact@med.uni-heidelberg.de
Website: www.klinikum.uni-heidelberg.de

Number of students: 81

Homburg (Saar)

Universitätsklinikum des Saarlandes
Kliniken für Zahn-, Mund- und Kieferkrankheiten
Kirrberger Str. 100
66421 Homburg/Saar
Tel: +49 6841 160
Fax: +49 6841 162 - 49 54
Email:
Website: www.uniklinikum-saarland.de

Number of students: 25

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:
Website: www.zzmk.uniklinikum-jena.de

Number of students: 57

Kiel

Universitätsklinikum Schleswig-Holstein
Standort Kiel
Klinik für Zahnerhaltungskunde und Parodontologie
Arnold-Heller Str. 3
24105 Kiel
Tel: +49 431 597 2781
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Website: www.uksh.de

Number of students: 67

Köln

Zentrum für Zahn-, Mund- und Kieferheilkunde
der Uniklinik Köln
Kerpener Str. 32
50931 Köln
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Fax: + 49 221 478 40 95
Email:
Website: www.zahnklinik.uk-koeln.de

Number of students: 61

Leipzig

Universitätsklinikum Leipzig
Zahnkliniken
Liebigstr. 10-14
04103 Leipzig
Tel: +49 341 9721 000
Fax: +49 341 9721 219
Email: zzmk@uniklinikum-leipzig.de
Website: www.uniklinikum-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 3041
Fax: +49 6131 17 66 02
Email:
Website: www.unimedizin-mainz.de

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 58 63 20 0
Fax: +49 6421 58 63 20 4
Email: mzzmk@med.uni-marburg.de
Website: www.uni-marburg.de/zahnmundkiefer/

Number of students: 69

München

Ludwig-Maximilians-Universität
Klinik und Poliklinik für Zahn-, Mund- und Kieferkrankheiten
Goethestr. 70, 80336 München
Tel.: +49 89 5160 9301
Fax: +49 89 5160 9302
Email:
Website: klinikum.uni-muenchen.de

Number of students: 119

Münster

Westfälische Wilhelms-Universität Münster, Zentrum für Zahn-, Mund- und Kieferheilkunde, Waldeyerstr. 30, 48149 Münster

Tel: +49 251 83 45 50 0
Fax: +49 251 83 47 89 4
Email:
Website: www.uni-muenster.de

Number of students: 115

Regensburg

Klinikum der Universität Regensburg
Klinik und Poliklinik für Mund-, Kiefer- und Gesichtschirurgie
Franz-Josef-Strauss-Allee 11
93053 Regensburg
Tel: +49 941 944 0
Fax: +49 941 944 44 88
Email:
Website: www.uniklinikum-regensburg.de

Number of students: 86

Rostock

Universität Rostock
Klinik und Polikliniken für Zahn-, Mund- und Kieferheilkunde
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18057 Rostock
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Fax: +49 381/ 494-65 09
Email: zmk@med.uni-rostock.de
Website: www.med.uni-rostock.de

Number of students: 25

Tübingen

Eberhard-Karls-Universität Tübingen
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Tel: +49 7071 29 82 15 2
Fax: +49 7071 29 57 89
Email:
Website: www.medizin.uni-tuebingen.de

Number of students: 72

Ulm

Universitätsklinikum Ulm
Department für Zahnheilkunde
Albert-Einstein-Allee 11
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Fax: +49 731 500 63 00 22
Email:
Website: www.uniklinik-ulm.de

Number of students: 54

Witten-Herdecke (PRIVATE)

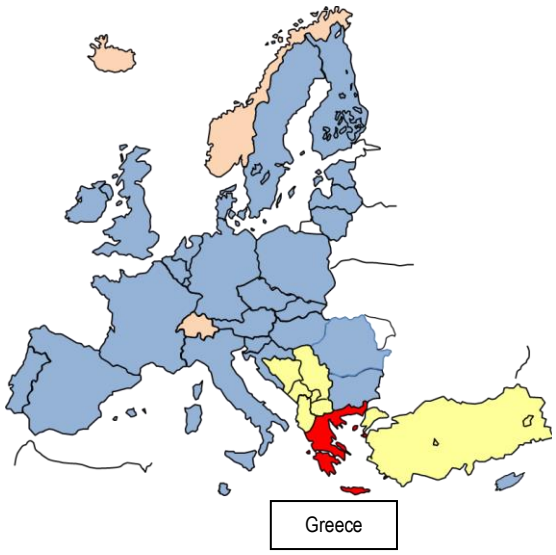
Private Universität Witten/Herdecke
Zahnklinik
Alfred-Herrhausen-Str. 45
58448 Witten
Tel: +49 2302 926 600
Fax: +49 2302 926 661
Email:
Website: www.uni-wh.de
Number of students:

Würzburg

Zahnklinik der Universwität Würzburg
Pleicherwall 2
97070 Würzburg
Tel: +49 931 201 0
Fax: +49 931 201 73 300
Email: mkg@mail.uk-wuerzburg.de
Website: www.uk-wuerzburg.de

Number of students: 102

Greece



In the EU/EEA since	1982
Population (2013)	10,772,967
GDP PPP per capita (2011)	€18,680
Currency	Euro
Main language	Greek

General healthcare is provided by a complex mixture of private practitioners & hospitals, the clinics of the National Organisation of Health Services and since 1983 by the National Health Service. Oral healthcare, besides preventive services offered free by NHS clinics to all children, is mostly provided by private practitioners, with patients paying the total or partial cost of care. Due to uninsured oral health care, one third of the total NHS expenditure is paid out of household budgets, while 96% of dentists are in private practice.

Number of dentists:	14,125
Population to (active) dentist ratio:	1,197
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. CPDevelopment is not mandatory in practical terms & is organised by the HDA and the dental societies in various fields and specialisations.

Date of last revision: 2nd January 2014

Government and healthcare in Greece

Geographically, Greece is a rural and mountainous country. However, due to extensive urbanisation, nearly half of the population (over 4 million people) live in its capital, Athens.

The Constitution of 1975 and its revisions 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 Government and the President of the Republic.
- 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. The number of the members of the Parliament, who are elected directly by the citizens, cannot be less than 200 or exceed 300.

The constitutional revision of 2001, reduced significantly the responsibilities of the President of the Republic and, at the same time, promotes decentralisation. Regional bodies of the State have general decisive competency for the affairs of their region - whereas central bodies of the State lead, coordinate and control the legitimacy of the actions of the Regional bodies.

It is important to add that the Constitution provides for the participation of Greece in International organisations and the European Union. Such organisations' legislation has a superior effect on national legislation.

Greece possesses a Constitution which enjoys political and historical legitimacy, is modern and adapted to international developments, and despite possible limitations 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 and delivery of many services more difficult. There are 13 regions but no regional governments and many services are provided locally by the 54 prefectures, which are directed by an elected prefect and have 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 (*ΕΣΥ*) afterwards, were intended to cover all the Healthcare requirements and demands of the entire Greek population. 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.

Primary Health Care services are also provided apart from Health Centres, and within the NHS by contracted private practitioners and medical centres of the central health provider ΕΟΠΥΥ which covers approximately 98% of the population, ΕΟΠΥΥ owns hospitals (secondary healthcare services) which will be, most probably, absorbed in the near future by the NHS. Additionally, ΕΟΠΥΥ directly through its own health facilities provides services to citizens of all ages who are insured under the other available security schemes.

		Year	Source
% GDP spent on health	9.0%	2012	OECD
% of this spent by government	65.1%	2012	OECD

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.

OGA, the insurance organisation for the agricultural labour force, as before regarding pensions and OAEE (Social Security Scheme of Liberal Professionals: covering tradesmen, craftsmen, and employees in the sector of Tourism) remains unchanged.

Oral healthcare

Public health care

		Year	Source
% GDP spent on oral health	1.10%	2013	HDA
% of OH expenditure private	96%	2013	HDA

The 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.

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 96% 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.

Within NHS hospitals dentists provide preventive care and emergency or full treatment as needed to all hospitalised patients, free of charge.

EOPYY: On January 1st 2012, there was a reform in primary and secondary health care of insured persons in Greece, due to the establishment and functioning of the National Organisation for Health Services (EOPYY) and the entry into force of the Integrated Health Care Regulation (EKPYY).

EOPYY was established and aims at equal access for all insured persons to a single system of provision of healthcare services. It is a Public Legal Entity and is subject to the Ministry of Health. The Health Care Sectors (with their units) of the majority of all Insurance Schemes, (ie IKA, OGA, OAEE, OPAD, DEH, HSAP, ETVA, OTE, OIKOS NAYTOY) are transferred and integrated - as services, competences and personnel - to this National Organisation for Health Care.

According to the Integrated Health Care Regulation (EKPYY), the basic health care providers of EOPYY, which the above-mentioned insured persons are entitled to visit, are the following:

- Health Care Units (former Health Care Units of IKA – ETAM)
- Physicians of the Health Care Units of EOPYY that receive patients in their private practice
- Private physicians that have a contract with EOPYY
- Outpatient hospital services of the National Health System (ESY)
- Health Care Centres of ESY
- Rural health clinics
- Regional health clinics
- Hospitals of the ESY for hospitalization
- Private clinics that have a contract with EOPYY
- Chronic dialysis units – dialysis units

According to the EKPY, the insured persons pay a 15% participation rate for paraclinical tests, insofar as these are not carried out in EOPYY units or ESY establishments.

Furthermore, when the medical visits, costs or hospitalisation are paid, then, they cannot be reimbursed.

Even though provision and indemnity for dental healthcare services are provided for in the EOPYY, no financial package from the budget had been allocated for contracting dentists, by 2013. Dental healthcare services are provided by the Hospitals and health centers of ESY and the former dental clinics of IKA and the other insurance schemes, which have been integrated into EOPYY.

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	1.56	2013	HDA survey
DMFT zero at age 12	62.0%	2013	HDA survey
Edentulous at age 65*	31.5%	2007	HDA survey

* Oulis et al.: Community Dent Health. 2012 Mar 29(1):29-32

"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 of any kind.

Education, Training and Registration

Undergraduate Training

There are two public dental schools in Greece., One is located in Athens and belongs to the National and Kapodistrian University of Athens and the other one is in Thessaloniki and belongs to the Aristotle University of Thessaloniki.. Admission to the school requires the successful participation to very competitive national exams.

Year of data:	2012
Number of schools	2
Student intake	250
Number of graduates	275
Percentage female	62%
Length of course	5 yrs

The duration of training is 10 semesters (5 years), during which the first two years are devoted to medico-biological sciences courses taught in the Medical school, along with Medical students. In 2013 there were approximately 1,300 dental undergraduate students in the two schools.

Qualification and Vocational Training

Primary dental qualification

The main qualifications which may be included in the dental register, in order to practise include:

- Diploma in Dentistry (*'Ptychio odontiatrikis*) and
- Certification (Licence to Practise Dentistry) from the Hellenic Dental Association.
- 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 mandatory, on the basis of an "unwritten law" and as an extra requirement for acceptance into the programme.

Registration

In order for a dentist to practise in Greece, he/she must have a recognised diploma from Greece or another European member state which is automatically recognised, once it complies with minimum training requirements of the Directive. Since January 2014 a licence to practice is provided by the Hellenic Dental Association, instead of the Prefecture (Law 4025/11). The Hellenic Dental Association is, on behalf of the Ministry of Health, the competent authority, to examine the diploma and, provided that the applicant has no criminal record, grants the licence to practise in Greece. After registration, the newly qualified dentist will be registered with one of the 52 competent Regional Dental Societies.

All regional Societies are automatically members of the Hellenic Dental Association. 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; this amount may vary, according to the needs of each Regional Dental Society. The average amount is €100. From this fee, a fixed amount (€45) is contributed to the HDA.

Language requirements

Dentists from other member-states of the EU, who wish to practise in Greece, need to show competency in using and communicating in Greek language, according to the rules of Article 7 of the Professional Qualifications Directive 36/2005.

Further Postgraduate and Specialist Training

Continuing Education

For dentists practising 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. By 2013 the Board of the Hellenic Dental Association had made a proposal to the Ministry of Health and Welfare and legislation is expected to be effected at a future date.

Specialist Training

Two dental specialties are recognised by the Ministry of Health and Social Solidarity, namely Orthodontics and Oral and Maxillofacial Surgery, with the latter requiring two diplomas, Dental and Medical.

Orthodontic training is provided in both dental schools and is for 3 years.

By a Law of 2003 the training period for the acquisition of the specialty of Oral and Maxillofacial Surgery, was increased to 5 years, and includes General Surgery and 48 months of specialty training. It is both a Dental and a Medical specialty and, although the specialty is under the Medical Directive, the holders of this specialty are required to be registered in both the Dental and Medical associations

Apart from the above the Ministry of Education has approved and recognises 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 to 3 years and a certificate along with the Master's Degree is awarded at the end of this period, for the following specialisations:

Specialty	Duration (years)
Prosthodontics,	3
Orthodontics,	3
Oral Biopathology oriented to Oral Surgery,	3
Endodontics,	3
Paediatric Dentistry,	3
Oral Biopathology oriented to Oral Diagnosis and Radiology,	3
Oral Pathology,	3
Operative Dentistry,	3
Dental Biomaterials,	2
Periodontics,	3
Implants Biology	3
Oral Biology	2
Community Dentistry	3
Oral and Maxillofacial Surgery (2 diplomas)	

There are various purely scientific societies for specialists. These are best contacted via the Hellenic Dental Association.

Following other Ministerial Decisions, the Ministry of Education has approved and recognised for the Dental School of the Aristotle University of Thessaloniki the existence of postgraduate programmes leading to the following specialisations:

Specialty	Duration (years)
Oral Surgery – Implantology and Dental Radiology	3
Orthodontics	3
Fixed Prosthodontics-prosthetic Implantology	3
Removable Prosthodontics	3
Endodontology	3
Operative Dentistry	3
Periodontoly-Biology of Implants	3
Oral Pathology	3
Preventive and Community Dentistry	3
Paediatric Dentistry	3
Oral and Maxillofacial Surgery (2 diplomas)	5

Workforce

Dentists

Year of data:	2013
Total Number	14,125
In active practice (Registered)	9,000
Dentist to population ratio*	1,197
Percentage female	47%
Qualified overseas	No data
* active dentists only	

The HDA have explained that due to the financial and fiscal crisis that Greece was suffering in the period until publication of the Manual, the number of active dentists, (meaning those dentists who have paid their Annual Subscription fees and are practising) changed dramatically, influencing concomitantly all the subcategories.

According to their calculations in 2013, the actual number of active dentists was approximately 9,000 and this is because a large number of dentists - due to a variety of reasons - did not pay their dues and do not practise. They estimated there was 12% unemployment, 20% not paying their financial obligations and approximately 4% have left the country to establish abroad, for economic or other reasons.

Specialists

There are two categories of recognised specialists:

- Orthodontists
- Oral Maxillo-facial surgeons

Most Orthodontists work in private practice, while most surgeons work in Hospitals and private practice.

Year of data:	2013
Orthodontics	476
OMFS	174
Endodontics	100
Paediatric Dentistry	200
Periodontics	200
Prosthodontics	200
Dental Public Health	
Others	

10% of orthodontists and 19% of OMF surgeons were female in 2013.

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, and dental chairside assistants. There are no denturists, hygienists or therapists.

Year of data:	2013
Hygienists	0
Technicians*	4,500
Denturists	0
Assistants*	2,000
Therapists	0
Other	0
*estimated	

Dental Technicians

In order to become a Dental Technician in Greece a 4-year training is required, in a Technical University School. In order to practise, a licence to practise issued by the Ministry of Health is required and registration with the syndicate of laboratory owners in the Local Small Industries Chamber is obligatory.

In order to become a Dental Technician Assistant it is necessary to train for 3 years in a Technical Professional Institute or Lyceum and work in a dental laboratory. Upgrading to a Dental Technician obtaining a licence to work, following exams, is with the Ministry of Health and Welfare.

Dental technicians are allowed to work independently, by establishing a private laboratory and working under the strict prescription of the dentist they can provide services to dentists only. Dental technicians are not allowed to work in the mouth of a patient by constructing or repairing r dental appliances in the mouth of patients.

In 2013 it was estimated (by the HDA) that there were 1,250 dental laboratories.

Dental Chairside Assistants

Dental Chairside Assistants are persons who are employed by a dentist in order to assist him/her in practising 4-handed sitting Dentistry and they are not permitted to work independently or 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, along with at least 6 months post-qualification in a practice. Obtaining a licence to work is with the Ministry of Health, following examinations. Registration in a State body is not obligatory.

Their duties include the preparation of the dental office and the patient before treatment, as well as reception duties, infection control, procedures, equipment maintenance, public relations, secretarial duties and assisting the dentist at the chairside.

The majority of dentists work without assistants, while only 23.3% of dental offices declare employment of a qualified (or not) assistant.

Practice in Greece

Year of data:	2013
General (private) practice*	7,404
Public dental service (exclusively)	452
Various Insurance Funds	781
University	237
Hospital	452
Armed Forces	71
Other Public services	55
General Practice as a proportion is	82%

*this figure includes only those in solely private practice. However, the other 1,144 dentists who work in one of the other services (but not those who are exclusively in the PDS) also work in private practice, meaning that 95% of dentists do some private practice.

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.

Working in General (Private) Practice

Dentists who practice on their own (solo practice), or in a group practice providing a broad range of dental treatments are called *Private General Dentists, while the ones working exclusively in the field of a specialty are called Private Specialists Dentists* About 85% of dentists work as General practitioners and 15% as Specialists

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 EOPYY social security, 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.

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, (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": children's oral health care, Aesthetic and reconstructive dental clinics etc.). In 2011, the Ministry of Health – issued new provisions for the establishment and function of Private Health Care Practices (Law 3919/2011).

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, and there is no limitation on the number of practices.

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. 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.

Working in Universities and Dental Faculties

Dentists who work in dental schools are employees of the universities. Full-time and part-time staff are free to work in private practice, but they must contribute 10% of their gross earnings to the University.

The main academic titles within a Greek dental faculty are full-time clinical instructor, assistant professor, associate professor and professor. "Faculty members" (ie. those at assistant professor grade and above and after 3 years of service, they may obtain a secure job tenure) but they must hold a PhD. or equivalent degree. When faculty posts become vacant they are filled by open competition, with the final decision made by the Assembly of the Electorate. According to a new Law 4009/11, the final decision is made by a 7 member body, two of them as external electors.

Working in the Armed Forces

Of the 71 dentists who work in the Armed Forces, only two are women (2013).

Professional Matters

Professional associations

	Number	Year	Source
Hellenic Dental Association	9,000	2013	HDA

There is a single national association, the Hellenic Dental Association which is a federation of 52 regional societies. All active dentists must belong to the HDA.

The 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

Under a Presidential Decree of 2001, companies could provide oral healthcare; the legal status of the companies could vary. But, only in Limited Companies could people other than health professionals (fund holders such as businessmen etc) participate.

Under a new law N.3919/2011 and a Ministerial Decision (24948/2011), dentistry has been liberalised, in terms of the provision and operation of dental practices. In particular, any natural or legal person may operate a dental practice or a dental company, provided that the scientific responsibility lies with the dentist.

There is no restriction with regard to share ownership of dental entities and the previous limitation 51%-49% (favouring dentists), is no longer in force. Finally, dentists can work in different entities of various forms (dental practices, clinics, multi-practice clinics and they can be responsible simultaneously in all of them, at the same time.

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.

Specific 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
Waste disposal	Ministry of Health & 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 Organisation
Infection control	Centre for Disease Control, Athens University-School of Dentistry, Regional Dental Society of Attica

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Financial Matters

Retirement Pensions and Healthcare

In April 2008, Law 3655/2008 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, as it was perceived that it will undermine their rights.

The pension system in Greece has historically been based on a public pension pillar, although by 2013 there had been severe changes. It consists of three parts: an earnings-related primary pension; an earnings-related supplementary pension; and minimum pension benefits.

The first pillar covers employees in the private sector and certain self-employed persons. The pension is financed on a pay-as-you-go basis and the contribution rate is unequally shared between the employee and the employer; the actual rate depends on the profession of the employee. Before 2010, it amounted to 6.67% for employees but increased to 8.87% in arduous occupations. The corresponding employer rate was 13.33% or 17.73% for arduous occupations – although in 2013 the Government was phasing in a programme for firms to cut these contributions by one-quarter. For the supplementary pension an additional contributions rate has to be paid.

Employees in the public sector are paid directly from the national budget during retirement. A number of cuts have seen public sector pension benefits decrease substantially over the past few years. Besides the earnings-related part of the pension system a minimum pension is paid to those without adequate means.

All dentists who practise, regardless of their working status (self-employed, employees, NHS) are obligatorily registered in the ETAA-ΤΣΑΥ. (Insurance and Retirement Fund of Health Professionals) and consequently, are entitled to receive a pension from it. Dentists who are exclusively self-employed, receive a full pension from ETAA-ΤΣΑΥ.

Dentists are entitled to more than one pension scheme; they receive a reduced pension from ETAA-ΤΣΑΥ, and a supplementary one from the organisation for which they provide their services. For example, a dentist employed by the NHS will receive a pension from the NHS and also a pension from the ETAA-ΤΣΑΥ.

The full pension of ETAA-ΤΣΑΥ for an exclusively self-employed dentist who has been practising for 39 years is approximately €1.562 a month (before taxes) in 2013.

For a full pension the minimum retirement age for both sexes is 62 years of age and having practised for 40 consecutive years. However, many work beyond this, in private practice.

Taxes

There are three rates of income tax for all employees and pensioners. For net income up to €25,000 a rate of 22% applies; from €25,001 up to €42,000 a rate of 32% applies and for income exceeding the €42,001 the applicable rate is 42%.

VAT

The standard rate of VAT in Greece is 23%. This is the rate charged on most dental materials and equipment. There is a reduced rate of 13% for dental materials and appliances for intraoral use are charged at this rate. Then, there is a super-reduced rate of 6.5% at which local anaesthetics are charged. No VAT applies on the payment of dental fees. Special rates apply to supplies on certain Aegean islands.

Various Financial Comparators *(Source: UBS August 2003 & November 2012)*

Athens ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	72.0	56.7
Wage levels (net)	37.3	30.2
Domestic Purchasing Power at PPP	46.7	47.1

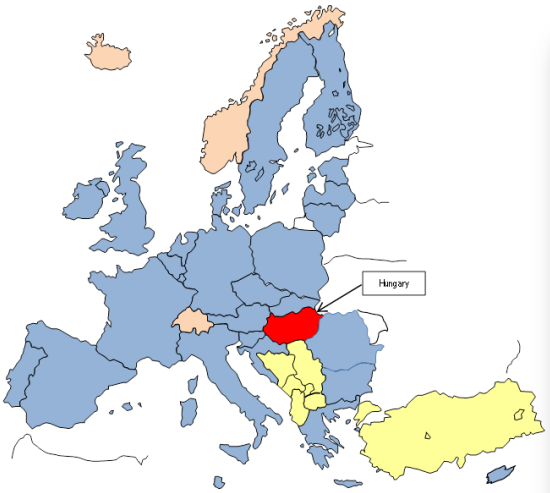
Other Useful Information

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 Website: www.eoo.gr	Ministry of Health 17-19 Aristotelous Street GR- 101 87 ATHENS GREECE Tel: + 30 213 216 10 10 Fax: Email: deyp@yyka.gov.gr Website: www.moh.gov.gr
Publications:	
Journal of the Hellenic Dental Association *Hellenic Stomatological Review*	

Dental Schools:

Athens	Thessaloniki
National & Kapodistrian University of Athens School of Dentistry 2 Thivon str., Goudi GR - 115 27 ATHENS Tel: +30.210.74.61.000 Fax: +30. 2 10 7461187 Email: secr@dent.uoa.gr Website: www.dent.uoa.gr Dentists graduating each year: 130 Number of students: 650	Aristotle University of Thessaloniki School of Dentistry University Campus GR-541 24 THESSALONIKI Tel: +30.231 999.471 Email: info@dent.auth.gr Website: www.dent.auth.gr Dentists graduating each year 140-150 Number of students: 650 to 700

Hungary



In the EU/EEA since	2004
Population (2008)	9,906,000
GDP PPP per capita (2007)	€15,012
Currency (1 July 2013)	Forint (HUF) 294 HUF = €1.00
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:	2,000
Members of (Dental) Chamber:	88%

There is a well developed system of specialists and 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: 26th January 2015

Government and 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 constitution dates from April 25th 2011 (the "Fundamental Laws"). 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 and signing or rejecting all bills submitted by the Parliament. 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 2011 (CLXXXIX) divided the responsibility for the ownership and management of health and social services between local and municipal governments, and the state. The majority of hospitals and large polyclinics are owned and governed by the state. .

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 employers who pay 5% and employees 6%. The self-employed contribute 9% and unemployed people do not contribute.

There is a global amount for public health expenditure is decided annually by Parliament.

		Year	Source
% GDP spent on health	7.9%	2012	OECD
% of this spent by government	65.0%	2011	OECD

Oral healthcare

Public compulsory health insurance

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 Dental Council of the National Board of Medicine . This board has 18 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 approx. 9.8 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, 19-62, above 62). 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 62 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 Dental Section of the Hungarian 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 62, do not have to pay for their 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. Even for those aged above 62 for full and partial dentures, 100% of the technical costs will be paid by the patient; the dentist cost is free and covered 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.

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.

There will be about 2,000 patients on a normal dental 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

About 30% of dentists work wholly privately, outside the State system (2013.) Many hundreds of Hungarian dentists work abroad. Patients pay their dentist directly, under an item of treatment system. There is no regulation of private fees. The only indicator is their good standing.

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	2.40	2008	WHO
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. No formal entrance exams or interviews are required. No other vocational entry is possible. Student intake depends on the results from secondary education.

Dental schools are known *as FogorvostudományiKar Dental Faculty* (Semmelweis University, Budapest, University of Szegedand the University of Debrecen); *FogorvostudományiSzak Dental "section"* (University of Pécs, where there is no extra faculty for dentistry, but it is part of the Medical Faculty).

Year of data:	2013
Number of schools	4
Student intake	310
Number of graduates	245
Percentage female	58%
Length of course	5 yrs
VT mandatory?	No

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 a minimum of 5,000 contact hours.

There are courses offered to foreign students in Budapest Semmelweis University, the University of Szeged, the University of Debrecen and Pecs. At Semmelweis in 2013, there were over 850 undergraduates, with about a third from EU and non-EU countries – from Germany, UK , Spain, Portugal, Norway, Israel and some countries in the Middle East, Iran and now from the USA and Canada.. Most are taught mainly in English, but there is also one course in German, with 80 undergraduates.

At Debrecen, about half of the 460 undergraduates are from outside Hungary, all but a handful being from outside the EU (2013). 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 are not Hungarian and the first dentists graduated 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 and also in 2011.

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 *Központigyakornok*, needed to hold Hungarian citizenship. The residents were mainly employed in the public sector.

Residents had to complete the courses, and pass various exams. 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, the programme was abolished in 2004 and there is now full access to free practice after graduation.

Registration

Dentists must register with the Ministry of Health. Whilst registration is free in 2013, the Chamber has speculated 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

A Hungaro-logic test (testing knowledge of the insurance and legal systems) which previously had to be passed by all, to work in Hungary was abandoned in 2006 and now language testing is not regulated.

Further Postgraduate and Specialist Training

Continuing education

Participation in continuing education has been mandatory since 1999. The system is delivered mainly by the Ministry of Health, and the Universities are 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 which is rare but, before that, the dentist has to work under supervision.

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: Dentoalveoláris szájsebész
- Conservative Dentistry and Prosthodontics - with the title: Konzerváló Fogászatés 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.

As stated above, 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.

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 4,500 dentists (by 2013) 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 after 2004 have gained qualification in only the new speciality of “conservative dentistry and prosthodontics”.

Workforce

Dentists

Year of data:	2013
Total Registered	5,500
In active practice	4,973
Dentist to population ratio*	2,000
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. The dental association's demographic figures show that there are a large number of dentists (both male and female) over the age of 50, who will be retiring in the years to 2020, more than the number of Hungarian nationals who will graduate from the four Hungarian dental schools during this period.

Unemployment in 2013 was estimated to be less than 50.

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:	2013
Orthodontics	379
Endodontics	
Paedodontics	254
Periodontics	65
Conservative dentistry &	924
Prosthodontics	
Oral Radiology	
Dental-alveolar	139
OMFS	157
Dental Public Health	

Auxiliaries

Later data was not available at January 2014

Year of data:	2010
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. Until 2008 they were trained in one of two state financed schools, specifically for dental hygienists, for one year, following two years' training as a dental assistant.

Since 2008, a State financed system has been extended by the private sector and it represents approximately 60%.

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 have to be registered, at the Office of Health Authorisation and Administrative Procedures.

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 also a couple of private schools; the training period is three 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 Commerce and 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 just four centres.

They have to be registered with the Hungarian Chamber for Health Care Professionals.

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:	2013
General (private) practice	3,790
Public dental service	20
University	240
Hospital	35
Armed Forces	40
General Practice is about	76%

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 and the uneven distribution of practices. In some regions, for example Budapest and Western Hungary, the patient to dentist ratio is very low. Conversely, in other areas, for example Eastern Hungary this is very high. List sizes here can be as many as 4,000.

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 knowledge of the university).

However, more usually they are full-time salaried employees of the University.

The titles of university teachers are: Assistant Lecturer or Assistant Professor, 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	718	2012	FDI
Chamber (Dental Section)	5,300	2012	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.By 2008, about 90% of all Hungarian dentists had 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 Chamber (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

Hungary has complied with the EU Directive of 2012 and so tooth whitening products of greater than 6% are prohibited as Cosmetic 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 existing units, but are where new units are equipped. The use of separators is recommended or advised by environmental managements for all units. By 2013, approximately 70%, 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 bio-hazardous 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 private dentists and their staff can work past then. From July 2013, doctors and assistants who work beyond the age of 62 do not get their pensions. At the time of the introduction of this new rule, more than 30% of all the state employed doctors and nurses were over the age of 62 and were receiving pensions as well as working part or full time. Employed health care providers now must choose between their pension or salaries, if they want to work after retirement.

There is a state-funded system of pensions, of which dentists and their staff are a normal part. The pension would be approximately €400 - 550 per month for dentists and approximately €300 - 350 for staff

Taxes

Hungary has a universal income taxation that is 16% independent of the total annual gross earnings.

VAT

Since 2010, there are three VAT rates: 5% (for medicaments), 15% (materials) and 27% for equipment, instruments and disposables).

Various Financial Comparators

Budapest ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	57.3	49.1
Wage levels (net)	15.6	13.7
Domestic Purchasing Power*	30.3	26.5

(* relative to net income)

Source: UBS August 2003 and November 2012

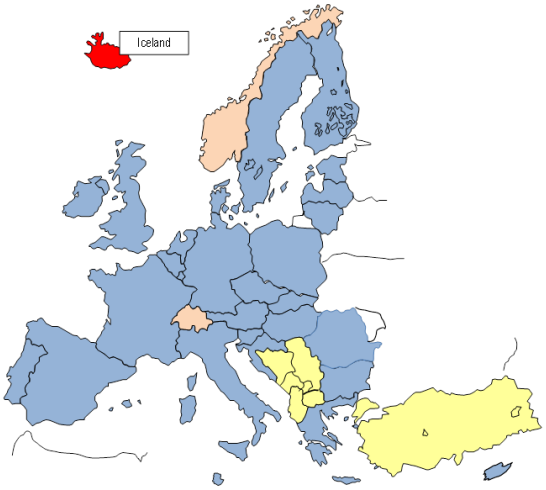
Other Useful Information

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. 47 H-1088 Budapest Tel: +36 1-267- 4907 (Prof Istvan Gera president) +36 1-317-1598 (Dr. Zsuzsa Toth Secretary-General) Email: toth.zsuzsanna@dent.semmelweis-univ.hu Website: www.mfe-hda.hu
Journals	
Name: Magyar Fogorvos Tel: +36 1 301 3879 Editor in Chief: Dr. Janos Gerle Editor: Prof Peter Hermann E-mail: magyarfogorvos@yoter.hu Website: www.magyar.fogorvos.hu	Name: FogorvosiSzemle Editor in Chief: Prof Pal Fejerdy Editor: Prof Peter Hermann Tel: +36 1 317 1094 Fax: +36 1 317 1094 E-mail: gecse.veronika@dent.semmelweis-univ.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: dekan@dent.semmelweis-univ.hu Website: www.sote.hu Dentists graduating each year: 156 Number of students (Hungarian): 533 Number of students (not Hungarian): 280	**City: Debrecen** Name of University: University of Debrecen Tel: +36 52 342-208 Fax: +36 52 342-224 E-mail: boszormenyi.eva@dental.unideb.hu Website: http://dental.deoec.hu Dentists graduating each year: 70 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: 45 (2013) Number of students (Hungarian): 219 Number of students (not Hungarian): 121 The foreign language courses were fairly new in 2013, so the numbers graduating in 2013 did not reflect the numbers being trained.	**City: Pécs** Name of University: University of Pécs, Medical Faculty, Dental School Tel: +36 72 535 920 Fax: +36 72 535 905 E-mail: fogaszat.titkarsag@pte.hu Web site: http://ftsz.pte.hu/index.php?nyelv=eng Dentists graduating each year: 40 (2013) Number of students (Hungarian): 185 Number of students (not Hungarian) : 234 The foreign language courses were fairly new in 2013, so the numbers graduating in 2013 did not reflect the numbers being trained.

Iceland



In the European Economic Area	
Population (2013)	322,930
GDP PPP per capita (2012)	€30,202
Currency	Kroner ISK)
	160 ISK = €1.00 (2013)
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 variable reimbursements from the Icelandic Health Insurance.

Number of dentists:	351
Population to (active) dentist ratio:	1,200
Members of Dental Association:	90%

The use of dental specialists is widespread. There are two types of clinical dental auxiliaries - dental hygienists and some dental technicians. Continuing education for dentists is not mandatory.

Date of last revision: 27th of January 2014

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 Reykjavík area (the capital).

Settled since 874AD, the present republic was founded in 1944 and is governed by the *Althingi* (Parliament) whose members are elected every four years. There is also a President who is elected every four years as well. The economy is heavily dependent on fisheries, with marine products constituting 43% of all exports. Other industrial products provide 53% of the export and include items such as aluminium from aluminium smelters powered with electricity from power sources using renewable energy.

The health service in Iceland is primarily financed by central government. Financing is mainly based on taxes with 18% as patient co-payments by way of fee for service in 2013. Care provided within hospitals is free at the point of delivery, except for some accident and emergency care.

		Year	Source
% GDP spent on health	8.9%	2012	OECD
% of this spent by government	80.4%	2012	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 Health Insurance (http://www.sjukra.is/english)

The national dental health insurance system pays according to a public fee schedule set by the Icelandic Health Insurance. 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 adults aged 67 years or older. For children under 18 years of age 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 (€ 937) according to special rules.

In April 2013 a new contract between the Icelandic Health Insurance and the Icelandic Dental Association for the dental treatment for children under the age of 18 years old was signed. Parents now register their children with a family dentist who takes care of all dental treatment, prevention and recall of that child. The fee-schedule is a fixed price and the treatment is paid by fee-for-service contract. Parents only pay a low co-payment of 2.500 ISK (€15.62) once every 12 months.

The contract takes effect in 7 steps. The first step was in May 2013 with 15-17 year old children being included. The second step was taken the 1st of September 2013 with 12-17 year-olds and 3 year-olds being included. The 1st of January each year thereafter two more age-groups will be added until all children 0-18 years old will be covered by the 1st of January 2018. Those children who are not yet included in the contract pay according to the regular free fee-schedule of their dentist and are reimbursed by a fixed fee-schedule that was issued by the Icelandic Health Insurance before the contract. Their out-of-pocket payment is, therefore, higher.

Socially-deprived children that are in immediate oral health need, and are not at the age covered by the contract, can have an exception, to permit them to receive emergency treatment by the same contract, only paying the low co-payment. This can only be done with a referral from health-, social- or children's services.

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 (€ 500) 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 are also reimbursed.

Dental treatment is not subsidized for the rest of the population. No private dental insurance is available either.

The Icelandic Health Insurance operates the system independently within the framework of health policy and budget set by the Ministry of Welfare and the Parliament. It spends an annual budget of central government funds, which is set by the Parliament. Within the Ministry of Welfare there is a Chief Dental Officer who works closely with the Minister of Welfare on building oral health policies and strategies.

		Year	Source
% GDP spent on oral health	0.57%	2012	Statistics Iceland
% OH expenditure private	86%	2012	Statistics Iceland

Information on how often the whole population visit their dentists is not collected on a regular basis, only for the population who are partially covered by the Icelandic Health Insurance, such as children and older adults. Only 60% of all children 0-18 years of age had visited the dentist in 2012.

Recall visits are normally carried out for most adult patients at 12-24 monthly intervals and children at 3-18 monthly intervals depending on their oral health risk status.

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 at the Directorate of Health, mostly through patient complaints. The Icelandic Health Insurance also performs a basic statistical analysis of the patterns of treatment provided by each dentist, and any practitioner whose profile differs substantially from the norm will need to explain why.

For most minor issues the Icelandic Health Insurance will issue a warning to the dentist; more serious cases are referred to a liaison committee where both the Icelandic Health Insurance and the dental association have their representatives.

Health data

		Year	Source
D3MFT at age 12 (with x-rays)	2.11	2005	Pubmed*
D3MFT at age 12 (visual exam onl	1.43	2005	Pubmed*
D3MFT zero at age 12 (w.x-rays)	34%	2005	Pubmed*
D3MFT zero at age 12 (visual exan	48%	2005	Pubmed*
Edentulous - age 65-74 years old	33%	2007	HIC

D3MFT zero at age 12" refers to the number of 12 year-old children who have no detectable caries at the D3MFT level.

Source: The latest information at a national level is from a study on 20% of all children age 6, 12 and 15 year-old in year 2005, where bite-wing digital radiographs were obtained as well as a thorough visual examination. D_3MFT scores by visual examination only were 1.43 but when including radiographs the D_3MFT score for 12 year old children rose to 2.11. (* Agustsdottir H, Gudmundsdottir H, Eggertsson H, Jonsson SH, Gudlaugsson JO, Saemundsson SR, Eliasson ST, Arnadottir IB, Holbrook WP. Caries prevalence of permanent teeth: a national survey of children in Iceland using ICDAS. Comm Dent Oral Epidemiol 2010; 38: 299-309).

This marked difference in DMFT scores when results from radiographic and visual examinations are compared show the importance of documenting well both the source and nature of the national data.

Edentulous at age 65-74 years refers to the proportion of people in the age group 65-74 years old with no natural teeth as obtained by a questionnaire sent by mail by the Public Health Institute of Iceland in 2007.

Fluoridation

There is no water-fluoridation in Iceland. There are school-based fluoride rinsing programs in three levels of elementary schools, in the first, fifth and seventh grades. There are plans (in 2014) to increase the number of levels of fluoride rinsing.

The general practice of tooth-brushing with fluoride toothpaste is heavily promoted and there are plans to introduce school-based toothbrushing for toddlers in primary schools and at the youngest level in elementary schools. An effort was made with a directive in year 2007 to make fluoride supplements more easily available. Fluoridated chewing gum, fluoride tablets and fluoride rinses are available without prescription over the counter.

Toothpaste with a high concentration of fluoride (5000 ppm) is available but only with a prescription.

Education, Training and Registration

Undergraduate Training

Iceland has one dental school: - the Faculty of Odontology of the University of Iceland in Reykjavík.

http://english.hi.is/school_of_health_sciences/faculty_of_odontology

Year of data:	2012
Number of schools	1
Student intake	7
Number of graduates	7
Percentage female	69%
Length of course	6 yrs

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, so this has ensured a very high standard of clinical training.

Clinical training is included in the undergraduate training programme and takes 84 weeks.

Qualification and Vocational Training

Primary dental qualification

The title on qualification is the degree *candidatus odontologiae,* which is a masters-length curriculum recognised as a dental qualification throughout the European Economic Area. It meets the requirements for the granting of a licence to practise clinical dentistry immediately following graduation.

Vocational Training (VT)

There is no post-qualification vocational or specialist training. Some aspects of continuing professional development are possible to cover in the University or through the Icelandic Dental Association.

Registration

The Directorate of Health http://www.landlaeknir.is/english/ is the competent authority responsible for issuing dental licences.

A dentist seeking recognition in Iceland should, therefore, approach the Directorate of Health – with an 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. This must be a country in the EEA and the valid dental licence must also be from an EEA country.
- a certified copy of the applicant's licence as a specialist (if applying for a specialty). The specialist subject must be one of the clinical specialties recognised in Iceland.
- 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 Directorate of Health 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 an EU/EEA Member State or has a dental qualification from outside the EU/EEA then 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 Faculty of Odontology of the University of Iceland, that is 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.

Language requirements

When an applicant for a licence to practise dentistry in Iceland does not have a licence from an EU/EEA country the Directorate of Health is obliged to consult the Faculty of Odontology of the University of Iceland for evaluation of the applicant´s dental knowledge and competence. The Faculty has a 3-step examination process that applicants need to pass. The examinations may only be taken twice, should the candidate fail the first attempt. The IDA can supply further information about this examination.

Cost of registration (2013)	€ 52

Further Postgraduate and Specialist Training

Continuing education

The Icelandic Dental Association (TFÍ) has an active continuing education system for Icelandic dentists. Continuing education for dentists is not mandatory according to law, but with the new contract in 2013 between the Icelandic Health Insurance and the Icelandic Dental Association for the dental treatment for children under the age of 18 years old, contracted dentists are obliged to fulfil a minimum of 75 hrs of CE every three years.

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. 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 peer-reviewed professional journals also merits points. The Professional Committee has 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 75 hours per each three-year period.

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 articles worth units in ACEID. The committee keeps a record of dentists' participation in ACEID.

Continuing education courses arranged by the Icelandic Dental Association are usually a 2-3 day seminar in the Autumn and one lecture series in January, as well as shorter courses on an irregular schedule.

Specialist Training

The Faculty of Odontology offers postgraduate training at masters and doctoral level but it has no clinical specialist training programmes. Specialist training courses are only available at universities outside Iceland. To get a specialist licence from the Directorate of Health training must be at least 3 years at an approved institution, approved by the University of Iceland and the Directorate of Health.

Workforce

Dentists

Year of data:	2012
Total Registered	351
In active practice	269
Dentist to population ratio*	1,200
Percentage female	33%
Qualified overseas	47

* this refers to *active* dentists only

The number of registered dentists includes all dentists alive who have, at some time or another, been registered as dentists. They may be retired or not working as dentists.

About 60% of practising dentists live, and work, in the Greater Reykjavík area.

Movement of dentists across borders

Whilst about 11% of the general dentists in the workforce and 100% of the specialists qualified overseas, there used to be very little movement of Icelandic-trained dentists to other countries, until the economic crisis in October 2008. Since then a few Icelandic dentists have emigrated – mainly to Norway and Denmark.

Specialists

Twelve specialties are recognized in dentistry in Iceland. These are Orthodontics, Endodontics, Paedodontics, Periodontics, Prosthodontics, Oral Radiology, Oral Surgery, Dental Public Health, Operative Dentistry, Occlusion, Oral Medicine and Geriatric Dentistry. All specialists work in private practice, although some do part-time work at the dental school and at the National Hospital.

Year of data:	2012
Orthodontics	15
Endodontics	2
Paedodontics	3
Periodontics	8
Prosthodontics	5
Oral Radiology	0
Oral Surgery	4
Dental Public Health	3
Others	6

Number of active specialists in 2012

Patients may go directly to a specialist, without the need for a referral from a primary dentist.

Auxiliaries

In Iceland, other than dental chairside assistants, there are three types of dental auxiliary:

- Dental hygienists
- Dental technicians
- Dental technician- denturists

Year of data:	2012
Hygienists-active	14
Technicians	101
Denturists	9
Assistants	320
Therapists	0
Other	0

Dental hygienists

There is no training programme available for dental hygienists in Iceland. The Directorate of Health decides which external diplomas are recognised and awards licences to dental hygienists to practice.

Dental hygienists may administer 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

Training for Dental Technicians is now at University level and is a 3 year B.Sc. degree at the Faculty of Odontology of the University of Iceland. Dental technicians are usually self-employed, working in their own laboratories or workshops – although some technicians are employees of a larger dental lab or work for an individual dentist or group practices.

Dental technicians can work without supervision, but may not do clinical work directly with patients, and the dentist is ultimately responsible for the quality of the prostheses.

Some dental technicians have acquired a special licence to make dentures and work in the mouth of the patient, after special training. These technicians are equivalent to denturists in some other countries.

Dental technicans apply for their licenses to the Directorate of Health now. Previously the Ministry of Industry issued their licenses.

Dental Chairside Assistants

Since 1990 a qualification has been in place for dental chairside assistants in Iceland and it is a requirement now to have a special qualification to work as a dental chairside assistant. The training is two years in high school and one year at the Faculty of Odontology at the University of Iceland. The Directorate of Health issues their licenses. Dental assistants are normally salaried.

Practice in Iceland

The majority of dentists in Iceland work in general practice. Some also teach part-time in the dental school, have a part-time position at the National hospital or are in public dental service, working in administration. The numbers below therefore add to more than the total number of active dentists.

Year of data:	2012
General (private) practice	269
Public dental service	3
University	23
Hospital	5
Armed Forces	0
General Practice as a proportion is	100%

Working in General (Private) Practice

Dentists who practise on their own or with 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 full-time practising dentist will normally look after about 800-1,000 regular patients on his/her "list".

All clinical 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, in general, they have a free fee-schedule. Some patient groups (0-18 years, older than 67 and the disabled) get partial re-imbursement from the the Icelandic Health Insurance.

The main treatments, for which the level of reimbursement is fixed, are examination and diagnosis, prophylaxis, fillings, X-ray investigation, periodontology, removable prostheses and endodontics. Reimbursements for more complicated treatment that is almost fully re-imbursed (95% of cost) for certain groups due to serious birth-defects are only decided after prior approval of the treatment plan by the Icelandic Health Insurance. The effects of some serious accidents are also covered.

Fee scales

The fee scale for the Icelandic Health Insurance subsidised treatment is a highly detailed list of over 100 possible treatment items. Specialist treatments are reimbursed 20% higher than the stated fixed fee for Icelandic Health Insurance 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 group practices. There are no standard contractual arrangements prescribed for dental practitioners working in the same practice.

The TFI Code of Ethics

Premises may be rented or owned. There is no state assistance for establishing a new practice, so normally dentists take out commercial loans from a bank. Occasionally small rural 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 shopping centres, health centres, in offices buildings etc., where the need for dental care and good access is the priority.

There are no specific or standard 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

Only a few dentists hold part-time positions in hospitals. The majority of them are Oral Surgeons. One specialist in Geriatric Dentistry and another in Oral Medicine have formal links to the National hospital. Urgent care may be provided in the hospital, but most treatment is deferred until the patient can attend a private practice.

Working in the University Dental Faculty

At the Faculty of Odontology 18 dentists are employed in 13 academic positions. Postgraduate training is required for all university professors, associate professors and assistant professors.

Working in the Armed Forces

There are no Armed Forces in Iceland.

Professional Matters

Professional associations

There is a single professional association for dentists in Iceland, the Icelandic Dental Association (*Tannlæknafélag Íslands* or *TFÍ*) to which over 90% of active dentists belong, as well as many retired dentists.

	Number	Year	Source
Icelandic Dental Association	270	2012	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 Ministry of Welfare and the Icelandic Health Insurance.

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 Icelandic Health Insurance, 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 Dental Association ~~TFÍ~~ and 3 from the Icelandic Health Insurance. 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, temporarily limited or suspended.

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, fee-schedule, 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 102,000 ISK (€640) per year in 2013.

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.

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% peroxide, supply and use is limited to dentists, but only under prescription.

Health and safety at work

Vaccinations, such as Hep B, are not a compulsory for the workforce, but highly recommended. All students in the Faculty of Odontology are vaccinated against Hepatitis B. The Dental Association organises inoculations for dentists and their staff every 5 years.

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 regulations 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 radiation protection. There is no mandatory continuing training for radiation protection.

Hazardous waste

The EU law on the disposal of clinical waste are enforced. Since the year 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, until the age of 70. After that they can apply for a special permission to practice for two more years from the Chief Medical Officer. This permission can be given a maximum of three times.

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 and corporate income tax. Income tax is deducted at source, known as pay-as-you-earn (PAYE). Each employee has a personal tax credit of 44,205 ISK (€276) per month; unused credit may be transferred to one's spouse. Up to 8% of gross income may be deducted for private pension insurance.

Income tax is progressive, from 37.32% for the first 241,475 ISK (€1,509) of monthly income - to 46.22% above 739,510 ISK (€4,621). The rate includes 14.44% collected by municipal authorities.

Individuals pay 20% capital gains tax. The corporate tax rate is 20%.

VAT

The standard VAT rate is 25.5%. There is a reduced rate of 14% on hotel and guestrooms and other accommodation services and a reduced VAT rate of 7% which applies to specific goods and services. A VAT rate of 0% applies on certain services and goods (for example, exported goods as well as labour and services provided abroad)

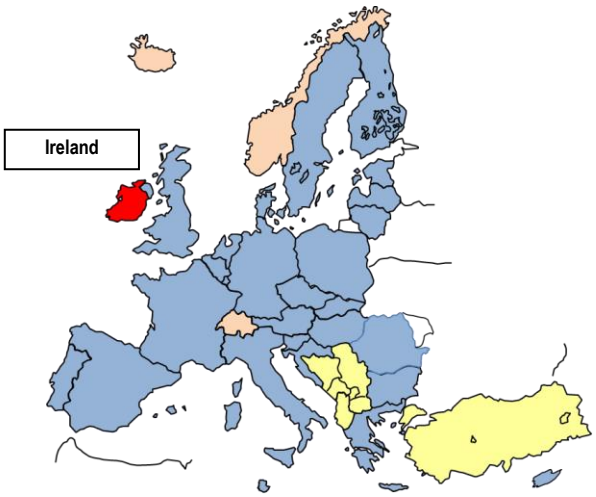
Another VAT change is that became effective on January 1st 2013, was that movie tickets to Icelandic films are no longer exempt from VAT, but are subject to the standard VAT rate of 25.5%.

Dental equipment and consumables are at the standard rate of 25.5% but dental services are VAT-exempt.

Other Useful Information

Main National association and information centre	***Competent Authority:***
Tannlæknafélag Islands Icelandic Dental Association Síðumúla 35 Box 8596, 128 Reykjavík, ICELAND Tel: +354 57 50 500 Fax: +354 57 50 501 Email: tannsi@tannsi.is Website: http://www.tannsi.is	Ministry of Welfare Hafnarhusinu vid Tryggvagotu IS-150 Reykjavik - Iceland Tel: +354 545 8100 Fax:+354 551 9165 E-mail: postur@vel.is Website: http://eng.velferdarraduneyti.is/ For dental licences: Directorate of Health Barónsstíg 47 IS-101 Reykjavík - Iceland Tel: +354 510 1900 Fax: +354 510 1919 E-mail: mottaka@landlaeknir.is Website: www.landlaeknir.is/english/
Dental School:	***Publication:***
The Faculty of Odontology 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: 42	The Icelandic Dental Journal – information can be found at: http://www.tannsi.is/tfi---ymsar-upplysingar-/tannlaeknabladid/

Ireland



In the EU/EEA since	1973
Population (2013)	4,591,087
GDP PPP per capita (2012)	€31,351
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:	2,627
Population to (active) dentist ratio:	2,087
Members of Dental Association:	82%

There is a well developed system of specialists, and dental hygienists clinical dental technicians and orthodontic therapists also provide care. Continuing education for dentists is recommended but not mandatory.

Date of last revision: 26th January 2014

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. State healthcare expenditure grew by an average of 6.5% per year between 2000 and 2009. In 2010 state expenditure was €2,862 per head of population. This represented 9.2% of total health expenditure as a share of GDP However, since then the share of state health spending has been decreasing rapidly. Cuts in government spending drove total health spending per capita down by changes to the system, a reduction in the number of healthcare workers, cuts in wages, as well as to the fees paid to healthcare professionals and pharmaceutical companies.

		Year	Source
% GDP spent on health	8.9%	2011	OECD
% of this spent by government	79.0%	2011	OECD

So, whereas in 2011 the state share of health spending was 79%, provisional figures indicate that it stood at 70% in 2013,

while the share of out-of-pocket payments by households increased.

Thus, a significant proportion of healthcare is now privately funded. However, the private sector is partly subsidised through tax allowances for health insurance premiums.

The public healthcare system is governed by the Health Act 2004, which established a new body to be responsible for providing health and personal social services to everyone living in Ireland – the Health Service Executive (HSE). The HSE came into being officially on 1 January 2005. But, the HSE was being abolished in 2013 as part of the Government's reform programme.

All persons resident in Ireland are entitled to receive health care through the public healthcare system, which is managed by the HSE and funded by general taxation. A person may be required to pay a subsidised fee for certain health care received; this depends on income, age, illness or disability. All maternity services and child care up to the age of six years are provided free of charge. Emergency care is provided at a cost of €100 for a visit to the Accident and Emergency Department.

Everyone living in the country, and visitors to Ireland who hold a European Health Insurance Card, are entitled to free maintenance and treatment in public beds in HSE and voluntary hospitals. Outpatient services are also provided for free. However the majority of patients on median incomes or above, are required to pay subsidised hospital charges.

The Medical Card is available to those receiving welfare payments, low earners, those with certain long-term or severe illnesses and in certain other cases. The card entitles holders to free hospital care, GP visits, dental services, optical services, aural services, prescription drugs and medical appliances. In 2013, 31.9% of the population held a Medical Card. Those on slightly higher incomes are eligible for a GP Visit Card which entitles the holder to free general practitioner visits. For persons over 70 years who are not entitled to a medical card or GP visit card they instead receive an annual cash grant of €400, up to a certain income.

People who are not entitled to a Medical Card (68.1% of the population) must pay fees for certain health care services. In 2013, there was a €100 A&E charge for those who attend an accident and emergency department without a referral letter from a family doctor (a visit to which usually costs €50-75). Hospital charges (for inpatients) are a flat fee of €100 per day

up to a maximum of €1000 in any twelve-month period, irrespective of the actual care received. Specialist assessments and diagnostic assessments (such as X-rays, laboratory tests, physiotherapy, etc.) are provided for free. If a person cannot afford to pay hospital charges, the HSE will provide the services free of charge.

Voluntary private health insurance

There a number of providers of voluntary health insurance.

The Voluntary Health Insurance Board (VHI) is the largest provider of voluntary private health insurance. It is a statutory body whose board is appointed by the Minister for Health. Laya Healthcare, Aviva, GloHealth and the Hospital Saturday Fund Health Plan (does not provide cover for hospital in-patient costs) also operate as voluntary private health insurance providers.

There are a number of long-established health insurance providers that deal only with particular groups of employees; membership is confined to employees and retired employees and their dependants. These schemes are known as restricted membership schemes. Examples include schemes for the police service and prison officers. Under their schemes insured persons and their spouses receive care in private and public hospitals, and outpatient specialist clinics, together with limited 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.

General Medical Service from Health Service Executive (HSE)

The General Medical Service (or GMS) provides standard public, primary care services to medical card holders i.e. low-income families, those with chronic illness, all persons of 70+ and dependants of those working in another EU member state. The services are provided free of charge to the patient.

There is an annual predetermined budget by the Department of Finance and the Department of Health.

Oral healthcare

The majority of dental services are provided by dentists in the private sector, while the HSE is responsible for providing dental services to children and adults with special needs.

According to Department of Health statistics for 2011, 43% of adults attended a dentist in the previous 12 months.

		Year	Source
% GDP spent on oral health	0.33%	2004	OECD
% of OH expenditure private	47%	2004	CECDO

Public health insurance

Department of Social Protection Dental Treatment Benefit Scheme (DTBS)

All employees who make Pay Related Social Insurance (PSRI) contributions, and their dependent spouses/civil partners/cohabiters, are entitled to this scheme. This scheme is run centrally by the Department of Social Protection. The number of adults entitled to claim benefit under this Scheme was about 2 million in 2013 ie 45% of adults. Prior to 2010 a range of fully and partly subsidised routine dental treatments were available under the scheme. In 2010 this scheme was limited to one treatment – the annual oral examination.

Prior approval from the Department is not required under this Scheme. In 2013, 1719 dentists held a contract with the Department of Social Protection to operate the DTBS. €8.9 million was spent on the scheme in 2012, when 270,602 people claimed their benefit. The overall percentage uptake of the scheme is 13.53%.

Department of Health Dental Treatment Services Scheme (DTSS)

Dental care provided under this scheme is budget-limited. This 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 adults under this scheme. In 2010 the budget for it was capped at €63 million. Treatment available under the scheme was restricted to emergency treatment and high risk patients only. A limit of two emergency restorations per annum is allowed. Prophylaxis treatment is suspended, except for high risk patients. Prior approval for treatment is required for endodontic, prosthetic or periodontal treatment.

In 2012 394,000 patients were treated, with €63m in fees being paid to contracting dentists. In 2013, 1,429,560 patients were entitled to treatment under the scheme. Also, 1,594 dentists participated. The overall percentage uptake of the scheme in 2012 was 27.84%. The percentage uptake of the annual oral examination was 27.96%.

HSE Public Dental Service

Dental services for children and adults with special needs are provided by the HSE's Public Dental Service. The service is expected to target children at three stages in their development (in 2nd, 4th and 6th class in primary school) when children should be screened and provided with any follow-up treatment required. 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. In addition, emergency dental treatment should be available to all children up to 16 years. Pre-school children receive what amounts to an advisory service with emergency dental care available on demand.

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.

The demand for this service currently far outweighs the resources in terms of the workforce available to provide the services.

Since March 2009, the number of dentists working in the Public Dental Service has reduced by nearly 20%. (From March 2009 to November 2012, the number of Whole Time Equivalents (WTE) reduced by 67.4 from 360.1 to 292.7).

This reduction in headcount, coupled with an increase in the target population has led to huge pressure on the service, resulting in targets not being met.

Private Care

The majority of oral healthcare is privately funded.

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 and prison officers. Under these schemes the patient pays for treatment and then claims a partial subsidy.

There are a small number of free-standing private dental care plans in Ireland.

The cost of paying privately for a limited number of items of non-routine dental care or via insurance premiums is tax-deductible at a rate of 20% under current taxation law.

The Quality of Care

For treatment provided under a state scheme, the standard of dental care is mainly monitored by the funding body. The Central Payments Boards of the Department of Social Protection 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 Protection uses examining dentists to check the quality and quantity of dentists' work. These checks are done at random or in response to particular complaints. The treating dentist must 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.

Complaints relating to private dental care, are normally addressed to the treating dentist directly in the first instance. If the complaint or misunderstanding cannot be resolved, it is open to the patient to refer the complaint to the regulatory body, the Dental Council of Ireland or instigate civil litigation in the

civil courts. Ultimately, the Dental Council has a statutory responsibility to promote high standards of professional education and to ensure high standards of professional conduct amongst dentists. A voluntary mediation service was established by the Irish Dental Association in 2012, the Dental Complaints Resolution Service, which has proved successful in resolving complaints.

Health data

		Year	Source
DMFT at age 12	1.10	2007	CECDO
DMFT zero at age 12	54%	2007	CECDO
Edentulous at age 65	41%	2007	CECDO

"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. 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 no milk fluoridation or salt fluoridation schemes. A small number of supervised school-based fluoride mouth rinsing schemes operate in isolated areas such as the islands off the coast of Ireland.

It is recommended not to use fluoride toothpaste 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

Undergraduate training of five years duration may be undertaken in the two dental university schools in Cork and Dublin. Applicants must obtain the required number of points in the Leaving Certificate Examination. No other vocational entry is possible.

There are two schools, both publicly funded: Dublin Dental University School and Cork Dental University School.

Year of data:	2013
Number of schools	2
Student intake	86
Number of graduates	76
Percentage female	54%
Length of course	5 yrs

A small number of Irish students study dentistry in the UK.

Quality assurance of the curriculum is monitored and checked by the Dental Council of Ireland.

Qualification and Vocational Training

Primary dental qualification

The title on qualification is Bachelor of Dental Science (B Dent Sc) from Dublin Dental University School; and Bachelor of Dental Surgery (BDS) from Cork Dental University School.

Vocational Training (VT)

There is no mandatory post-qualification vocational training. A voluntary scheme which had been in operation for some years was suspended in 2011. A significant proportion of Irish graduates currently enter vocational training schemes in the UK.

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.

Language requirements

For citizens of EU/EEA countries holding EU/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.

Cost of registration (2013)	€ 200

Further Postgraduate and Specialist Training

Continuing education

The Dental Council obliges dentists to keep their professional knowledge and skills up-to-date and undertake continuing professional development (CPD). 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 CPD Certificate. This is known as "Verifiable CPD".

The Dental Council recommends dentists complete and keep records of at least 50 hours of CPD per year, at least 20 of which should be verifiable CPD.

While the amount of CPD hours completed may vary from year to year, dentists should complete at least 250 hours of CPD every five years, of which a minimum of 100 hours should be verifiable CPD.

There is an extensive system for the delivery of continuing education, through courses provided by the Dental Schools, the Royal College of Surgeons, the Irish Dental Association, and various societies.

Specialist Training

There are two recognised specialties:

- 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 provide dental care during their training and would normally be paid as appropriate.

On completion of training as a specialist they normally receive a Certificate of Completion of Specialist Training in orthodontics or oral surgery, issued by the competent authority (the Dental Council of Ireland). Then, their name is 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:	2013
Total Registered	2,627
In active practice	2,200
Dentist to population ratio*	2,087
Percentage female	44%
Qualified overseas (2008 data)	634

* this refers to "active" dentists

Movement of dentists across borders

There were 110 of new registrants in 2012 - 60 female and 50 male. The total number of new registrants comprised of graduates from the following countries:

- 36 graduates from Ireland
- 22 graduates from Hungary
- 12 graduates from the UK
- 12 graduates from Romania
- 17 graduates from other EEA/EU countries
- 11 graduates from outside of EU.

There are a small number of unemployed dentists. No official statistics are available. An increasing number of younger Associates are working on a part-time basis in multiple practices rather than having one full–time position.

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

The main types of dental auxiliary are as follows:

- Dental hygienists
- Dental technicians
- Clinical Dental Technicians
- Orthodontic Therapists
- Oral health educators
- Dental nurses

Year of data:	2013
Hygienists	458
Technicians	350
Clinical Dental Technicians	24
Orthodontic Therapists	5
Assistants (DSAs)	629
Non registered DSAs*	633

*estimated

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. Qualification is by way of a diploma, which is a registrable with the Dental Council before they can practise.

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. HSE hygienists are paid a salary.

Dental technicians

Dental technicians 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, 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 (CDT). They are legally entitled to provide dentures directly to members of the public. CDTs are obliged to comply with the Dental Council's 'Code of Ethics and Conduct for Clinical Dental Technicians'. This Code was published in March 2010.

In order to quality as a CDT, a Postgraduate Diploma in Clinical Dental Technology must be attained. This course is available in Dublin Dental University Hospital. Applicants must possess a degree in Dental Technology or equivalent qualification. Entry to training in clinical dental technology would normally follow, as a minimum, a three-year period of professional experience in a dental laboratory. Applicants must have evidence of satisfactory sero-conversion for protection against Hepatitis B. Regulations also require testing for Hepatitis C for new entrants to the HSE. Applicants are required to undergo Garda (Police) Vetting

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 registrable qualification for oral health educators although courses in Oral Health Promotion are available. There is no available data about their numbers.

Orthodontic Therapists

Orthodontic Therapists carry out certain parts of orthodontic treatment which may only be carried out under the supervision of a dentist registered in the Orthodontic division of the Register of Dental Specialists. Any such dental work must only be carried out after the orthodontist has examined the patient and has indicated to the orthodontic therapist the course of treatment to be provided.

As there are no programmes approved in Ireland for the purposes of registration in the Orthodontic Therapy Register, the Dental Council has decided that the procedure set out above will be applied to its consideration of any UK based training programme submitted for approval as a registrable programme in the orthodontic therapist register. This is to allow Irish dental nurses to obtain a UK qualification while undergoing their clinical training in Irish based Orthodontic practices.

Dental Assistants (Nurses)

Dental nurses assist the dentist at the chairside. Many undergo formal training in one of the dental schools. 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. Dental nurses are obliged to adhere to the Dental Council's 'Code of Ethics & Conduct for Dental Nurses'.

Practice in Ireland

Year of data:	2013
General (private) practice	1,800
Public dental service	333
University	50
Hospital	10
Armed Forces	5
Limited practice	150
Administrative	0
General Practice as a proportion is	68%
Number of general practices (2008)	700

"Limited practice" is where a dentist limits his/her practice to a single type of dentistry, for example: endodontics, paedodontics, periodontics, prosthodontics, for which there are no specialist registers.

To accept patients and receive remuneration under the Department of Social Protection Dental Benefits Treatment Scheme and the HSE Dental Treatment Services Scheme, dentists must enter into a contract with the Dental Section of the relevant Government Department.

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 mainly through fees from patients, and partly from fees received under the government subsidised treatment schemes.

A general practitioner would normally treat about 20 patients a day.

Fee scales

For care carried out under the HSE scheme there is a standard fee scale covering different types of treatment. The patient pays nothing and the dentist claims the total fee.

For care (limited to the annual oral examination since 2010) carried out under the Department of Social Protection Scheme the dentist claims the total fee (€33) and the patients pays nothing.

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. Incorporated bodies are precluded from the practice of dentistry under the the Dentists Act 1985. This prohibition is expected to be abolished in the new legislation (expected to be introduced in 2014) which will govern dentistry in Ireland.

Working in the Public Dental Service

The HSE public dental service mostly provides services to primary school children, and also to others who are institutionalised, medically compromised or otherwise limited in their ability to access a general dental practitioner. The HSE employs salaried dentists (approximately 292.7 full time equivalents employed in 2013), including a small number of orthodontists (approximately 40.2 full time equivalents employed in 2013). These services are generally provided in HSE clinics but in some areas dentists in private general practice do sessional work.

The public dental service employs several categories of dentists such as *Clinical Dental Surgeons, General Dental Surgeons, Senior Dental Surgeons* and Senior Administrative Dental Surgeons with special skills in various specific disciplines, including treatment of patients with special needs. The manager of the dental service in each local HSE area, the *Principal Dental Surgeons* also has 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.

Within the public dental service there is a greater opportunity for job-sharing - working on a part-time basis with the retention of pension rights. There tends to be a higher proportion of female dentists working in the public dental service than private 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, the HSE has its own complaints-handling procedure.

Working in Hospitals

A small number of dentists work in hospitals, other than the university 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 both basic specialty training (3 years), to obtain accreditation, and higher specialty training of 3 years, to obtain fellowship status, is required.

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 university dental hospitals. 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 Defence Forces

Only a very small number of dentists serve full-time in the Defence Forces. No data is available about 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	1,700	2013	IDA

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 are obliged to adhere to the Dental Council's 'Code of Practice on Professional Behaviour and Dental Ethics'. 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 schemes 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, via the HSE or to the Minister of Social Protection

Most Dental Associates are engaged on a self-employed basis. A dentist's employees, such as dental surgery assistants/dental nurses, enjoy the protections afforded by national and European employment laws.

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. Dentists are obliged to adhere to the Dental Council's 'Code of Conduct Pertaining to Public Relations and Communications'. This permits 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

Corporate Bodies are precluded by law from engaging in the practice of dentistry.

Professional Indemnity

Liability insurance is provided for HSE Public Dental Surgeons and is compulsory for general practitioners participating in either the Department of Social Protection-or the Department of Health schemes.

The Dental Council's Code of Practice regarding Professional Behaviour and Ethical Conduct states that all registered dentists must hold appropriate professional indemnity cover (insurance).

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 €6,000 annually. This will also cover them for a limited period whilst working abroad.

Tooth whitening

A Statutory Instrument was introduced in October 2012 giving effect to the European Communities (Cosmetic Products) (Amendment) Regulations 2012.

The legislation includes the following:

- Consumers may only be directly sold products containing a limit of 0.1% hydrogen peroxide;
- Products containing more than 0.1% and up to 6% hydrogen peroxide should only be administered by a dentist and should not be used on the under-18s;
- Products with more than 6% hydrogen peroxide (16.62% Carbamide Peroxide) are illegal;
- There is required information to be present on the label of tooth whitening products;
- Importing these products from outside the EU makes the Responsible Person legally accountable for compliance with the legislation.

The Irish Medicines Board and the HSE are responsible for overseeing the compliance with this legislation. Guidance on usage is also available from the Dental Council.

Dental hygienists in Ireland cannot administer whitening products containing more than 0.1% hydrogen peroxide.

The IDA has reported that there is some (continued) illegal practice by people such as beauticians etc.

Health and Safety at Work

A known Hepatitis B carrier may not 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. The Dental Council recommends that dentists complete at least 5 hours in every 5 year cycle in radiation protection.

Qualified dental nurses and hygienists may train to provide these services but there is no validation of this training. Dental nurses who have registered with the Dental Council may take radiographs on completion of a course which has been approved by the Dental Council.

EU Directive 97/43/ Euratom was transposed into Irish Law by a Statutory Instrument of 2002. This law requires dentists to adhere to best practice in radiology. All dentists must acquire a licence from the 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.

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 normal retirement age in Ireland is 65 however this is not compulsory. Self-employed dentists may practise beyond 65 years of age.

Sickness benefit is available from the state in the case of an employed person, or from private income protection insurance in the case of a self employed person.

Taxes

There is a national income tax (dependent on salary – the lower rate is 20% and 41% is paid on incomes exceeding €32,800-€41,800 dependent on individual circumstances), Pay Related Social Insurance (PSRI) and Universal Social Charge.

VAT

VAT/sales tax is payable at 21% on some goods; including dental equipment and consumables. There is no VAT on healthcare services including dentistry. VAT at 23% is payable on toothpaste and tooth brushes.

Various Financial Comparators

Dublin ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	89.2	68
Wage levels (net)	66.1	59.6
Domestic Purchasing Power at PPP	76.5	74.1

Source: UBS August 2003 and November 2012

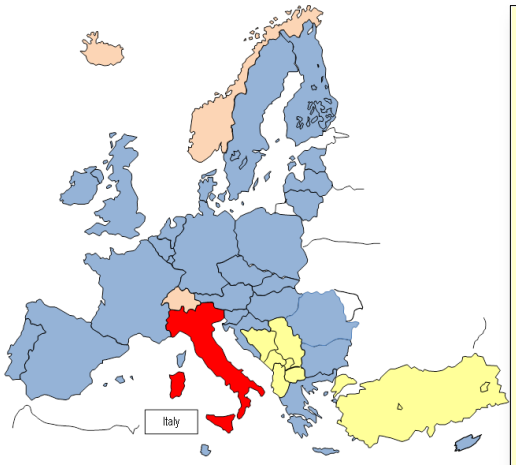
Other Useful Information

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 info@dentalcouncil.ie Website: www.dentalcouncil.ie
Publication:	
Journal of the Irish Dental Association 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	

Dental Schools:

City: Dublin	**City: Cork**
Name of University: Dublin Dental University Hospital 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.dentalhospital.ie/ Dentists graduating 2012: 39 Number of students: 200	Name of University: Cork University Dental School and Hospital The Dean University Dental School and Hospital Wilton Cork IRELAND Tel: +353 21 454 5100 Fax: +353 21 434 3561 Email: dental@ucc.ie Website: www.ucc.ie/en/dentalschool/ Dentists graduating 2012: 29 Number of students: 220

Italy



In the EU/EEA since	1957
Population (2013)	59,685,227
GDP PPP per capita (2012)	€22,955
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:	58,723
Population to (active) dentist ratio:	1,300
Members of Dental Associations (two):	52%

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.

Date of last revision: 31st January 2014

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 Rome.

\there is a central government elected by (mainly) proportional representation. The country is divided into 20 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. The central government establishes health coverage, namely, the typology of services guaranteed under the NHS provision called LEA - (Livelli essenziali di assistenza = Essential Level 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. Meanwhile 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 President of the Region, acting through the "*Assessore alla sanità*" (Health Commissioner, who is a member of the Regional Government.). The organisational 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 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.

		Year	Source
% GDP spent on health	9.2%	2012	OECD
% of this spent by government	78.2%	2012	OECD

Oral healthcare

In principle, there is a comprehensive oral health care system, which functions within the National Health Service (SSN). 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, dental care provided by NHS dentists comprises restorative treatment and only occasionally prosthetics and implants, with co-payment by the patient.

		Year	Source
% GDP spent on oral health	0.82%	2007	CECDO
% of OH expenditure private	95%	2007	CECDO

Dentistry should be considered as private sector treatment in Italy, as only 4% of dental care is provided within the NHS. However, the two main dental associations, ANDI and AIO agree that in the last few years, there have been signs of an increase of public supply, both in the form of new models of delivery, and of joint public/private care.

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 was estimated in 2013 to be about €10 billion.

LEA

The revision of the LEA in 2008 redefined and updated the range of services and treatments offered by the SSN.

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 then current interventions at regional level, led to the activation of programmes for the 0-14 years group, which include the monitoring and treatment of cavities, the diagnosis of malocclusions and 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' are 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 health 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 detail, 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 must be punctually defined.

Treatments:
Considering the extent and the gravity of the pathologies, people with the so-called sanitary vulnerability undertake all dental treatments prescribed by the individual sanitary plan and included in the general nomenclature, which is guaranteed treatment, with the exception of prosthetics and aesthetic interventions.

SOCIAL VULNERABILITY

Receivers:
The Regions and other self-ruling Provinces should choose instruments for the evaluation of the socio-economic situation, 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. provision of dental appliances to subjects from 0 to 14 years of age with an IOTN index = 5 (but not including the cost of the fabrication)
6. deep pulpotomy in immature root apices, for 0 to 14 years groups.

GENERAL POPULATION

Finally, to all citizens, included those who are not part of the indicated protection groups, the following treatments are guaranteed:

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.

In 2010, an average Italian family (4 persons) spent €1,000 per year on oral health care.

Private insurance for dental care

There are some private healthcare insurance plans. Some include routine dental care and prosthetic appliances.

However, by 2013, this market was changing, because there is a trend to develop dental plans as a part of the coverage provided by all supplementary health insurances.

Quality of Care

'Clinical Recommendations' were elaborated by several universities and scientific and professional associations, including ANDI and AIO. In 2012, they were approved for use by Ministry of Health.

Both public and private practices are checked or "authorised" by District Health Service (ASL) which means that they have to comply with certain professional and structural standards, which may be different from Region to Region.

Beside mandatory standards, some regions have developed and applied further standards of accreditation, to permit work on behalf of NHSAccording to a 2012 survey by ANDI (Servizio Studi, in collaboration with the ISCO Institute) 93% of Italians highly trust their dentists with the same level of confidence they have with their family doctor.

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.

According to a 2010 study (Servizio Studi ANDI) based on ISTAT data, 39.7% Italians visited a dentist at least once a year, compared to 11.5% who never visited.

However, intensity of treatment, that is the number of dental visits per person per year, is estimated to be low compared to international standards.

Re-examinations for adult patients occur usually on an annual basis.

Health data

		Year	Source
DMFT at age 12	1.00	2009	OMS-MdP
DMFT zero at age 12	No data		
Edentulous at age 55	18%	2009	OMS-MdP
Source: OMS on ANDI's Mese della Prevenzone 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 prevention dedicated leaflets 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:	2013
Number of public schools	32
Number private schools	2
Number hygienist schools	31
Dental student intake	984
Number of graduates (2012)	883
Percentage female	47%
Length of course**	6 yrs

** The course was lengthened in the academic year 2010/11 to 6 years

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 and San Raffaele in Milan. The dental course is 6 years in length. Students in the private dental schools are responsible for paying their own fees.

The number of non-resident foreign students is announced annually by ministerial decree: in 2013 it was 86.

Quality assurance for the dental schools is provided by the M.I.U.R.(Ministry of Education, University and Research), with some joint responsibility with the Ministry of Health.

Qualification and Vocational Training

Primary dental qualification

A dentist is a professional holding a university degree in medicine and surgery, or in dentistry and prosthetics. A dentist is responsible for the prevention, diagnosis and treatment of diseases of the teeth, mouth, jaws and associated tissues.

Law 409/1985 established the profession of dentist, and defined the requirements for education and professional qualifications.

The legal practise of dentistry is permitted (in 2013) by:

- graduates in Dentistry
- graduates in Medicine and Surgery enrolled in a university course before January 28th 1980, with or without a specialisation in Dentistry
- graduates in Medicine and Surgery enrolled in the university course after 28 January 1980, holding the diploma of specialisation in dentistry or authorised to practice dentistry according to D. lgs. 386/98.

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)

Vocational training is not mandatory.

Registration

To register as a dentist, an applicant must have a degree or diploma in dentistry included in the Annex of the EU Drective 2005/36 or be recognised both by the Ministry of Health (Foreign Affairs) and by one dental faculty, This means that a new graduate from another EU country, who is not yet practising, must pass a post-qualification examination to register to practise dentistry. For graduates from non-EU countries the degree must be validated by Ministry of Health with a proper examination.

The prerequisite for professional practice is the registration as a dentist at a related provincial Chamber.

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.

After registration, the dentist can practise anywhere in Italy.

Language requirements

The Dental Chamber may verify a foreign dentist's knowledge of language and professional rules, according to the D.lgs 9 November 2007, n. 206, and the following decree of Ministry of Health 29 July 2010, n. 268

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'

Medical trainees are paid during the period of training for their specialisation, when specialisation follows the first degree. Trainees in dental specialist training are not paid. 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.

A new system for dental specialist training has been approved allowing a title in Orthodontics, Pediatric Dentistry, Oral Surgery, General clinical dentistry, but the rules are not yet in place.

Workforce

Dentists

Year of data:	2012
Total Registered	58,723
In active practice	45,896
Dentist to population ratio*	1,300
Percentage female	34%
Qualified overseas	550
* this refers to "active" dentists	

There is some reported unemployment amongst dentists in Italy, because of supply-demand imbalance, mainly in southern Italy.

Movement of dentists across borders

In 2013, this was a negligible phenomenon and was limited to areas near the borders.

Specialists

Year of data:	2012
Orthodontics	1,795
Oral Surgery	16
OMFS	640

Stomatology	11,016

In Italy, two specialties, Oral Surgery and Orthodontics are recognised. There is also a medical specialty of Oral Maxillo-facial surgery.

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 (up to 5%).

Please see the next column for more details of specialties

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.

Numbers with "special interest" in each subject

Description	Number
Odontostomatologic surgery	344
Odontostomatologic surgery N.O.	4
Dental practice	37
Dental and stomatological practice	214
Dentistry	1,031
Dentistry and prosthetics	143
Dentistry and dental prosthetics	957
Dentistry and prosthetics	1,319
Dentistry and stomatology	129
Odontostomatology	5,850
Odontostomatology II	68
Odontostomatology N.O.	651
Stomatology	114
Stomatology (oral diseases and prosthetics)	110
Stomatology and dentistry)	45
	11,016
Orthodontics and gnathology	9
Orthodontics	23
Orthodontics and gnathology	1,763
	1,795
Oral surgery	16

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

The profession is ruled by Law n. 43/2006

Education and training is provided by universities and is for three years, leading to a diploma, which must be obtained before a dental hygienist may legally practice. There is a *Numerous Clausus* to access the course and an exam of admission has to be passed. There is no compulsory registration upon qualification.

A two years' postgraduate specialisation is available.

Hygienists can only work under the prescription of a dentist. Their duties (defined by Decree in 1999) include oral hygiene and prevention instructions. Hygienists are not permitted to provide local anaesthesia. Most of hygienists work as independent professionals, with no fixed fees.

Dental Technicians

Dental technicians are trained in technical schools, in a three plus two year course, which is needed to get the diploma of a technician. After the first three years, the student must pass an examination to become '*Operatore meccanico odontotecnico,*' which will entitles practise exclusively as an employee.

For a self-employed practice, the student must continue the course for another two years, and then pass another examination, which will lead to a licence to practice. Students passing this examination will also achieve a 'high school' level diploma, which eventually could permit the access to the university course in Dentistry.

The qualification has to be registered to the *Camera di Commercio* of each Province.

To be entitled to be a manufacturer of custom medical devices, a dental technician must apply for a special registration, at the Ministry of Health.

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.

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

Their duties, as stated by the CCNL (National Collective Work Contract), 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:	2011
General practice (see below) *	41,939
Public dental service **	3,157
University	400
Hospital	300
Armed Forces	100
General Practice as a proportion is	91%

* Source: Agenzia Entrate 2011

** Source: Ministry of Health

General Practice figures *	
Dentists, independent practice	35,339
Dental clinics	5,062
Dental companies	1,538

*** This refers to "associates offices" ("studi associati") which are, under a statutory law, different both from single practitioners' offices and "dental companies".These are included in general practice.

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".

About 42,000 dentists were self-employed in 2013, including a number of physicians practising general medicine who have dental equipment in their office. The Ministry of Finance lists as dentists those who have a specific fiscal dentistry code They charge fees almost exclusively as 'items of service', the levels of which are controlled by market forces. They work work mostly in small or medium sized practices (80%) in relation to the number of patients and staff. Not all are owners – many are "associates" who work on commission.

A survey by ANDI Servizio Studi (Research Department), carried out at the beginning of 2012, showed that many dentists struggle to open their own practice within 5 years from the date their professional registration. Despite this fact, in 2011, 91% of registered dentists had their own practice.

The ANDI study, referred to earlier, indicated a deterioration of employment from the previous year. Nevertheless, the majority of Italian dentists were reacting to this situation by investing in their profession and in particular by modernising their practices, in particular by investment in high-tech equipment.

The structure of practice is slowly changing. Increasing numbers of dentists share offices and establish multiprofessional clinics. Many young dentists are forced tby economic factors to become salaried other than self-employed dentists.

Employment contracts for dental staff members are agreed at national level. This contract, which rules salary, hours of work, sickness insurance, holidays, maternity leave, retirement and social security, is not exclusive to dental practice, but to all regulated professions which run independent offices.

Joining or establishing a practice

Dentists must apply to the Region in order to get the authorization to establish a practice. The relevant requirements may vary from Region to Region.

Fee scales

The law for liberalisation (L. 248/06) has abolished dental minimum fees. In November 2007 ANDI produced and published the "Nomenclature & Fees Booklet", which Italian dentists follow on a voluntary basis.

Future developments

Italian dentists overwhelmingly (69%) disagree with the rules on tariff liberalisation in terms of advertising, including professional societies, etc. In particular, they are against the possibility of creating partnerships between professionals with capital partners. Those in agreement with the rules (15.7%) were predominantly women under 35 years of age. Despite the criticism on this new instrument of practice, which is awaiting the issue of decrees leading to operation, nearly half of all dentists will consider the possibility of joining these companies (see "Corporate Dentistry" in the next section).

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.

Theoretically, everyone is eligible to receive this service, but in reality it is mostly used by the lower or 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.

Working in Hospitals

Some dentists are employed in hospitals, either full or part-time, to treat hospitalised and non-hospitalised patients.

To gain access to hospital employment dentists must apply a local or national call for tender.

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

There are two main national dental associations, the Associazione Nazionale Dentisti Italiani (ANDI) and the Associazione Italiana Odontoiatri (AIO).

	Number	Year	Source
ANDI	23,396	2012	ANDI
AIO	7,053	2012	FDI

ANDI

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 (as ANDI was called at that time) changed its constitution to allow them to become members.

ANDI has an Executive Board formed by the President, 4 Vice Presidents, 1 National Secretary, 1 Secretary dedicated to cultural issues, 1 Secretary dedicated to the issues concerning the management of profession and a Treasurer. They are elected, according to the 2010 Constitution, every four years by the Elective Congress.

ANDI has its own Head Office located in centre of Rome with a full time staff of 10 employees and a second national office dedicated to specific services (ie insurance, media center, Fondazione ANDI) in Milan. From May 2008 all the activities carried out by ANDI Headquarters have been certified according ISO-9001 Certification.

ANDI has 20 regional branches and 100 provincial branches with their own offices and employees.

ANDI Publications are distributed free of charge to all members and Institutions.

AIO

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 two employees. AIO has 50 provincial/district branches in every region and Italian province, with their offices and employees. AIO Publications are distributed free of charge to all members and another 18,000 dentists. The AIO website www.aio.it is the most visited dental website since 2004. AIO is an ISO 9001 provider of Italian Ministry of Health for Continuing Education in Medicine for all health professionals.

AIO has received the Patronage of the Italian Ministry of Health for the publication of the Guidelines for Prevention in Dentistry.

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 (National Federation of Medical and Dental Chambers).*

It was founded in 1946 with the purpose to coordinate the provincial Chambers 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 Chambers that the National Federation represents unitarily, develop different functions and the more important are :

1. Keep the Roll
2. To maintain the independence and dignity of the Chambers 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 provincial medical and dental chamber by a commission of 5 dentists, who are elected every three years. There is no consumer or other citizen/patient representation but legal advice may be available.

At the beginning of each mandate, the Presidents of the Provincial commissions elect a national commission, again composed of 5 members, which then appoint its own national president.

ANDI has adopted in 2013 a specific and more restrictive Ethical Code for its own members.

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 code infringement, a dentist can have imposed four levels of sanctions: warning, censorship, temporary suspension from practising for up to a maximum of six months, or erasure from the register.

Dentists can appeal to a National Appellate Court for disciplinary judgments (Central commission for health prefessions – Ministry of Health. *Commissione Centrale Esercenti professioni sanitarie – CCPS.*)

Patients may report ethical problems before opening a lawsuit.

Standards

There is no formal monitoring in any sector, other than patient complaints. In private practice these would be directed to the appropriate ethical committee.

In the Public Service they are first investigated by a clinical officer who, theoretically, has the power to suspend or discharge the dentist concerned. In practise 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/sensible 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. A National Authority is in charge for surveillance upon citizens' request

Advertising

Dental services can be advertised according to the Code of Ethics and general law. Dentists (and physicians as well) cannot make any comparative advertising. They can only inform patients about every aspect of the profession (ie office staff, fees, provided services) as long as they are–related to the argument to be advertised, truthful and correct, not violating the obligation of professional secret, not ambiguous, misleading and denigratory (Presidential decree n. 137/2012, art.4)

Insurance and professional indemnity

Liability insurance will be compulsory for dentists and physicians from August 2014.

A general national insurance policy does not exist. There are instead a number of private insurance companies as well as insurance policies proposed by professional associations. There are no uniform costs, as they depend from the specific professional activity the dentist is practicing.

Corporate Dentistry[26]

From 2013 a new kind of professional company has been introduced in Italian law: Società Tra Professionisti (STP). This professional company allows dentists to join together with other (non-dentist) professionals and with non-professional associates, but clinical matters must be the responsibility of a Dental Director.

Registration of the STP is mandatory, both in a special register kept by the local Medical and Dental Chamber, and in local Trade Chamber - similarly to any other trade company.

[26] In 1997 the law 1815/39 (from 1939), preventing professionals from establishing joint companies with non-professional associates, was abrogated. But at that time (in 1997), the government did not introduce new legislation on "professional companies", which operate in other EU countries. This "vacatio legis" permitted dentists to "legalise" their practices with a "commercial company" in which they owned the office and equipment, while "officially" the practice was run by a "health director" (physician or dentist) who may or may not be an associate. Sixteen years later and after many legislative failures, a new law offers the opportunity of establishing a professional company where non-professional associates cannot prevail. The 1,538 dental companies recorded above are pure commercial companies with or without professional associates

Tooth whitening

Cosmetic Directive 2011/34 was implemented in Italian law in October 2012. At September 2013 tooth whitening products (TWP) containing more than 6% of hydrogen peroxide were still available for professional dental use labelled as "medical devices".

The Minister of Health granted the requests made by ANDI, to put forward a Law Decree, approved in July 2013 by the Council of Ministers, a rule which heavily penalises those who exercise and those who favour the illegal exercise of a health profession

Health and Safety at Work

In case of accidental inoculation or wound from sharp instruments used on patients - potentially "high risk, public health services are immediately available for any dental staff member to make any appropriate laboratory exam or prevention treatment. Each employee is furthermore protected by compulsory workers' national insurance (INAIL).

Ionising Radiation

Radiation protection is regulated by law, according to UE Directives. Continuing education in radiation protection is mandatory for dentists with updates on a regular basis.

The X-ray equipment must be registered and, every two years, equipment must be checked by a "qualified expert", ie an engineer or a nuclear physicist.And, continuing education and training of 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

For self-employed dentists the mandatory contribution to the professional pension fund (ENPAM, co-shared by both dentists and physicians) is 12.5% of gross earnings. Starting from 2014, this will be raised gradually to 21% in year 2021.

Besides the pension benefits based on individual contributions, this pension scheme provides coverage for ill-health retirement, maternity leave, and survivors' pension benefits.

Dentists who are employed in the NHS or other private or public clinics and offices are entitled to pay a reduced rate of 2% to ENPAM, besides what is paid to the mandatory national general pension fund (INPS): 8,89% charged on the employee salary and an additional fee, up to 32,7 %, paid by the employer.

Retirement pensions in the public sector are usually based on 80% of the final salary. Retirement ages are 63 (women) and 65 (men).

In the public sector dentists can practice until the age of 70. In private practice the self employed dentist retirement age is a free choice.

Taxes

Taxation in Italy is progressive. From 2011, personal income taxation varies in five bands, from 23% for income up to €15,000 to 43% for income over €75,000.

Currently (in 2014) self-employed people pay 5% extra tax on their gross annual income, as a contribution to public health.

VAT/sales tax

VAT is payable at various rates depending on the type of goods. Standard VAT rate: is 22% (Oct 2013), and there are reduced rates of 10% on pharmaceuticals, passenger transport, admission to cultural and entertainment events, hotels, restaurants. A reduced rate of 4% is applied to foodstuffs, medical, books

Dentists pay 22% 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

Rome ***Zurich = 100***	**2003**	**2013**
Prices (including rent)	79.7	72.0
Wage levels (net)	33.4	36.4
Domestic Purchasing Power	44.3	48.6

Source: UBS August 2003 and November 2012

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 journals There are also several journals published by scientific societies in different clinical areas: endodontics, prosthetic, implantology, restorative, pedodontics, prevention, etc.

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: +39 071 2206219/20 Fax: +39 071 2206221 Email: m.procaccini@univpm.it Dentists graduating each year: 25 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: +39 080 5478762 Fax: e-mail a.desiate@doc.uniba.it Dentists graduating each year: 18 Number of students: 140
Name of school: Bologna **UNIVERSITÀ DEGLI STUDI DI BOLOGNA** **DIPARTIMENTO DI SCIENZE ODONTOSTOMATOLOGICHE** Via San Vitale 59 - 40125 Bologna ITALY Tel: +39 051 278011 Fax: +39 051 235208 E-mail: carlo.prati@unibo.it Dentists graduating each year: 30 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: +39 030 394544-3995780-383424 Fax: +39 030 303194 Email: paganell@med.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: +39 070/537411 Fax +39 070/537416 e-mail: vpiras@unica.it Dentists graduating each year: 20 Number of students: 100	**Name of school: Catanzaro** **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 09613697215 Fax: +39 09613697276 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	**Name of school: Chieti** **UNIVERSITÀ DEGLI STUDI DI CHIETI** **Dipartimento di Scienze Odontostomatologiche** Via dei Vestini, 31 - 66100 CHIETI ITALY

ITALY Tel. and Fax +39 095/3782759 E-mail: malber@unict.it Dentists graduating each year: 23 Number of students: 120	Tel +39 0871 3554070 Fax +39 08713554070 e-mail: artese@unich.it Dentists graduating each year: 54 Number of students: 200
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. +39 032-205277 Fax. +39 032-202329 Email: g.calura@unife.it Dentists graduating each year: 20 Number of students: 70	**Name of school: Toscana - 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. +39 055/331130 Fax +39 055/331130 Email: odontopdm@odonto.unifi.it Dentists graduating each year: 22 Number of students: 110
Name of school: Foggia **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 0881 588041 – e-mail: presidenza.odontoiatria@unifg.it Dentists graduating each year: none yet Number of students: 70	**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. +39 010/3537235 or 7370-7362 Fax. +39 010/3537352 Email: giorgioblasi@unige.it Dentists graduating each year: 25 Number of students: 140
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 0332 825625 Fax +39 0332 825655 Email angelo.tagliabue@uninsubria.it Dentists graduating each year: 20 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 0862433836 Fax: +39 0862433826 Email: roberto_gatto@virgilio.it Dentists graduating each year: 30 Number of students: 150
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. +39 090/ 2216901 Email: cordasco@unime.it Dentists graduating each year: 25 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 02/50320237 or +39 02/50320238 Fax +39 02/50320239 Email: andrea.sardella@unimi.it Dentists graduating each year: 60 Number of students: 240

Name of school: Milano **UNIVERSITÀ DEGLI STUDI DI MILANO - BICOCCA** **Dipartimento di Neuroscienze e Tecnologie Biomediche CLINICA ODONTOIATRICA** Azienda Ospedaliera S. Gerardo ITALY Tel. +39 039.233-2301/2143/3485 Fax +39 039/2333482 e-mail: marco.baldoni@unimib.it Dentists graduating each year: 30 Number of students: 130	**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. +39 059/4222326-361181 Fax +39 059/373428 – Email – segr.clopd@unimore.it Dentists graduating each year: 15 Number of students: 70
Name of school: Napoli **UNIVERSITÀ DEGLI STUDI DI NAPOLI** **Dipartimento di Scienze Odontostomatologiche e Maxillo-facciali** Via Pansini, 5 – 80131 Napoli ITALY Tel. +39 081/7462192 Dipartimento: Tel. +39 081/7462089 Segreteria: Tel. +39 081/7462088 – Fax: +39 081/7462197 E-mail: matarass@unina.it Dentists graduating each year: 30 Number of students: 120	**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. +39 081/5665476 Fax +39 081/5665477 Email : gregorio.laino@unina2.it Dentists graduating each year: 24 Number of students: 120
Name of school: Padova **UNIVERSITÀ DEGLI STUDI DI PADOVA** **Dipartimento Integrato Interaziendale di Odontoiatria** Via Venezia, 90 – 35100 Padova ITALY Tel. +39 049 8213999 - 8218669 Fax +39 049 8070364 Email: marialuisa.valente@unipd.it Dentists graduating each year: 25 Number of students: 140	**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. +39 091.6552208 Fax +39 091.6552203 e-mail: giuliana@unipa.it Dentists graduating each year: 25 Number of students: 120
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 0521292759 or +39 0521702033 Fax +39 0521292955 Tel. +39 0521986722 e-mail: mauro.gandolfini@unipr.it Dentists graduating each year: 25 Number of students: 100	**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 0382-423516 Tel +39 0382-516203 e-mail: discodon@unipv.it Dentists graduating each year: 22 Number of students: 110

Name of school: Perugia

UNIVERSITÀ DEGLI STUDI DI PERUGIA
CORSO DI LAUREA IN ODONTOIATRIA E PROTESI DENTARIA
Policlinico Monteluce - 06100 Perugia
ITALY
Presidenza: Tel. +39 075/5855804
Segreteria: Tel. +39 075/5855808 or +39 075/5855809
Email: stefano.eramo@alice.it
Dentists graduating each year: 15
Number of students: 75

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 "TOR VERGATA"
CORSO DI LAUREA IN ODONTOIATRIA E PROTESI DENTARIA
Policlinico "Tor Vergata" Viale Oxford, 81 00133 Roma
ITALY
Tel. +39 06/20900270
Fax +39 0620900269
Email: paolacozza@tiscali.it

Dentists graduating each year: 33
Number of students: 160

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 06/44230812
Fax +39 0649976603
Email: ersilia.barbato@gmail.com
Dentists graduating each year: 66
Number of students: 300

Name of school: Roma (PRIVATE)

UNIVERSITÀ CATTOLICA DEL SACRO CUORE
ISTITUTO DI CLINICA ODONTOIATRICA
Largo "A. Gemelli", 8 - 00168 ROMA
ITALY
Tel. +39 06/30154079 - +39 06/30154286
Fax +39 06/3051159
e-mail: iclod@rm.unicatt.it
Dentists graduating each year: 25
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. +39 079/228507
Fax +39 079/228541
Centralino Università: Tel. +39 79/228211
Email: pfluglie@uniss.it
Dentists graduating each year: 20
Number of students: 100

Name of school: Toscana -Siena

UNIVERSITÀ DEGLI STUDI DI SIENA
DIP. DI SCIENZE ODONTOSTOMATOLOGICHE
Viale Bracci – Policlinico Le Scotte,
53100 Siena
ITALY
Segreteria: Tel. +39 0577/585771
Direzione: Tel. +39 0577/585772 or +39 0577/42383
Fax +39 0577/586155
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 0116334045-4055-4043
Fax +39 0116636489
Email: stefano.carossa@unito.it
Dentists graduating each year: 45
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 +39 040/3992263
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Email r.dilenarda@fmc.units.it
Dentists graduating each year: 30
Number of students: 100

Name of school: Verona

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
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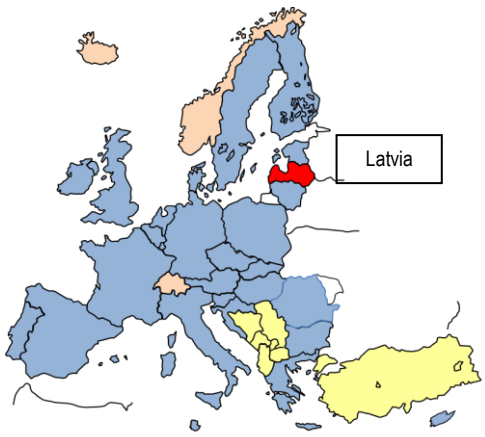
ITALY
Tel. +39 045581212 - +39 0458124251
Fax +39 0458027437
Email: pierfrancesco.nocini@univr.it
Dentists graduating each year: 25
Number of students: 100

Name of school: Milano (PRIVATE)

UNIVERSITÀ VITA SALUTE SAN RAFFAELE - MILANO
CORSO DI LAUREA IN ODONTOIATRIA E P.D.
Via Olgettina 48. 20132 Milano
ITALY
Tel. +39 02/26432970 - +39 02/26432994
Fax: +39 02/26432953
Email: gherlone.enrico@hsr.it
Dentists graduating each year: none yet
Number of students: 70

2012	Number of dental students	Annual dental graduates	Number of hygienist students	Annual hygienist graduates
Ancona	120	24	45	15
Bari	140	18	45	15
Bologna	150	30	45	15
Brescia	100	20	45	15
Cagliari	100	20	60	20
Cantazaro (new school)	30	0	30	15
Catania	120	23	15	
Chieti	200	54	30	10
Ferrara	70	20	30	10
Firenze	110	22		
Foggia (new school)	35	0		
Genova	140	25	72	24
Insubria	100	20	60	20
L'Aquila	150	30	30	10
Messina	120	25	10	
Milano	240	60	240	80
Milano Bicocca	130	30	90	30
Modena	70	15	30	10
Napoli	120	30	60	20
Napoli	120	24	45	15
Padova	140	25	90	30
Palermo	120	25	40	20
Parma	100	25		
Pavia	110	22	48	16
Perugia	75	15		
Pisa	75	14	45	15
Roma Tor Vergata	160	33	60	20
Roma La Sapienza	300	66	150	50
Sassari	100	20	20	10
Toscana-Siena	120	24	105	35
Torino	200	45	90	30
Trieste	100	30	45	15
Verona	100	25	70	20
Public total	4,065	859		
PRIVATE				
Roma	120	24	60	20
Milano San Raffaele (new)	70	0	75	25
Overall total	4,185	883	1,880	630

Latvia



In the EU/EEA since	2004
Population (July 2013)	2,178,443
GDP PPP per capita (2012)	€13,905
Currency	Euro
Main language	Latvian

Medical services thus provided are free for patients, through the NHS. Oral healthcare for adults is paid for through private practice. State funded healthcare is free for children (except orthodontics), the military and persons affected by Chernobyl.

Number of dentists:	1,724
Population to (active) dentist ratio:	1,478
Membership of Dental Association:	100% of active dentists

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

Date of last revision: 20th January 2014

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.

Latvia changed its currency to the Euro on January 1st 2014.

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 National Health Service (NHS) 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 adults who are victims of the Chernobyl nuclear catastrophe, are exempt from charges.

		Year	Source
% GDP spent on health	6.5%	2010	LDA
% of this spent by government	55.4%	2010	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 publicly financed through the the National Health Service (NHS) for children up to the age of 18 (with the exception of orthodontic treatment). In 2011, the average cost per child was €38.54 per year and covered approximately 54.1% of all children. 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 institutions of the NHS, 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 National Health Service NHS, local governments, school councils, dental and general medical staff, 4 regional and 4 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 54.1% of under-18s are known to visit a dentist at least once a year. As Latvia is a small but densely populated country, some problems with access to oral healthcare for patients are reported.

		Year	Source
% GDP spent on oral health	0.20%	2010	LDA
% of OH expenditure private	78%	2010	LDA

Quality of Care

The competent authority which maintains dentists' registration and dental practice accreditation (every five years) is the Health Inspectorate (HI), 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 HI 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	2.90	2012	LDA
DMFT zero at age 12	21%	2012	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 2013. 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 secondary school graduate,

2. there is competition among applicants after they have completed a high school diploma.

3. Additional reguirements – there is a Test on Professional Suitability

Year of data:	2012
Number of schools	1
Student intake	35
Number of graduates	32
Percentage female	87%
Length of course	5 yrs

There is one dental faculty, which is located in the Riga Stradinš University and is publicly funded. More than 5 in 6 of graduates are female. In 1993 a new dental education programme was introduced for students and dental hygienists, which was established 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: *zobārsts (dentist).*

Vocational Training (VT)

Following undergraduate training, the new dentist receives professional certification. There is no longer any Vocational Training in Latvia.

Registration

The register is administered by The Health Inspectorate. 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. Re-registration is necessary every 5 years.

There is no fee for registration.

To register a dentist must have a recognised degree or diploma.

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.

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 practise. 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 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, "residency training" (by competition for a vacancy), which is completed by a successful defence of one's doctoral dissertation.

Training is provided within the Riga Stradinš University's Faculty of Stomatology. In 2013 there were 10 doctors in specialist training as residents, but three of them were on sabbatical leave. Specialist training takes 3 years on average.

Trainee specialists are paid during training.

Workforce

Dentists

Year of data:	2012
Total Registered	1,724
In active practice	1,474
Dentist to population ratio*	1,478
Percentage female	87%
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 1999 certificates for good practice have been issued to 5.6% of Latvian dentists. There are no data about returned professionals. There are a small number of dentists practising who qualified outside Latvia.

Specialists

Six dental specialities are recognised, besides Oral Maxillo-facial Surgery.

Year of data:	2012
Orthodontics	24
Endodontics	10
Paedodontics	23
Periodontics	0
Prosthodontics	19
Oral Radiology	0
Oral Surgery	0
Dental Public Health	0
OMFS	39

Patients normally only attend specialists on referral from a primary practitioner.

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:	2012
Hygienists	219
Technicians	551
Denturists	0
Assistants	1,360
Therapists	87

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.

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. The majority of those formerly trained are now retired.

Dental Technicians

Training as a dental technician takes place at Riga 1st Medical Colleague 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:	2012
General (private) practice	1,402
Public dental service	10
University	31
Hospital	31
Armed Forces	0
General Practice as a proportion is	95%
Number of General practices	727

Working in General Practice

Dentists practice in *individual dental practices* – by registering with the Latvian Physicians' 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 or private dentistry depends on the demands of the patient.

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. Adults pay the full set treatment fees of 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 provided universally to all, including children, children with pathologies, oral-maxillofacial surgery treatments and for any person who needs emergency health care.

Dental care is free of charge for children up to 18 years, except orthodontic therapy, for which they have to pay in full. Basic oral maxilla-facial surgery is free for all patients, although patients have to pay an appointment fee.

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 programmes, 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 48 public or municipal 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 second largest city – 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

There are no longer any dentists who work for the Armed Forces.

Professional Matters

	Number	Year	Source
Latvian Dental Association	1,474	2012	LDA

Professional association and bodies

There is a single main national association, the *Latvian Dental Association*.
The organisation is representative of dentists (only) and has an elected board and President. There is a central office with part-time staff. Membership is not mandatory.

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 (auxiliaries),
- 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.

The Minister of Health appoints the director of the Centre as a member of Council of Strategy 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 Inspectorate (HI) 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 HI 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 HI provides a detailed explanation of the situation at hand and provides a justification for its decision. In cases when claim is sound, the HI 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. The cost depends upon the insurance company and the dentist's speciality. There will be a Medical Risk fund from 2014.

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 Health Inspectorate. 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 ten years. There is a State Register of radiation equipment, furthermore postgraduate training of competent dentists in the field of radiation protection is held every 5 years. 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	The Health Inspectorate
Medical devices	The Health Inspectorate
Waste disposal	State Environmental Health Ministry

Financial Matters

Retirement pensions and Healthcare

The 2013 Law on State Pensions stipulates that the then current retirement age of 62 will be increased by three months every year, starting from 2014, until it reaches 65 in 2025.

Social security contributions are levied on both employees and employers. The general contribution is 35.09%, which consists of an employer portion of 24.09% and an employee portion of 11%.

Compulsory social insurance contributions are determined by law and paid into a special fund that gives an insured person the right to receive social insurance services.

Resident employers must pay national social insurance on a monthly basis.

The amount of pension depends on social taxes paid and social funds accrued.

Taxes

The tax rate on income for an individual is 24% and is 15% for capital gains. There is a 10% rate for other types of income from capital, such as dividends, securities and interest income.

VAT/sales tax

Value added tax is levied on the sale of goods and the supply of services at a standard rate is 21%, with a reduced rate of 12% applicable to certain goods and services. Certain supplies are zero, including dental treatment.

Various Financial Comparators

Riga ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	49.9	46.0
Wage levels (net)	16.2	16.2
Domestic Purchasing Power	32.5	31.1

Source: UBS August 2003 and November 2012

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: info@lza-zobi.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 "Zobārstniecības raksti" Tel/Fax: +371 6745 5058 E-mail: gzigurs@acad.latnet.lv

Dental Schools:

For dentists:	***For hygienists:***
Ingrida Čēma 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

Government

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 37,009 (2013) 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.

Date of last revision: 24th September 2013

Liechtenstein has been a member of the European Economic Area since May 1995. The unit of currency is the Swiss Franc (CHF).

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 2,500 (€1,715). 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

There is no public fluoridation in Liechtenstein, although there is salt fluoridation.

		Year	Source
% GDP spent on oral health	3%	2004	OECD
% of OH expenditure private	No data		

Training

There is no dental school, so 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 be registered by the *Amt für Gesundheitsdienste*, a public authority. The annual registration fee in 2013 was €820.

Workforce

Dentists

Year of data:	2013
Total Registered	57
In active practice	48
Dentist to population ratio*	771
Percentage female	23%
Qualified overseas	57

* active dentists only

Most dentists in Liechtenstein work in general practice. There are few working in the research in the dental industry.

The usual retirement age for dentists is 65.

Specialists

In 2013 there were 2 orthodontists, 1 periodontist and 1 oral surgeon in Liechtenstein.

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:	2013
Hygienists	8
Technicians	27
Denturists	0
Assistants	105
Therapists	0
Other	

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 is no fee for registration of chairside assistants or dental technicians.

Practice

Year of data:	2013
General (private) practice	45
Public dental service	
University	
Hospital	
Armed Forces	
General Practice as a proportion is	94%

Professional Matters

	Number	Year	Source
Liechtenstein Dental Association	28	2013	LDA

The Liechtenstein Dental Association also had 16 guest members in 2013. 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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Financial Matters

GDP at PPP (per capita) in 2009 was €66,300 [source CIA Worldfactbook]

Pensions

These are paid from the age of 64 and are based on annual average earnings, calculated based on employment income, contributions made while nonemployed, and recognised care-giving periods for children or persons in need of care.

They are funded by proportionate contributions from earnings (up to 7.8% for the self-employed), with no maximum limit of earnings.

Taxes

Income Tax

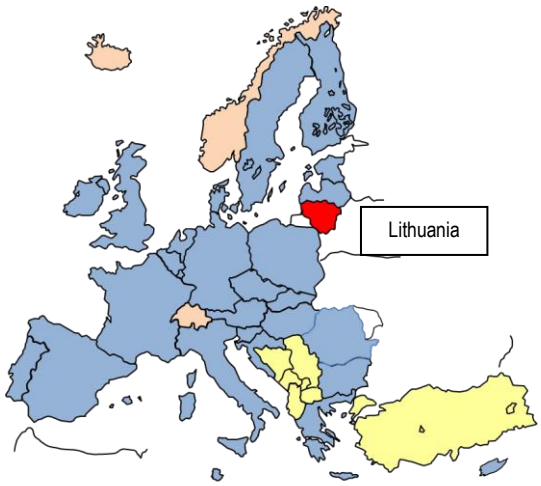
Rates for national income tax are progressive up to 7%. Municipal multipliers range from 1.5 to 2.5 (ie theoretical maximum combined rate of 24.5%, although in 2013 the multiplier does not exceed two in any municipality)

VAT

Based on the Customs Union Agreement of 29 March 1923, Liechtenstein is considered part of Switzerland for VAT purposes. VAT applies to the sale of goods and services in Liechtenstein, and to the import of goods and services into Liechtenstein. Exports of goods and services are, in principle, zero-rated

The standard VAT rate is 8%. Dental materials are charged at this standard rate. Certain goods and services are subject to a reduced rate of 2.5% (this includes medicaments and prophylaxis materials). Other services (for example, dentistry and most banking services) are exempt. A special 3.8% rate applies to the hotel and lodging industry.

Lithuania



In the EU/EEA since	2004
Population (2008)	2,962,000
GDP PPP per capita (2012)	€16,465
Currency	Litas (LTL)
	3.45 LTL = €1.00 (2013)
Main language	Lithuanian

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:	3,660
Population to (active) dentist ratio:	820
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.

Date of last revision: 26th January 2015

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 Republic of Lithuania 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 2013, average monthly earnings were about 2,233 litas (€647) and unemployment was about 13% 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 on 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 18.2% of the population was over 65 years in 2013.

The social insurance system is administered by a number of organisations:

		Year	Source
% GDP spent on health	6.6%	2011	World Bank
% of this spent by government	71.3%	2011	World Bank

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 Minister 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 3,200 people, is responsible for the administration of the SSIF through its central office in Vilnius and 13 institutions function under SoDra's subordination: 10 territorial offices, the Branch of Military Structures and Other Similar Structures, Foreign Benefit Office and Training Center.

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 to be 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	0.16%	2012	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 year 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. A study carried out in 2009 showed that the prevalence of malocclusion among 7–15-years old Lithuanian schoolchildren was 84.6%. The need for orthodontic treatment in the group of 10–11 years old children was 49.9 % and the need for orthodontic treatment in the group of 14–15-years old children was 33.9 %.

Public compulsory health insurance

The national health insurance system scheme offers reimbursement of the cost of some dental treatment. In 2012, 158.35 million Litas (€45.86 million) from the compulsory health insurance fund (SSIF) was allocated to dental care. More than two thirds (68.6%) of this was for primary dental care. About two thirds of this was for primary dental care.

In 2013 there were 266 public and 1817 private clinics (registered with the Chamber).

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

Private insurance for dental care is not available 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 certification.

The State Inspectorate of Medical Audit (SIMA) was reorganised by merging the State Health Care Accreditation Agency under the Ministry of Health. This 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 into the investigation of patient complaints about the quality of care.

Health Data

		Year	Source
DMFT at age 12	3.70	2005	WHO
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 year old children with a zero DMFT. "Edentulous at age 65" refers to the numbers of over 64s with no natural teeth

Oral health care institutions in Lithuania use these data for monitoring oral health status, namely the DMFT index and type of occlusion. This enables the collection of epidemiological data about dental caries prevalence and incidence in the country, as well as the prevalence of malocclusion.

From 2013, all children under 18 years of age have to deliver a certificate to schools and kindergartens, from oral health care institutions, about their oral health status, namely DMFT index and type of occlusion. This will enable epidemiological data about dental caries prevalence and incidence in the country, as well as the prevalence of malocclusion, to be recorded. In addition, the monitoring of the dynamics of disease and levels of dental care for children in Lithuania will be possible.
There is a State programme for sealing pits and fissures of premolar and molar teeth in children. Every child in the country between 6 and13 years of age has a right to receive sealants for free.

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 in the Faculties of Odontology of the two universities: Vilnius University and the Lithuanian University of Health Sciences. Admission to the study programme is carried out according to joint regulations
of Lithuanian Higher Institutions Association for Organising Joint Admission (LAMA BPO). Both dental schools are publicly funded.

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 their secondary education final examination (biology, chemistry, Lithuanian language, mathematics), and annual marks averages. Each year the admission system is updated and upgraded.

Year of data:	2013
Number of schools	2
Student intake	161
Number of graduates	161
Percentage female	83
Length of course	5 yrs

Student numbers in 2013 were reported by the Chamber as 805, so it appears that there are no students failing to complete the course..

The undergraduate training programme is for 5 academic years (300 ECTS) with integrated internship studies. In the final year, a mandatory subject in the 10th semester is an internship (20 credits) during which students, supervised by teachers, consolidate the theoretical and practical knowledge gained during earlier semesters in operative dentistry, prosthetic dentistry, paediatric dentistry, oral surgery and orthodontics. It was integrated in 2003. Teaching languages are English and Lithuanian. Teaching is undertaken by full or part time university teachers who hold contracts with the university.

The Chamber reported in 2013 that there were 60 students from outside Lithuania studying at the two dental schools and 16 foreign students graduated that year.

The responsibility for quality assurance in the faculties is by the Centre for Quality Assessment in Higher Education, Ministry of Education, the Chancellor of the University, local Study committies of universities 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)

There is no post-qualification vocational training; it is integrated into the 5-year under-graduate curriculum

Registration

Access to the profession is regulated by the statutes and is restricted to the holders of the *Licence to practice* - odontologist or specialist in odontology (endodontist, orthodontist, paedodontist, periodontologist, prostho-dontist, oral 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 (2013)	€ 19

There is also an annual fee of 200 Litas (€57.90) 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.

Postgraduate and Specialist Training

Continuing education

The Lithuanian Dental Chamber coordinates the continuing education of dentists and oral health care specialists. This function is performed by the Commission on Informal Education. It sets up main principles of the Continuing Professional Development 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

3-year postgraduate specialist training programmes (Residency) in order to obtain the specialist diploma - *License of Odontologist Specialist in endodontology, orthodontics, paedodontics, periodontology, prostho-dontics and oral surgery* are undertaken at the The Lithuanian University of Health Sciences or the University of Vilnius.

Workforce

Dentists

The active dental workforce is stable, but increasing slowly. There is no reported real unemployment among dentists, although individuals may not be working for short periods.

Year of data:	2013
Total Registered	3,660
In active practice	3,610
Dentist to population ratio*	820
Percentage female	83%
Qualified overseas	94
* this refers to "active" dentists	

Movement of dentists across borders

Approximately 94 dentists asked for a "Certificate of Good Standing" to work abroad through the years from 2008 to the end of 2013, but there is no a reliable source of information how many of them left Lithuania.

Specialists

There are 7 recognised specialties in Lithuania:

Year of data:	2013
Orthodontists	93
Endodontists	44
Paedodontists	56
Periodontists	57
Prosthodontists	270
Oral Radiologists	
Oral Surgeons	92
OMFS	23

Dental specialists comprise about 17% 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 a patient wishes to go directly for a specialist consultation, this is acceptable, but he/she would then have to pay the fees.

Auxiliaries

Dental auxiliaries are known as *Oral Health Care Specialists*. They must be registered with the 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:	2012
Hygienists	572
Technicians	1,114
Denturists	0
Assistants	1,823
Therapists	0
Other*	81
* Assistant's Helpers	

Dental Hygienists

Hygienists are permitted to work only provided they have a diploma. They are trained at the University of Applied Sciences of Kaunas, Panevezys, Utena, Šiauliai and Klaipeda for 3 years; and the Lithuanian University of Health Sciences for 4 years.

Graduates of the Lithuanian University of Health Sciences 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. There are 16 to 18 graduates each year.

Hygienists can practise as an employee, employer or freelancer. They may accept payments from patients. They have competence to undertake 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. Its aims are: to ensure the possibilities of improving qualification, represent its members, cooperate with other analytical organisations, provide preventive work of oral health care, inform the public about the dental hygienist academic and other achievements.

In 2013 it was reported by the Chamber that about 50 hygienists were members of the Dental Hygienists' Association.

Dental Technicians

Dental technicians train in the University of Applied Sciences 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.

The Lithuanian Association of Dental Technicians suspended operation in 2004. In 2010, the activities were restored. By 2013, there were 147 oficially registered members of the Association. .

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 a Dental Assistant; they are registered with Lithuanian Dental Chamber and have a Licence to practice. They are trained for 3 years in the University of Applied Sciences specifically for dental assistants. The University is in Panevezys, Kaunas, Klaipeda and Utena. 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 2007. Besides assisting the dentist, they are permitted to undertake oral health education.

There is a Lithuanian Dental Assistants Association.

Assistant's helpers

Nursing staff development and specialisation centers educate assistants' helpers. They do not need to register with the Chamber, as their work does not need to be licensed.

Practice in Lithuania

Year of data:	2008
General (private) practice	2,219
Public dental service	538
University	80
Hospital*	
Armed Forces (2013)	13
General Practice as a proportion is	61%

* all OMFS (medical) practitioners

Numbers of dentists in each sphere of practice

These are mostly figures of 2008. Dentists in Lithuania are allowed to work in both private and public dental practice at the same time and the Chamber were unable to provide more up to date data.

Numbers of clinics

Year of data:	2013
GP (private) clinics	1817
Public dental clinics	266
University dental clinics	3
Armed forces clinics	11

Working in Private (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 civil liability of dental practices 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 municipal ambulatory dental departments.

Working in Public Clinics

Approximately 18% of dentists work in municipal ambulatory dental departments (2013). 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 are 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, as listed above. They are the Lithuanian University of Health Sciences and the other the Faculty of Medicine at Vilnius University. Teaching staff are employed according to the requirements set by the university. .

In order to maintain their position to work, teaching staff in every five year period participate in a public competition. If they meet the requirements, they sign a fixed-term employment contract for five years. If the applicant under assessment does not meet the set criteria of pedagogical research or practical work requirements for the position, their academic activity is terminated. The titles of university teachers are: assistant (title As.), lector (title lect.), docent (title assoc. prof.) and professor (prof.). For the positions of lector, docent and professor it is necessary to have the PhD degree.

Staff members are graded as professors (10%), associate professors (30%), lecturers (10%) and assistants (50%). About 50% of staff members are full-time teachers. The teacher/student ratio is 1:8. The qualified academic dental staff members provide supervision during clinical training.

Dentists can work as full-time or part-time employees of the university. According to the employment conditions their salary range is €300-1000 per month. Combination of part-time teaching employment and private practice is permitted by the universities.

Working in the Armed Forces

Dentists serve full-time in the Armed Forces, of whom 9 were female in 2013.

Professional Matters

Professional associations

	Number	Year	Source
Lithuanian Dental Chamber	3,660	2013	Chamber

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 health care specialists - to present them to the Ministry of Health

Odontologists are members of the Lithuanian Dental Chamber (*Lietuvos Odontologų Rūmai*). Membership has been compulsory since July 2004, by law.

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,
- Ministry of health of the Republic of Lithuania
- 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.

According to the data for 2013, a minimum sum of 30,000 litas (€8,688) is estimated for a clinic for one insured event and a minimum sum of 300,000 litas is estimated for all insured events during one year of validity of the insurance contract.

The insurance does not cover for dentists/hygienists 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

Lithuania complies with the Directive of 2011. The use of tooth whitening products is regulated by Lithuanian Hygiene Standard HN 62:2003 "Cosmetic products: general requirements, prohibited and restricted substances"

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.

Each employee must undergo periodic medical examination. There is a 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/ her team. Non-compliance causes sanctions.

Ionising Radiation

There is a requirement to have a Licence for using radiation equipment. There is a primary education period of 20 hours and in every 5 year period persons who work with X-rays (dentists or dental assistants), need to attend 8 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.

Regulations for Health and Safety:

For	***Administered by***
Ionising radiation	Radiation Protection Centre
Electrical installations	The State accredited electrical technicians
Waste disposal	Local government, Ministry of Health
Medical devices	Lithuanian Dental Chamber; State Health Care Accreditation Agency under the Ministry of Health; National Health Insurance Fund under the Ministry of Health; Patient health damage detection Commission; The courts & others.
Infection control	Public Health Center

Financial Matters

Retirement pensions and healthcare

In 2013, the normal age for retirement for women was 61 and for men 63 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. In addition to withholding a 3% pension social insurance and a 6% health insurance contribution on behalf of an employee, an employer must contribute to social insurance at a rate between 30.98% and 32.6% of the employee's gross salary, depending on the risk group. An employer must contribute 0.2% of an employee's gross wages to the Guarantee Fund.

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

Income derived by individuals is generally subject to personal income tax at the standard rate of 15%, although there is a complex system of tax exempt amounts for lower incomes and exceptions apply, such as dividends and other profit distributions are taxed at a personal income tax rate of 20%; income from individual business activities (except income from some professional activities and income from securities is taxed at a rate of 5%.

VAT

The standard rate of VAT is 21% (since 2009). The main dental materials: filling materials, impression materials, instruments, gloves, anaesthetics, disinfectants are charged at this standard 21%. Some auxiliary materials, such as radiographic materials, instruments and equipment for laboratories are also charged at 21% VAT.

There is a reduced rate of 9% on books and a further reduced rate of 5% on pharmaceuticals and medical items.

The cost of dental health care (and other health care too) is VAT free.

Various Financial Comparators

Vilnius ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	46.1	42.4
Wage levels (net)	10.1	16.0
Domestic Purchasing Power	23.4	32.6

Source: UBS August 2003 & November 2012

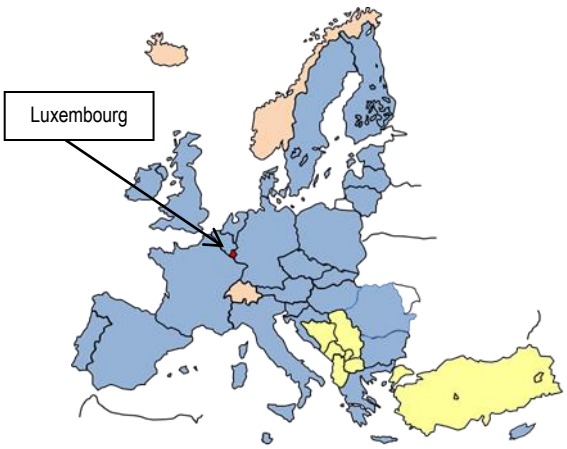
Other Useful Information

Competent authority and main associations:	
Lithuanian Dental Chamber J. Jasinskio g. 16 LT 01112 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 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. The Chamber is responsible for licences and certification	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
Lithuanian Dental Hygienists Association LT-08217 Vilnius Tel: +370 61211514 Email: info@lbhd.lt Website: www.lbhd.lt	Lithuanian Dental Assistants Association Rinktines str. No 4-13 Vilnius LT-09312 Tel/fax: + 370 5 27353 77 Mobile: +370 6 98808 36 Email. tatjana.tomasevic@pylimas.lt
-***Main journal:*** Stomatologija – Baltic Dental and Maxillofacial Journal Kanto 4-1, Kaunas LT-44296 Phone/fax: +370 37 228307 Mobile: +370 6 1271707 +370 683 09583 Email: edoffice@sbdmj.com Website: http://stomatologija-bdmj.lt/apie_zurnala.html	
Main information centre: Statistics Lithuania Gedimino ave 29, LT-01500 Tel: +370 5 2364800 Fax: +370 5 2364845 Email: info@stat.gov.lt Website: http://www.stat.gov.lt/en/home	***Lithuanian Health Information Centre:*** WHO Collaborating Centre Didzioji str. 22, LT-01128 Vilnius, Tel.: +370 52773303, Fax: +370 52624663 e-mail: lsic@lsic.lt or institutas@hi.lt Website: http://sic.hi.lt/html/en/lhic.htm

Dental Schools:

The Lithuanian University of Health Sciences (LUHS) Faculty of Odontology A. Mickevičiaus str. 9, LT – 44307 Kaunas Tel.: +370 37 327201, Fax.: +370 37 220733, E-mail: ricardas.kubilius@kaunoklinikos.lt Website: http://lsmuni.lt/en/ Number of dentistry students (2013): 740 Graduated in 2013: 153	Vilnius University Faculty of Medicine Institute of Odontology M. K. Čiurlionio str. 21, LT-03101 Vilnius Tel. +370 85 239 8700 Fax. +370 85 239 8705 Email: mf@mf.vu.lt Website: http://www.mf.vu.lt/index.php Number of dentistry students (2013):145 Graduated in 2013: 27

Luxembourg



In the EU/EEA since	1957
Population (2013)	537,000
GDP PPP per capita (2012)	€60,028
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:	512
Population to (active) dentist ratio:	1,188
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.

Date of last revision: 29th January 2014

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).
There is one healthcare scheme, the *Caisse Nationale de Santé (CNS),* which is made up of several sick funds. In the board of the *CNS* the representatives of employees and employers have the same number of votes. The President of the *CNS* is a functionary sent by the government, so if the representatives of employees and employers do not find an agreement, the President can determine the outcome.

		Year	Source
% GDP spent on health	8.2%	2009	OECD
% of this spent by government	90.9%	2006	OECD

The evolution of the budget of the *CNS* is determined by law. It is funded by contributions from employers and employees, funded half and half by each. So, employees pay 3.05% of their salary for the sick fund and 8% for the pension fund - with the employer paying the same as the employees. For the state employees, 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*CNS*, 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 *Caisse Nationale de Santé* and the different sick funds are responsible for reimbursements to the patient and are 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	0.63	2012	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 (2013)	€ 275

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:	2013
Total Registered	512
In active practice	452
Dentist to population ratio*	1,188
Percentage female	40%
Qualified overseas	512

Each year the total number of dentists increases by between 10 and 20. The dentist to population ratio has reduced in recent years, especially because of immigration, despite the population increasing. However, this population growth is increasing much less than in former years.

The dental association believe that the number of practitioners has reached saturation point and that Luxembourg continues to have an excess of dentists over need.

Movement of dentists across borders

By 2012 only a few non-EU/EEA national dentists 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:	2013
Hygienists	0
Technicians	82
Denturists	0
Assistants	390
Therapists	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:	2013
General (private) practice	448
Public dental service	3
University	
Hospital	
Armed Forces	1
General Practice as a proportion is	99%

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 *Caisse Nationale de Santé*. 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 more and more 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 2012.

Professional Matters

Professional associations

	Number	Year	Source
Association des Médecins et Médecins-Dentistes	410	2013	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 *Caisse Natianale de Santé,* 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

The EU Cosmetics Directive of 2011 has been enacted, but tooth whitening is considered a medical act, and is therefore limited to dentists to provide. There are reports of some activity by non-dentists, which are pursued by an officer of the Ministry of Health for the illegal exercise of dentistry, with appropriate punishments.

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 theCaisse Nationale de Santé.

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

Income tax rates are progressive. They vary from 0% up to 40%. A 7% surcharge for unemployment fund applies on the income tax due. This surcharge for employment is 9% for taxpayers in tax class 1 or 1A, with a taxable annual income exceeding €150,000 (or €300,000 for taxpayers in tax class 2). So, the highest rate of income tax is effectively almost 50%.

VAT

The standard rate of VAT is 15%. An intermediate rate of 12% applies to wines, advertising and printed marketing materials. A reduced rate of 6% applies to gas and electricity, and a special 3% rate applies to printed materials, ebooks, water, pharmaceuticals, most food products, medical equipment, passenger transport, newspapers, admission to cultural, sporting and entertainment events, hotels, restaurants and radio and television broadcasting services.

Exemptions include some financial services and health and medical services.

Various Financial Comparators

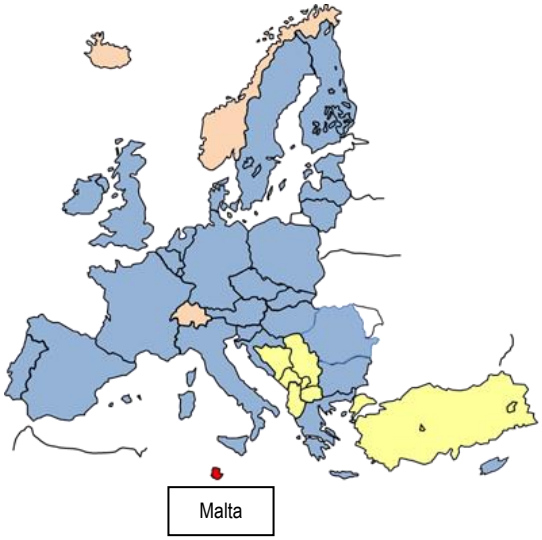
Luxembourg ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	75.3	83.3
Wage levels (net)	75.4	82.9
Domestic Purchasing Power at PPP	88.6	78.7

Source: UBS August 2003 and November 2012

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



In the EU/EEA since	2004
Population (2013)	421,364
GDP PPP per capita (2012)	€20,680
Currency	Euro
Main languages	Maltese and English

The State provides a free medical service to every citizen who lives in Malta. Those suffering from chronic diseases are entitled to free medicines. Public clinics provide some free comprehensive healthcare. However, most oral healthcare is provided in wholly private practice.

Number of dentists:	230
Population to (active) dentist ratio:	2,479
Membership of Dental Association	76%

There is a use of locally and overseas trained specialists in both the public and private sectors. Dental hygienists are also available. Continuing education is not mandatory.

Date of last revision: 4th February 2015

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 Malta and Gozo, is 316 sq km. The terrain of the islands is mostly low, rocky, flat to dissected plains, with many coastal cliffs.

The capital is Valletta.

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 may be given to a party, if necessary, to respect the proportion of votes obtained by each party; 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 Prime Minister. The President is elected, by simple majority, by the House of Representatives for a five-year term. The leader of the majority party or leader of a majority coalition is usually appointed Prime Minister by the president for a maximum of five-years after which fresh elections are to be held.

The State provides free medical service, including hospitalisation, to every Maltese citizen who lives in Malta. Anybody who is suffering from chronic diseases listed in a schedule to the Social Security Act, such as hypertension, diabetes mellitus, asthma etc., is entitled to free medicines. Citizens could also be entitled to free medicines if they satisfy a means test.

There are eight community Health centres spread around the islands that 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. There is also another hospital on the sister island of Gozo, Gozo General Hospital (GGH).

		Year	Source
% GDP spent on health	8.7%	2011	World Bank
% of this spent by government	64.0%	2011	World Bank

Source: National Health Accounts (NHA) - http://apps.who.int/gho/data/node.main.75

Oral healthcare

The responsibility for planning oral healthcare in Malta lies with the Ministry for Health. Dentistry, like the other medical professions, is governed by the Health Care Professions Act of 2003. The dental register is held by the Medical Council of Malta.

		Year	Source
DMFT at age 12	1.30	2005	SPH
DMFT zero at age 12	49%	2005	SPH
Edentulous at age 65	8%	2002	HIS

The Dental Department within the Ministry of Health looks after all the services provided in the main Dental clinic at Mater Dei Hospital. There is no payment for any treatment carried out by the public dental service.

Private practice contributes significantly to the provision of dental services in Malta. Patients pay directly for the dental treatment received. Private medical insurance only covers limited procedures, such as surgical extractions. Private fees are fully "free market" in nature and they are determined in agreements between dentists and their patients.

It is not possible to identify the proportion of expenditure on oral healthcare that is private.

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 local regulations set by the local standards authority.

Health data

		Year	Source
DMFT at age 12	1.30	2005	SPH
DMFT zero at age 12	49%	2005	SPH
Edentulous at age 65	8%	2002	HIS

SPH – Superintendence of Public Health

HIS – Health Interview survey

"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.

The Dental Public Health Unit in conjunction with the University of Malta is currently carrying out its national survey on 3, 5, 8, 12, 15, 18, 35 – 44 year olds and >65year olds.

Fluoridation

There are no fluoridation schemes in Malta.

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. With the further upgrading of the reverse osmosis plants in Gozo, has been further reduced.

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:	2013
Number of schools	1
Student intake	8
Number of graduates	8
Percentage female	38%
Length of course	5 yrs

The dental school derives the legislative framework under which it educates dental students from the Education Act. 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. As from October 2013, the University of Malta, Faculty of Dental Surgery has a new credit based course structure, which is in line with EU Directive 36.

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 being compulsory). There is a *numerus clausus* and those applying with the highest grades are accepted following an interview. 70% of the weighting for entry relates to their performance in their advanced and intermediate examinations. The course opens on a yearly basis and up to 6 EU students and 2 students from third country nationals (non-EU/EEA) are accepted. These 2 overseas places are not necessarily filled. The University Admissions Board controls the applications.

Quality assurance is regulated by the Programme Validation Committee that may refer a programme of studies to external review abroad.

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). However, students who started university in October 2013 will qualify with an MDS (Master of Dental Surgery)

Vocational Training (VT)

There is no obligatory vocational training (VT). A graduate dentist has a licence to practice after the 5 years' training course.

Registration

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.

Cost of registration (2013)	€ 35

Language requirement

Maltese is not needed as a language requirement for an EU/EEA dentist to register 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, and the Dental Public Health Unit have 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 2013.

Specialist Training

The framework for specialist training in Orthodontics and Oral Surgery exists under the auspices of the University of Malta, King's College London, the Ministry for Health and the Royal College of Surgeons of Edinburgh. Five dentists completed their specialist training in Orthodontics by October 2013.

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.

Workforce

Dentists

Year of data:	2013
Total Registered	230
In active practice	170
Dentist to population ratio*	2,479
Percentage female	36%
Qualified overseas**	28

* This figure relates to *active* dentists
** 15 inactive and 13 active

There is a large difference between the numbers registered and those "active". The reasons are that Malta has a large number of dentists who are retired (but still registered), Maltese dentists who are studying or working abroad abroad and retain their Maltese registration, and EU dentists who are registered in Malta but not practising there.

There is no reported unemployment of dentists in Malta.

Specialists

Year of data:	2013
Orthodontics	7
Oral Surgery	9
OMFS	1

Dental specialties have been recognised only since the Health Professions Act was fully implemented in 2004. Only Orthodontics and Oral Surgery are recognised in 2013..

Year of data:	2013
Paedodontics	2
Periodontics	3
Prosthodontics	3
Oral Radiologists	1
Gerodontology	2
Dental Public Health	3
Oral Pathology	1

However, a number of dentists have additional qualifications in specific areas of dentistry. Whilst not recognised officially as specialists, patients are referred to them by other dentists.

Auxiliaries

Year of data:	2013
Hygienists	21
Technicians	53
Denturists	0
Assistants*	100
Therapists	0

** *estimated

- Dental Hygienists
- Dental Technicians
- Dental Surgery Assistants

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, by the Faculty of Dental Surgery, University of Malta. The Board for Professions Supplementary to Medicine is responsible for the registration of dental hygienists.

Dental hygienists work under the prescribed instructions of a dentist, both in public or private practice. Their work includes scaling and normal dental hygiene, oral hygiene instruction, dietary advice and oral health promotion.

Most registered dental hygienists work in the public sector but a handful work privately, usually on a part-time basis. The 14 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, organised by the Faculty of Dental Surgery, University of Malta. The Board for Professions Supplementary to Medicine holds the register.

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 reported that people have their dentures repaired directly by them.

Most dental technicians work in the public sector (29) but over a third work solely in private practice. Some of those who work in the public sector also work in private practice.

Like hygienists, the 29 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)

DSAs are now officially qualified. A two-year course for DSAs commenced in October 2007 There were 15 trainees, and this course led to a Diploma. Previously DSAs were trained by the dentists themselves.

Those working in the public sector are trained DSAs but some of those working in the private sector have no qualifications and were trained by the dentist who employed them.

It is estimated that 85% of dentists in private practice have an assistant working with them. There were 30 nurses working as DSAs in the public sector in 2013.

Practice in Malta

Year of data:	2013
General (private) practice	167
Public dental service	35
University	24
Hospital	31
Public administration	3
Armed Forces	0
General Practice as a proportion is	98%
Number of general practices	102

Oral health services are provided in both the public and private sectors with most of the dentists working in the public sector also working in private practice.

As in many countries, several dentists actually practice in more than one sector. In Malta, most dentists practise in private practice, but many of them also practise in another sector. Only 3 active dentists do not practice in general practice at all.

Working in General Practice

Dentists who practice on their own or as small groups, outside the hospital 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. They then practice in their private clinic from late afternoon.

About 50% 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 on average 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 some group practices where the overall expenses are shared between the partners, but the income from the patient fees is on a separate basis. The number of such group practices is increasing.

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 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.

A dentist in Malta would typically look after 1,000 to 1,500 patients on their "list".

Working in the Public Dental Service and Hospitals

In the **main dental clinic at Mater Dei Hospital** diagnostic, preventive and emergency care is provided together with minor and major oral surgery, under local or general anaesthesia, free of charge to all patients. Some services, such as Restorative Dentistry and Prosthetics (mainly acrylic dentures) are provided only to patients in low-income brackets (means tested). In 2013 there were 26 dentists working at the main Dental clinic at Mater Dei Hospital.

The public service also offers comprehensive free treatment to all children below the age of 16. 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 is a dental clinic in the sister island of Malta, Gozo in the **Gozo General H**ospital and in 2013 there were 2 dentists working there.

There are 2 dentists working in a dental clinic in a retirement home **(SVPR)** providing free prosthetics and restorative treatment to those patients who are entitled to it; and one dentist working in an institution for mental care **(MCH).**

There are 2 dentists working in the **Dental Public Health** Unit, Superintendence of Public Health.

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 University of Malta is in the process of building a mobile dental Unit, which together with the Dental Public health Unit will help increase accessibility

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 some on a full time and some on a part time basis, as salaried employees of the university. There are also medical staff that lecture to the dental students. 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 Associate Professsor, senior lecturer, lecturer, assistant lecturer, both in

the resident and visiting streams, and clinical demonstrators. Most will also have received a specialist clinical training.

A PhD starts the dentist at a Lecturer position. Senior lecturer is obtained by time; Associate Professor by papers published and Full professor by papers published and contribution to University in general.

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 are three dental associations - the Dental Association of Malta (DAM). the Malta Post-Graduate Dental Association, (MPGDA) and the Malta College of Dental Surgeons. None of these associations are trade Unions.

	Number	Year	Source
Dental Association of Malta	130	2013	DAM

The main national association is the Dental Association of Malta (DAM). Over 76% of dentists are members. The Dental Association of Malta is a founder member of the Malta Federation of Professional Associations.

The Dental Hygienists have also set up an association, in 2013. This is known as the Malta Association of Dental Hygienists (MADH). The Dental Technologists have another association, which is the Malta Dental Technologists Association (MDTA).

Ethics and Regulation

The Medical Council

The Medical Council of Malta consists of a legal practitioner, medical practitioners, dental practitioners and representatives of the public. Some are nominated and some are elected. Dentistry is incorporated under the Medical Council with appropriate representation of the dental profession on the body.

Ethical Code

Dentists are subject to analogous 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, ethics or professional misconduct. There are no legal specific contractual requirements for dentists working together in the same practice. Dentist's employees are protected by the national employment legislation.

Fitness to Practise/Disciplinary Matters

Maltese dentists are regulated by the Health Care Professions Act, which came into force 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 a financial penalty.

Data Protection

Professional confidentiality has for long time been ensured under the criminal code. However in respect of certain other data, 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.

For more details see http://www.dataprotection.gov.mt

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,

Insurance and professional indemnity

Indemnity insurance is mandatory as from October 2013. A patient is entitled to lodge 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, where the Cosmetics Directive (2011) requirements dictate. However, non-dentists such as beauticians still carry out tooth whitening, when inspected by health authorities, provided they use products containing less than 0.1% peroxide or they us other bleaching materials.

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 under the Public Health Act (Legal notice 353/2003 entitled Medical Exposure (Ionizing Radiation) Regulations, 2012.) Protection of the workers and the general public is regulated under the Nuclear Safety and Radiation Protection Regulations, 2003 made under National Interest (Enabling powers) Act (CAP. 365).

Under both these regulations there is a requirement that the employer ensures that staff have adequate 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	The Radiation Protection Board/ Superintendence of Public Health
Electrical installations	Private company
Infection control	Directorate of Health Care Standards, Superintendence of Public Health
Medical devices	Malta Standards Authority
Waste disposal	Private (All private companies are licensed by the Superintendence of public Health and Transport Malta).

Financial Matters

Retirement pensions and Healthcare

The National Insurance premiums include a contribution to the national pension scheme. Public pensions in Malta are typically two thirds (66%) of a person's salary on retirement up to a maximum of €14,000 for citizens born on or after 1962.

The official retirement age in Malta was 61, but this has now been increased up to a maximum of 65 for citizens born on or after 1962.

Dentists practise, on average, to a little over 65 years, although they can practice beyond this age.

Taxes

For the majority of the Maltese population general health care is paid for mainly through general taxation and national insurance. Income tax is payable on earnings. The maximum amount of tax that can be paid is 35%.

National Insurance premiums are an additional 10% of salary or income, up to a maximum of approx €2000 per annum paid each by both employer and employee. For the self-employed, the National Insurance (NI) contribution is 15% of the net annual income up to a maximum of approx. €3100 per annum.

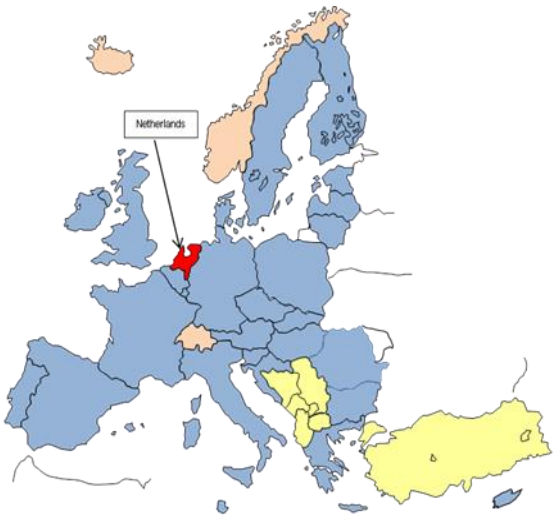
VAT/sales tax

There is a value added tax (VAT), payable at a rate of 18% on purchases. Medicinals, X-Ray equipment and certain filling materials are exempt from VAT; some are taxed at 5% and the rest at 18%. Dental services are not subject to VAT

Other Useful Information

Main national association and Information Centre:	***Competent Authority:***
Dental Association of Malta, Federation of Professional Associations, The Professional Centre, Sliema Road, Gzira, Malta GZR 1633 Tel: +356 213 12888 Fax: +356 213 12004 Email: info@dam.com.mt Website: www.dam.com.mt	The Superintendent of Public Health, Superintendence of Public Health SLH/OPD Level 1 St Luke's Square G'Mangia, Malta PTA 1010 Tel: +356 2595 3302/3 Fax: +356 2595 3304 Email: sph.mfh@gov.mt Website: http://www.ehealth.gov.mt
The Medical Council of Malta:	***Council for the Professions Complementary to Medicine:***
Superintendence of Public Health SLH/OPD Level 1 St Luke's Square G'Mangia, Malta PTA 1010 Tel: +356 212 55540 Fax: +356 212 55542 Email: medicalcouncil.mhec@gov.mt Website http://www.ehealth.gov.mt	Superintendence of Public Health SLH/OPD Level 1 St Luke's Square G'Mangia, Malta PTA 1010 Tel: +356 212 55538 Fax: +356 212 55541 Email: cpcm@gov.mt Website: http://www.ehealth.gov.mt
Publications:	***Dental School:***
The Probe Dental Association of Malta, Federation of Professional Associations, Sliema Road, Gzira, Malta GZR 1633 4 times a year newsletter, by the Dental Association of Malta. Editor: Dr David Muscat. E-mail: editor@dam.com.mt Website: www.dam.com.mt	The Dean Faculty of Dental Surgery Medical School, Mater Dei Hospital Block A, Level O Msida MSD2090, Malta Tel: +356 23401875 Fax: +356 23401208 Email: vania.tabone@um.edu.mt nikolai.attardi@um.edu.mt Website: http://www.um.edu.mt/about/uom Dentists graduating each year: 8 (2 from third countries) Number of students: 39 (some from third countries)

The Netherlands



In the EU/EC since	1957
Population (2013)	16,789,800
GDP PPP per capita (2012)	€32,489
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:	12,169
Population to (active) dentist ratio:	1,914
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: 28th January 2015

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 408 (2013) 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.

The Health Care Insurance Act of 2006 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 the content and the quality of care, as well as the honest competition between insurance companies and healthcare providers.

There is a predetermined budget for healthcare, set by the government.

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		Year	Source
% GDP spent on health	11.4%	2012	Min of Health
% of this spent by government	94.3%	2012	Min of Health

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 2012, the total expenditure on healthcare costs (welfare excluded) was 67.7 milliard of which 2.9 milliard was spent on oral healthcare (4.3 %). This second figure refers to expenditure outside the basic insurance

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		Year	Source
% GDP spent on oral health	0.36%	2012	NMT
% of OH expenditure private	74%	2007	CBS/CVZ

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;
- perform patient interviews every five years
- run a visitation every five years (this is an official visit for the purpose of inspection or examination by colleagues).

Since 1 July 2007, this Quality Register has been available to the public.

Health data

		Year	Source
DMFT at age 11	0.70	2011	TNO
DMFT zero at age 11	73%	2011	TNO
Edentulous at age 75	53%	2009	CBS

TNO = "Innovation for Life" CBS = "The Central Bureau for Statistics"

These figures are for a slightly different age group than other countries

"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:	2013
Number of schools	3
Student intake (2012/13)	243
Number of graduates (2012/13)	268
Percentage female	57%

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 (2013)	€ 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 2013 there was a balance between supply and demand.

Year of data:	2013
Total Registered	10,780
In active practice*	8,773
Dentist to population ratio**	1,914
Percentage female	35%
Qualified overseas	818
* dentists under 65 years with private or practice address in the Netherlands	
** active dentists only	

In 2013 about 48% of the dentists in active practice were over 50 years of age.

Movement of dentists into and out of the Netherlands

Also in 2013, about 9% of the dental workforce had qualified outside the Netherlands. The number of dentists with foreign qualifications entering the Netherlands to work is increasing each year. This is evident from the Capacity Plan 2013 that was published by the *Capaciteitsorgaan*, a foundation for advanced medical and dental programmes.

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 1:14.

Numbers under the age of 64 years who are registered to work are in the following tables:

Year of data:	2013
Orthodontics	331
Oral Surgery	
OMFS	265

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.

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).

Year of data:	2013
Endodontics	73
Paedodontics	46
Periodontics	81
Prosthodontics	
Oral Radiologists	
Dental Public Health	

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:	2013
Hygienists	3,200
Technicians (2011)	5,000
Denturists	370
Assistants	19,000
Therapists	0
Other	0

All are estimated figures

Dental Hygienists

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:	2013
Gen practice (owners)	7,205
Gen practice (locums)	1,568
Public dental service (2007)	250
University	110
Academic (non-univ)	0
Hospital (all OMFS) (2007)	214
Armed Forces	30
General Practice as a proportion is	100%
Number of general practices	5,600

The figures above are more than 100% of active dentists, as almost all dentists work some of the time in general practice.

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 82% work in their own general practice - about 60% of which are "single-handed" practices (only one dentist in the practice). The remainder work in practices of two or three dentists, with a few larger groups. About 1,600 dentists (so called 'ZZP'; independent without personnel) 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 (2011).

Fee scales

There is a fee scale of maximum charges, and dentists bill every treatment. The maximum fees are set by the Health Care Authority (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 2008).

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[27].

	Number	Year	Source
Nederlandsche Maatschappij tot Bevordering der Tandheelkunde	6,653	2013	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.

[27] In June 2014, following publication of this Manual, the NMT became 'Royal': it is now the Koninklijke Nederlandse Maatschappij tot bevordering der Tandheelkunde or Royal Dutch Dental Association (KNMT).

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

The EU Regulations on Tooth Whitening was enacted in the Netherlands in November 2012.

There is no information about whether there Is any continued illegal tooth whitening in the Netherlands.

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.

Under the influence of European regulations, a new Radiation Protection Decree was introduced on 1 January 2014. In the run-up to 1 January 2014, the NMT amended its Dental Radiology Practice Guidelines. The revised guidelines focus on a responsible and effective implementation of X-ray diagnostics in dental medicine and provide recommendations for the correct use of X-rays in dental diagnostics.

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. But, more and more the pension depends of the average earnings.

From 2013, the age of retirement is gradually being increased to 67, by 2021.

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:

For 2013, income tax for persons under 65 is as follows:

- For the part of income up to €19,645: 5,85% (plus mandatory Premium National Insurance 31.15%)
- For the part of income between €19,645 and €33,363: 10.85% (plus mandatory Premium National Insurance 31.15%)
- For the part of income between €33,363 and €55,991 : 42%
- On all income over €55,991 : 52%

VAT

The standard rate is 21% (since October 2012). There is a reduced rate of 6% on foodstuffs, books, pharmaceuticals, medical, passenger transport, admission to cultural and amusement events, hotels, accommodation.

The lower rate of 6% is applied to dental materials or 21% on instruments and equipment.

Various Financial Comparators

Amsterdam ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	81.0	67.3
Wage levels (net)	57.0	52.4
Domestic Purchasing Power at PPP	67.6	68.4

Source: UBS August 2003 & November 2012

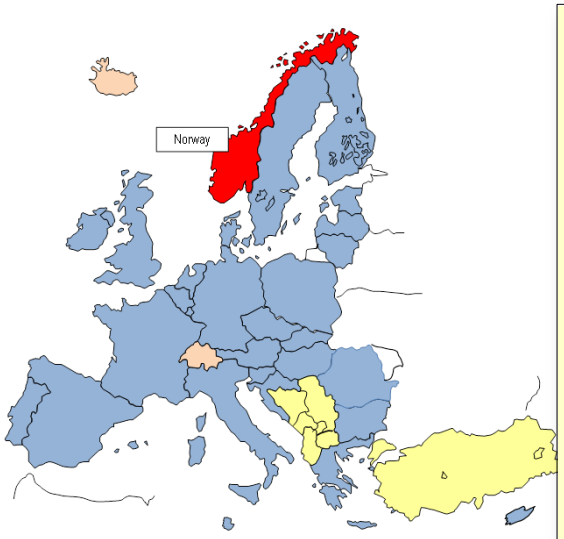
Other Useful Information

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.bruinsslot@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 Number of students: unknown, Intake in 2012/2013: 128	**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.umcn.nl Number of students: unknown, Intake in 2012/2013: 67
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 Number of students: unknown Intake in 2012/2013: 48	

Norway



Member of the European Economic Area	
Population (2013)	5,063,709
GDP PPP per capita (2012)	€41,886
Currency	Kroner (NOK)
	8.09 NOK = €1 (2013)
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:	5,350
Population to (active) dentist ratio:	1,107
Membership of the NDA:	90%

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.

Date of last revision: 28th January 2014

Government and healthcare in Norway

Norway is a Nordic country, the most northerly in Europe which covers 385 000 square kilometres. It is a mountainous country, and virtually all 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 Storting authorises plans and guidelines for the activities of the State and debate broader domestic and foreign policy issues. There are 169 elected members of the Storting. Parliamentary elections take place every four years. There are no by-elections, nor is there any constitutional provision to dissolve the Storting between elections.

The capital is Oslo, with a population of approximately 634,000 at the end of 2013 (Statisics Norway).

General health services are funded through a form of national insurance, the Folketrygden, which is administered by 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	9.4%	2012	OECD
% of this spent by governm't	85.1%	2012	OECD

The national Fiscal budget is predetermined for one year at a time.

Oral Healthcare

Oral healthcare in Norway is divided into the public and the private sectors. Approximately NOK 4.7 billion (€590m) was spent on Public Dental Care 2012

		Year	Source
% GDP spent on oral health	0.50%	2012	CECDO
% of OH expenditure private	71%	2011	CECDO

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 to be accountable for the Public Dental Health Service, and for coordinating this service with private dental practices.

The Public Dental Health Service (PDHS) is country-wide and is organised and funded by the counties. Approximately 32.5% of all active dentists work full-time in the public sector, the remainder working in private practice. The PDHS 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 0-18 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 19-20 years of age
- other groups defined by the county or the government, inter alia imprisoned persons and drug and alcoholic addicts in a rehabilitation program.

Annually approximately 64% of the population in the priority groups receive screening and/or treatment (2012) and about 10% of the non-priority group adults also receive their care from the PDHS.

The PDHS is free of charge for patients, except for orthodontic treatment. However, youth of 19 and 20 years must pay 25% of the costs. Adults pay in full for oral health care, except for the exemptions mentioned above.

National Insurance Scheme (NIS)

In general, there is no reimbursement for dental treatment for the adult population. However, there are a number of exemptions to the general rule. The following 14 groups of conditions release reimbursements to some extent: Rare medical diagnosis (listed by the health authorities), cleft of the lip, jaw or palate, oral cancer, immune system depression, diseases/ anomalities in the mouth and jaw, treatment and rehabilitation of marginal periodontitis, tooth development disturbances, orthodontic treatment, severe pathological attrition, hyposalivation, allergy to dental restorative materials, occupational accident trauma, dental trauma and reduced ability for self care.

There is a “high cost protection”, valid only for expenses linked to dental conditions covered (partly) by the NIS; diseases and anomalies in the mouth and jaw, examinations prior to jaw orthopaedic treatment and treatment and rehabilitation of marginal periodontitis. The maximum payment, the "roof', in this system is NOK 2 620 (€330 in 2013) per year, referring to the specified amount that is defined as "own risk" payment. In addition to these dental conditions, the maximum "own risk" amount could cover expenses for physiotherapy, therapy in specified training institutions and at certain overseas treatment clinics.

Only specified treatment as mentioned is included in the high cost protection system. A patient paying more than NOK 2,620 in approved user fees for the above treatments during 2013, is entitled to an exemption card for user fees (group 2). However, dentists are not bound by set rates. Even with an exemption card, a patient must pay the difference between the price charged by the dentist and the amount covered by the NIS.

There is also a family reduction, for families with more than one child in need of orthodontic treatment.

Most dentists 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 still a voluntary system.

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 the full cost of their dental treatment, without any government funded financial support.

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.

A large proportion of adults see a dentist on a regular basis (about 80% every 12 months, more than 90% within 2 years), even though they may have to pay the full cost of the treatment. 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 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 is not available in Norway (2013).

The Quality of Care

Standards in dental practice are governed by several 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 County Executive Officer in each of the 19 counties. They normally use designated dentists to supervise and assess the dental medical standards, quality assurance programmes etc.

The Norwegian Consumer Council is responsible for ensuring that prices are displayed and that quotations are given to

patients. A new "regulation on information on prices of goods and services" came into action from 2013. This regulation also covers dentistry and has specific paragraphs concerning dental health services.

The Norwegian Labour Inspection Authority is responsible for monitoring employees' conditions, legal, physical and psychosocial. Radiation protection is monitored by the Norwegian Radiation Protection Authority, and waste disposal by the Norwegian Environment Agency.

Guidelines for "Good clinical practice" were introduced by the Norwegian Directorate of Health in 2011. From 2008 the use of 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	1.10	2012	Statistics Norway
DMFT zero at age 12	54%	2012	Statistics Norway
Edentulous under age 65	0.5%	2008	Statistics Norway
Edentulous age 65 +	13.30%	2008	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:	2013
Number of schools	3
Student intake	153
Number of graduates	138
Percentage female	75%
Length of course	5 yrs

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 Health Faculty.

There are no private dental schools. There are about 765 undergraduates in total (2013) for the 5-year course. After graduation the candidates may be authorised as dentists.

Vocational training is a pre-qualification, integrated part of the undergraduate study. In Tromsö, a large part of the clinical training is taken in designated dental clinics around the country. In Bergen (mandatory) and Oslo (voluntary) the training covers just a few weeks and is organised somewhat more at random.

Quality Assurance

The Norwegian Agency for Quality Assurance in Education (NOKUT) is an independent body under the Ministry of Education. NOKUT´s purpose is to ensure and promote quality in higher education and vocational education through:

- supervising and encouraging the development of quality education at Norwegian universities, colleges and vocational schools.
- approving higher education taken abroad and informing about other authentication and authorisation schemes for foreign education

Qualification and Vocational Training

Primary dental qualification

The title upon qualification is: *Master of Dentistry*

Vocational Training

There is no post-qualification training in Norway.

Registration

Graduates must register with the Norwegian Registration Authority for Health Personnel (SAK). After the age of 75 a dentist's registration can only be renewed if the practitioner is considered fit to continue practising. The applicant must show a doctor´s approval to have his registration renewed, which is administered by SAK. 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 (2013)	€ 200

Norway is part of the EEA Agreement. Thus dentists qualified in other EEA states may practice in Norway, after registering at SAK.

Non-EEA dentists must apply to the SAK for recognition. The SAK examines whether their education is in line with the Norwegian. If not, it is possible to apply for a one year updating course, but very few are accepted into this programme.There is a language requirement for speaking and writing in a Scandinavian language for those who get accepted into this programme.

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.

For all dentists it is mandatory that the patient records are 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 continuing education courses for dentists in practice. As dentists have an obligation to treat their patients in accordance with the professional standard (based on the current knowledge and common accepted procedures at the time), the NDA has found it necessary to require that members adopt new knowledge. So, since 2012, it has been mandatory for NDA members to obtain 150 credit hours over a 5 year period.

However there are no national requirements from the health authorities concerning this.

Specialist Training

There is an organised full-time postgraduate training period for specialists in universities, in the seven recognised dental specialities:

- endodontology,
- orthodontology,
- dento-maxillo-facial radiology,
- oral surgery and oral medicine,
- paediatric dentistry,
- periodontology
- prosthodontology.

Oral surgery/medicine has a 5 year training period, while the other 6 specialities are 3 year programmes.

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. Specialist Approval is given by the Norwegian Directorate of Health.

Projects for decentralised training in recognised specialist clinics at Regional Odontological Centers of Competence have been completed, but no formalised programmes had been set up by 2014.

At the Institute for Clinical Odontology in Tromso a 3-year specialist training programme for Clinical Dentistry is being tested as a project, from which 4 candidates graduated in January 2014.

Workforce

Dentists

Year of data:	2013
Total Registered	5,350
In active practice	4,576
Dentist to population ratio*	1,107
Percentage female**	47%
Qualified overseas**	859
* active dentists only	
** estimated	

The figures for the percentage of females and the numbers of dentists qualified outside Norway are estimated by the NDA, from the members' register.

Almost a quarter of Norway's dentists qualified overseas.

The dental workforce is increasing, partly due to the increased number of inland dental graduates (40 per year in Tromso from 2009), partly as a result of an increased number of Norwegian dental students abroad and to some extent a result of increased immigration of foreign dentists. However, there was not yet any relevant unemployment amongst dentists in 2013, but the competition for vacant positions is increasing as a result of this new workforce situation.

Specialists

In Norway seven dental specialities are recognised:

Year of data:	2013
Orthodontists	206
Endodontists	63
Paedodontiists	20
Periodontiists	90
Prosthodontists	65
Dento-maxillo-facial radiologists	7
Oral Surgery (excl OMFS)	68

These are approximate numbers of "active" specialists, excluding those who have retired.

A majority of oral surgeons work either in public hospitals or universities. Many also work (part-time) in private practice. Most orthodontists work in private practice, although some are also employed in the Public Dental Health Service (PDHS).

Paediatric dentists and dento-maxillo-facial radiologists work mostly in the PDHS while endodontists, periodontists and prosthodontists work 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

There are 3 types of dental auxiliary:

- Dental hygienists
- Dental technicians
- Chairside assistants (secretary)

According to the Health Personnel Act from 1999, all dental auxiliaries have to be registered with the Norwegian Registration Authority for Health Personnel (SAK) in order to use the titles mentioned.

Year of data:	2013
Hygienists	902
Technicians	703
Denturists	0
Assistants	3,671
Therapists	0

Dental Hygienists

To be admitted to training as a hygienist, the applicant must have completed higher secondary school. Dental hygienists undertake 3 years of education and training at Hygienist Schools, which are located in Oslo, Bergen, Elverum and in Tromsø. The schools are either part of a University and located in connection with the dental schools (Oslo, Bergen, Tromsø), or part of a University college (Elverum).

Dental hygienists normally work together with dentists, as salaried employees, both in private and public clinics. However, they may have their own private practice. They may diagnose as well as treat conditions covered by their undergraduate curriculum (mostly prophylaxis, public health and periodontal disease). Hygienists 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.

Technicians normally work in commercial laboratories and charge the dentists for their services. Some work as employees in dental clinics. They may not deal directly with the public, although they do take legal responsibility for their own work.

Dental Chairside Assistants (Secretaries)

Dental assistants have to undertake 3 years of 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 can be awarded the title.

Practice in Norway

Year of data:	2013
General (private) practice	3,175
Public dental service	1,109
University	234
Hospital	35
Armed Forces (2008)	23
General Practice as a proportion is	69%

Working in General Practice

Dentists who practise on their own or as part of small/medium size 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, and price cartels are forbidden. Every dentist must display the cost of treatments offered in his/her waiting room, either as a poster or a complete list of prices for patients to take away. Dental practices with websites must also display their price list online. If the cost of treatment exceeds NOK 5,000 (€625) the dentist must provide the patient with a written quotation. If a treatment plan is changed later, and the quotation along with this, then the patient must be informed. When the treatment is finished, the dentist must give the patient a written description of what care has been provided, along with a specfication of the costs.

A dentist working full-time would normally have on his regular "recall list" about 1,900 patients, and would undertake re-examinations annually for regular adult patients.

Fee scales

Reimbursement by the National Insurance Scheme is given in accordance to a fixed price scale, set by the Health and Care Department (HCD), as mentioned on page 2. Only the reimbursement amount is covered by NIS, both the deductible and the difference between the HCD set price and the dentist's actual price must be paid by the patient himself.

Orthodontic treatment is reimbursed in accordance with 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, mostly cosmetic malocclusions.

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. Anyone can own and run a private dental practice.

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

Working in the Public Dental Service

The Public Dental Health Service (PDHS) is organised on a county level. It started 100 years ago, 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 PDHS 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). Salaries differ between the 19 counties.

A few counties employ specialists, and most orthodontic treatment is delivered in private practice.

A limited number of adults (approximately 10%) are treated in the PDHS. Some counties allow public dental service dentists to rent their clinic to provide dentistry to adults as private patients.

Working in Hospitals

Oral surgeons normally work in hospitals as salaried employees, either full- or part-time, often in combination with private practice. To practise as an oral surgeon in a hospital, it is necessary to be a recognised specialist.

There is no fixed salary for such positions.

Working in University Schools

University Dental Schools employ dentists both in academic positions, as teachers and scientists, and as clinical instructors, at the training clinic for undergraduate students. Typical academic titles within a Norwegian University Dental School are Professor, Associate Professor, 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 candidates, on the other hand, have less teaching responsibilities and no administrative duties.

Most academic posts require a minimum of a PhD (Dr. Odont. in the Norwegian Academic System used earlier) 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.

Working in the Armed Forces

About 30% of the dentists in regular positions in the Armed Forces are female.

Professional Matters

Professional associations

	Number	Year	Source
Norwegian Dental Association	4,539	2012	FDI

There is one ~~a~~ single main national association, the Norwegian Dental Association (NDA). About 90% of active dentists in Norway are members. The NDA represents both private and public service dentists. The NDA consists of 21 local associations, and primarily, there is one association for each county. All members of the NDA are also members of a local association. In addition, there are 7 specialist associations.

The NDA is a democratic organisation. Every second year a General Assembly (GA) is held with representatives from all the local and specialist associations. The GA is the highest authority in the NDA. The GA decides on budget matters and guidelines to be followed in all matters of importance. The GA also elects a council of 9 NDA members (President, Vice-president and 7 regular members). The President is the chief executive of the NDA.

The NDA has a secretariat with 23 employees (2013), led by a Secretary-general. The secretariat carry out a number of tasks, such as legal services for members, salary negotiations for the public dental service, organisation of insurance, continuing education courses for dentists and auxiliaries etc, communication with members, as well as with the public, governmental bodies and authorities on questions concerning dentists and dentistry. The NDA is also responsible for the publication of the Norwegian Dental Journal.

Ethics and Regulation

Ethical Code

Dentists in Norway work under an ethical code which covers the contract with the patient, relationships and behaviour between dentists and towards the NDA. 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 violations of the ethical code are initially handled by the board of the local branch of the NDA. If the dispute is not settled there, the case is submitted to the NDA Board of Dental Ethics. The Board may – in cases of infringement of the ethical code - take action of which the worst case scenario is to propose for the NDA Council to exclude the dentist from membership of the Association.

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 dental services. 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 Health Supervision 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.

Data Protection

In accordance to national laws, 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. The EU Electronic Commerce Directive is being handled politically.

Corporate Dentistry

Dentists are allowed to form companies and the boards are not limited to dentists

Indemnity Insurance

All dentists in private practice, by law, have to register and pay membership fees to the Norwegian Patient Damage Insurance Scheme (NPE). This public insurance system offers economic compensation on an objective basis to patients who claim that their medical or dental treatment has applied damage to them. Certain criteria must be fulfilled for the patient to get compensated.

Patient complaints

All NDA local associations must have their own complaints committee (CC), to which paients may take their questions, problems or complaints, for a review and advice. The CC jurisdiction is limited to rule on reduction of pay, or for the dentist to replace the work done, if the patient accepts.

Tooth whitening

The EU Directive of 2011 on tooth whitening products has been implemented in Norwegian law.

The NDA has reported in 2013 that there may be some continued illegal practice in this field, but unauthorised providers of tooth whitening procedures appear to have have changed their conduct, after the Directive changes were implemented into Norwegian law.

A problem may be electronic commerce of such products. The Norwegian Food Safety Authority is responsible for the regulations concerning the Cosmetics Directive, including tooth whitening products.

Health and Safety at Work

There are a number of regulations concerning Health and Safety at work, for example concerning radiation protection,

handling of toxic substances etc. However, vaccination such as for Hepatitis B is 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. Dentists and dental hygienists may use x-ray equipment. It is mandatory for any person who handles x-ray equipment to take a "refresher" course every year.

Hazardous waste

Amalgam separators are required by law – since 1996. 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	Norwegian Directorate for Civil Protection
Waste disposal	Norwegian Environment Agency
Amalgam	Norwegian Environment Agency / Norwegian Directorate of Health
Medical Devices	Norwegian Directorate of Health
Infection control	Norwegian Institute of 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 Norwegian Labour and Welfare Administration (NAV) by the tax authorities.

The Norwegian retirement pension system was under revision in 2013. Until then, retirement pensions are paid by NAV on the basis of a dentist's income. The retirement age is 67 for NAV purposes. Dentists who work in the private sector receive the basic NAV pension each year and in addition a supplement based on the individual earnings from the years they have been member in NAV. In addition most private dentists 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. Retirement age in the PDHS is 65 years.

Dentists may work beyond the general retirement age if they wish and/or the employer accepts. In public service they may work until they are 70. Private practitioners can work as long as they want, as long as they are authorised. From the age of 75, a dentist can apply for a license, which is limited for one or two years.

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 actual income.

VAT/sales tax

The standard VAT rate in Norway is 25%. Dental materials, instruments and equipment are subject to this rate, and so these costs will be reflected in fees. There is a reduced rate of 15% for food and drink. There is also an 8% VAT rate for passenger transport; hotel accommodation; and some other items.

Dental treatment is excluded from VAT.

Various Financial Comparators

Oslo ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	111.3	102
Wage levels (net)	87.0	73.6
Domestic Purchasing Power at PPP	68.6	64.4

Source: UBS August 2003 & November 2012

Other Useful Information

Main national association and Information Centre:	***Competent Authority:***
Norwegian Dental Association POB 2073 Vika N-0125 Oslo Tel: +47 22 54 74 00 Fax: +47 22 55 11 09 Email: post@tannlegeforeningen.no Website: www.tannlegeforeningen.no	Norwegian Directorate of Health POB 7000 St. Olavs plass 0130 Oslo Tel: + 47 81 0 200 50 Fax: + 47 24 16 30 01 Email: postmottak@helsedir.no Website: www.helsedirektoratet.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.

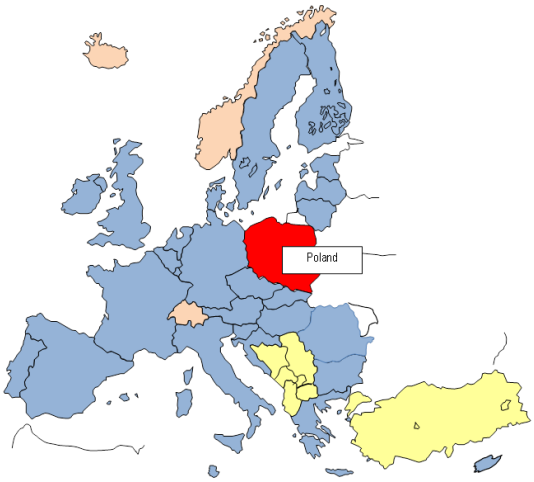
Dental Schools:

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: postmottak@odont.uio.no Website: http://www.odont.uio.no Dentists graduating each year: 63 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: www.uib.no/odontologi Dentists graduating each year: 45 Number of students: 240	Det helsevitenskapelige fakultet Institutt for klinisk odontologi Universitetet i Tromsø 9037 Tromsø Tel: +47 77 64 91 02 Fax: +47 77 64 91 01 E-mail: tann@helsefak.uit.no Website: http://uit.no/odontologi Dentists graduating each year: 30 Number of students: 200

Note that the actual intake of students is 65, 48 and 40, respectively. These are the numbers that add up to the noted "number of students" for each dental school.

The number of "dentists graduating each year" shows the output in 2013.

Poland



Date of last revision: 30th January 2014

In the EU/EEA since	2004
Population (2013)	38,533,299
GDP PPP per capita (2012)	€15,833
Currency	Zloty (PLN)
	4.25 PLN = €1.00 (2013)
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). The fund's budget is financed by an obligatory premium , of up 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 underfunding and very low budgetary expenditure on dentistry. Private care is freely available, however.

Number of dentists:	33,633
Population to (active) dentist ratio:	1,768
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). In 1999 statutory general health insurance was introduced. Until 2003 healthcare within the general insurance was financed by 17 health insurance institutions – sickness funds.

Since 2003, the system of statutory general health insurance has been administered and financed by one institution – the National Health Fund (Narodowy Fundusz Zdrowia, NFZ), with 16 regional branches. 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 are 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 (especially rare diseases) are also financed by the state's budgetary means, for example the comprehensive treatment of developmental clefts.

There is no private or state additional insurance, although attempts were being made by 2013 to introduce such forms of insurance.

		Year	Source
% GDP spent on health	7.0%	2012	PDA
% of this spent by governm't	70.0%	2012	PDA

Oral healthcare

Public compulsory health insurance

The Law on healthcare services financed from public sources determines the scope and principles of providing dental medical services financed by the NFZ. Subject to the Act, 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 in a regulation.

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 rendered by various providers on the basis of a contract with the Fund: private and public health care facilities or individual healthcare professionals – mainly dental practitioners running individual or group practices.

New starts for NFZ work are decided in a tender announced by NFZ. The main consideration for the Fund is the lowest price. Specialist treatment is paid at a higher rate of points. 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 of dental care is limited due to the Fund's underfunding and low budgetary expenditure on dental care. For this the Fund allocates about 2% of its total spending on healthcare services – thus the share of dental expenditure financed by public sources amounts only to 21% (private sources make up almost 80% of spending on dental care in Poland). 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 this, 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.

A dentist with a contract with the Fund to provide full time services would look after 3,500 – 4,000 insured persons, including children and the under-18s.

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.

Not all practitioners provide services within the insurance system, since its financial means are limited. About a third of dental practitioners work under a contract with the Fund. Others work exclusively outside the public insurance, practising in a self-employed capacity (individual or group practices) or as employees in dental care facilities.

		Year	Source
% GDP spent on oral health	0.20%	2004	Chamber
% of OH expenditure private	79%	2013	PDA

Fees for dental services provided outside the insurance system are not administratively regulated. 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.

Working time

Working time is determined in a contract with the Fund. In the case of employees, the working time is regulated under the labour code.

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	3.20	2010	WHO
DMFT zero at age 12	19.3%	2007	NOHM
Edentulous at age 65	44%	2009	NOHM

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 is natural fluoridation of the water to optimal levels in some areas. Additionally, fluoridation in schools is carried out by school general nurses.

Education, Training and Registration

Undergraduate Training

To be admitted for dental studies the applicant must submit the result of his/her maturity exam, which is taken into consideration in the admission procedure as each year there are over 5 candidates for every place.

In Poland a *numerus clausus* rule applies. The maximum number of students that can be admitted by each university is regulated every year by the Minister of Health. This is controversial as the Dental Practitioners' Committee of the Polish Chamber of Physicians and Dentists is of the opinion that the intake of students, as regulated by the Minister, is too large for future oral healthcare requirements in Poland and exceeds the capabilities of the universities. The Chamber has consistently called for limitation of student intake.

Year of data:	2013
Number of schools	10
Student intake	1,231
Number of graduates (2008)	809
Percentage female	80%
Length of course	5 yrs

Dental studies are provided by medical universities – public higher education institutions. Dentistry is not available in private higher education institutions. There were 10 universities educating dental students in Poland in 2013. They are listed at the end of this section.

In principle, dental studies are publicly funded (students do not pay tutition fees), although some places have funding available for students which covers tuition fees. There some universities which also provide dental studies in English – subject to payment, and offered in principle to people from outside Poland. In 2013, dentistry was being offered in English by the universities in Kraków, Lublin, Łódź, Poznań, Szczecin, Warszawa and Wrocław. There were 230 posts for dental studies in English available.

In 2002, the undergraduate training curriculum was changed to meet the requirements of the EU Directives. The standard of training (frame curriculum) is determined in a regulation of the Minister of Science and Higher Education (endorsed by the Minister of Health).

The length of dental studies is 5 years (10 semesters) of full-time training. The overall minimal number of training hours is 5,000, of which 4,485 are determined by the regulation and 515 are left to the discretion of the university.

Supervision over the medical universities (in terms of compliance with the law and internal regulations) is carried out by the Minister of Health

Those students who commenced training in academic year 2012/2013 will have the final year of the study in the form of practical training in dental care facilities – this change of the curriculum is a consequence of cancellation of post graduate internship.

An annual conference takes place in Nałęczów when the professors and deans of the Dental Faculties at the Polish Medical Universities meet. Representatives of the Dental Practitioners' Committee of the Supreme Chamber of Physicians and dentists also attend this annual event. Participants of the Conference thoroughly discuss under- and postgraduate dental education, especially specialist training. This meeting is an important forum of discussion and presentation of opinions and ideas related to dental education in Poland and its results are often the basis for future changes.

Qualification and Vocational Training

Primary dental qualification

The academic and professional title awarded after graduation is "lekarz dentysta".

Previously, between 1996 and 2004, the title was "lekarz stomatolog" (it reamins equivalent to "lekarz dentysta").

Vocational Training (VT)

In order to be awarded the *"Right to practice the profession"* a graduate has to complete vocational training – an obligatory one-year postgraduate internship (staż podyplomowy).

Each graduate of dentistry may apply for a "Limited right to practice the profession" (a licence). This licence is awarded in order to undergo the internship, which is aimed at improving practical skills and deepening theoretical knowledge. The internship is in form of professional practice under supervision of 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 2004 there is also an additional requirement to pass a state exam. Until 2013 it was called the State Dental Exam (Lekarsko-Dentystyczny Egzamin Państwowy), but since 2013 it is called Final Dental Exam (Lekarsko-Dentystyczny Egzamin Końcowy). This exam can be taken during or after the internship.

The postgraduate internship will not apply to students who commenced their dental studies in 2012. They will not be required to complete this internship. In effect the last postgraduate internship will be organised in 2016 for those dental graduates who commenced their studies in 2011.

The requirement to complete internship and pass the exam is not applicable to dentists from other EU/EEA Member States who hold the evidence of formal qualifications, subject to automatic recognition under the Directive 2005/35/EC.

Registration

In Poland, a dental diploma awarded upon graduation does not in itself 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 their place of residence, with the Regional Chamber of Physicians and Dentists *(Okręgowa 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. Following the registration dentists pay membership fees to the regional chamber.

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

Postgraduate education and training in dentistry takes place in 3 forms:

- Continuing education – mandatory for all dentists
- Specialist Training
- Academic Training

Continuing education

Dental practitioners have an ethical and legal obligation to undertake 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. A credit-point system is applied, 200 credit points have to be collected in a 4-year period.

The contents and quality of continuing education courses are supervised by Regional Chambers. The Chambers hold the register of providers of continuing professional education events.

Continuing education is conducted in various forms and in accordance with a grading scale. There is a wide offer of courses and training conferences in Poland.

Many Regional Chambers organize courses and other forms of education; they are generally free of charge. Also the scientific dental societies (15 in 2013) are active in providing continuing education.

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 (Final) 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 Kształcenia 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 formally recognised dental specialties:

- conservative dentistry and endodontics
- paediatric dentistry
- dental prosthetics
- periodontology with oral medicine
- orthodontics
- oral surgery
- oral maxillofacial surgery (this is also a medical specialty for physicians)

Besides these, dentists may take up the following fields of specialisation:

- hygiene and epidemiology
- organisation of health care

After completion of specialist training and a positive result of the specialist examination, a dentist may formally use specialist title, eg dental practitioner (lekarz dentysta) 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:	2012
Total Registered	33,633
In active practice	21,800
Dentist to population ratio*	1,768
Percentage female	78%
Qualified overseas	600

* active dentists only

In 2013 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:	2012
Retired with right to practise	5,000
Emigrated but with right to practise	1,500
Physicians with dentist qualifications	600
Maternity leave	1,400
Limited practice through internship	1,900

Source: Central Register of Physicians and Dentists.

The Polish Chamber reports that in 2013 about 40% of all dentists were over 50 years old, and it is assumed that most of these dentists will retire in within the following 20 years (dentists normally retire at 70 or younger). Approximately 300 registered dentists were over 65 years old.

It is reported that there are no permanently unemployed dentists. However, young dentists register themselves as unemployed, which facilitates obtaining credits or other allowances to start their professional activity.

As indicated in the description of education, the Chamber is of the opinion that there are too many active dentists in Poland (in relation to the amount of pubilc funds allocated to dental care).

Movement of dentists across borders

Since the accession of Poland to the EU in 2004, 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 is the UK. They have reported that the outflow of dentists has not influenced the provision of dental care in Poland.

Specialists

Dental specialists may have contracts with the national Health Fund. To get specialist dental treatment patients do not have to provide referal from primary care 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:	2012
Orthodontics	1,115
Conservative & Endodontics	1,561
Paedodontics	486
Periodontics	420
Prosthodontics	1,453
Oral Radiologists	
Oral Surgery	805
OMFS	227
Dental Public Health (2008)	71
Hygiene & epidemiology (2008)	122

Source: Central Register of Physicians and Dentists

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 2013 there were no more up to date numbers, although it was reported that discussions regarding a national register for auxiliaries were taking place.

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 2013 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 2013 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

Year of data:	2013
General (private) practice	20,850
Public dental service**	500
University	400
Hospital	250
Armed Forces	300
General Practice as a proportion is	96%

** There is no real public dental service as such. There are some publicly owned facilities, but they provide dental treatment in the same way as private dental facilities – ie either paid directly by patients or under contract with the National Health Fund. There are some dentists involved in administration eg in the NHF.

In order to start, dental care facilities have to meet specific requirements concerning the premises, the sanitary and epidemiological arrangements. They are registered with the regional bodies of public administration – voivods.

The supervision is carried out by the voivode, through the voivodeship consultants, who are dental surgeons, although most often academic workers.

Working in Liberal (General) Practice

The majority of dentists exercise the profession in their own private practices (usually individual practices, but also some group practices). Individual and group dental practices are the most common form of exercising dental profession.

Some dentists set up and work in dental care facilities (entities larger than practices, required to fulfil some more conditions) or work as employees of dental care facilities.

The law does not preclude the exercise of the profession in more than one form.

Fee scales

Fees for dental services provided outside the insurance system are not administratively regulated. They are set between dentists and their patients.

Joining or establishing a practice

Dentists can exercise the profession in the form of an individual or group practices. Group practices are established by dentists associated in a partnership. In order to set up a dental practice 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.

Dentists 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. The Chamber maintains a register of individual and group practices and supervises them. Authorised representatives of the Chamber may control the practice to check if its activity is in compliance with the law.

Working in Public Clinics

There is no public dental service in its strict meaning. Dental services financed from public sources (within the general health insurance) are rendered by those providers who have a contract with the National Health Fund.

There are some public clinics that are owned by public authorities (e.g. municipalities or voivodships). They provide dental treatment either under the contract with the National Health Fund or outside the general insurance system.

Working in Hospitals

Hospitals are mostly public property. There are a small number of private hospitals run, for example run by the Church or individuals. Dental 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 about 400 dentists who work in the 10 dental schools. 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 who work for the armed forces provide dental care to the members of the forces. These dentists may either be regular personnel or at the same time be members of the armed forces.

Professional Matters

Professional associations

	Number	Year	Source
Polish Dental Association (Society)	5,400	2013	Chamber
Chamber of Physicians & Dentists	21,800	2013	Chamber

The Polish Supreme Chamber of Physicians and Dentists (*Naczelna Izba Lekarska*) and the regional chambers of physicians and dentists (*okręgowe izby lekarskie*) are the organisational bodies of the professional self-government of physicians and dental practitioners who are associated in the chambers with equal status.

There are 23 regional chambers and a separate chamber of military physicians and dentists, operating nationwide, which has legal status of the regional chamber.

Chambers deal with all kinds of problems of practising medicine and dentistry in Poland. They represent and defend the interests of the two professions, as well as act as regulatory authorities – award the right to practise and supervise the exercise of the professions.

The jurisdiction of individual regional chambers of physicians and dentists and their headquarters are determined by the Polish Supreme 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. Every physician and every dental practitioner who holds the right to practise the profession in Poland is a member of the chamber by virtue of the law.

Besides professional self-government there are numerous other professional and scientific dental associations in Poland. There are ~ 15 scientific dental societies

The Polish Dental Society (Association) is the largest scientific dental association Membership of this, and other associations, is voluntary.

Each division organises area meetings in which papers, lectures and scientific research are delivered. The functions are often carried out in cooperation with the regional Chambers.

Other registered and acting scientific and specialist societies are in particular: 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, fine, 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 disciplinary procedure is determined the Law on the Professions of Physician and Dental Practitioner. Disciplinary sanctions are imposed by a judgement of Medical Court which is a part of the Chamber. The Regional and Supreme Medical Courts comprise of dentists and physicians. However, cases rigidly connected with dental practice would be heard 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

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.

In case of a dispute a patient who demands compensation from a dentist (either directly or through the indemnity insurance) has to commence civil proceedings in a court of law.

Corporate Dentistry

Dentists in Poland may form commercial companies to carry out the activities in the field of dental care; a non-dentist can be a shareholder or a member of the board of a company that sets up a dental care facility. General regulations of the Polish company law apply - there are no limitations as to the number of non-dentist shareholders.

Tooth whitening

Generally the use of tooth whitening products in Poland is regulated in accordance with the EU Directive on cosmetic products (recently amended). The Directive's provisions related to tooth whitening products have been transposed into Polish law.

There have been cases of illegal use of tooth whitening products by non-dentists.

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

Dentists are subject to the general pension scheme in Poland.

In 2013, those who work in an employed capacity pay retirement contributions at the amount of 19.52% of the employee's taxable income (split equally between employer and employee, which means that in fact the employee pays 9.76% of income).

Those working in a self-employed capacity pay contributions on the declared amount, but not lower than 19.52% of 2,227.80 PLN (approximately €520).

The retirement age was until 2013: 60 for women and 65 for men. But, commencing from 2013, it is gradually being raised – in order to reach 67 for both genders in due course.

Taxes

In 2013, personal income tax was calculated according to the following tax scale:

Taxable base in PLN up to ZLN 85,528 (€20,124), the tax payable is 18% minus the tax reducing amount of PLN 556.02 (€130.82). For incomes more than PLN 85,528 the tax is PLN 14,839.02 + 32% of the surplus over PLN 85,528.

VAT

The standard VAT rate is 23%. Preferential rates of 5% and 8% apply to certain goods and services; other goods and services (for example dental treatment, are zero)

Various Financial Comparators

Warsaw ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	51.8	46.7
Wage levels (net)	11.4	16.5
Domestic Purchasing Power at PPP	23.2	30.7

Source: UBS August 2003 & November 2012

Other Useful Information

Details of information centres:	
Misterstwo Zdrowia (Ministry of Health) Website: www.mz.gov.pl	Narodowy Fundusz Zdrowia (National Health Fund) 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 Siedziba Prezydenta PTS ul. Montelupich 4 Małopolska 31-155 Kraków Polska Tel: +48 12 424-54-42 Fax: +48 12 424-54-94 Website: http://www.pts.net.pl
Other useful contacts:	
Centrum Medyczne Kształcenia 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

The monthly magazine of the Chamber - "Gazeta Lekarska" - regularly contains information about national and international developments in the field of dentistry, incl. reports on activities of CED, ERO, FDI.

There are 23 scientific dental periodicals. Two of them, "Journal of Dentistry" and the "Journal of Prosthodontics" 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 Przegląd 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 2013
Białystok	309	78
Gdańsk	300	64
Zabrze (Katowice)	518	77
Kraków	380	84
Lublin	479	103
Łódź	662	92
Poznań	460	83
Szczecin	439	86
Warszawa	500	100
Wrocław	460	83
Overall total	**4,507**	**850**
About 5% of places for Polish students are private*		

* fees are payable by them

City: *Bialystok*
The Dean
prof. dr hab. Irina Kowalska
Oddzial Stomatologiczny
Wydział Lekarski z Oddziałem Stomatologii i Oddziałem Nauczania w Języku Angielskim
Uniwersytet Medyczny
ul. Kilinskiego 1
15-089 Bialystok, POLAND
Tel: +48 85 748 54 30
Website: www.amb.edu.pl
e-mail: dzwl@umb.edu.pl
Dentists graduating each year: 78
Number of students: 309

City: *Gdansk*
The Dean
Medical University of Gdansk
dr hab. med. Maria Dudziak, prof. nadzw.
Oddzial Stomatologiczny
Wydział Lekarski z Oddziałem Stomatologicznym
Uniwersytet Medyczny w Gdańsku
Al. Zwycięstwa 41/42
80-210 Gdansk, POLAND
Tel: +48 58 349 1005
Website: www.gumed.edu.pl
deanmed@gumed.edu.pl
Dentists graduating each year: 64
Number of students: 300

City: *Krakow*
The Dean
dr hab. Bartłomiej Loster, prof. UJ
Oddzial Stomatologiczny
Uniwersytet Jagielloński Collegium Medicum
Wydział Lekarski
ul. Św. Anny 12 31-008 Krakow
POLAND
Tel: +48 12 422 54 44
Website: www.wl.cm-uj.krakow.pl
dziekwl@cm-uj.krakow.pl
Dentists graduating each year: 84
Number of students: 380

City: *Lublin*
The Dean
prof. dr hab. n. med. Ryszard Maciejewski
Oddzial Stomatologii
I Wydział Lekarski z Oddziałem Stomatologicznym
Uniwersytet Medyczny
Aleje Raclawickie 1
20-059 Lublin, POLAND
Tel: +48 81742 3679
Website: www.umlub.pl/
ryszard.maciejewski@umlub.pl
Dentists graduating each year: 103
Number of students: 479

City: *Lodz*
The Associate Dean
dr hab. n.med. prof. nadzw. Jerzy Sokołowski
Uniwersytet Medyczny
Wydział Lekarski
Oddział Stomatologiczny
ul. Pomorska 251
92-213 Lodz, POLAND
Tel: +48 42 675 74 46
Fax: +48 42 675 74 56
Website: www.umed.lodz.pl
jerzy.sokolowski@umed.lodz.pl
Dentists graduating each year: 92
Number of students: 662

City: *Zabrze / Katowice*
The Dean
prof. dr hab. n. med. Maciej Misiołek
Wydział Lekarski z Oddziałem Lekarsko-Dentystycznym w Zabrzu
Śląski Uniwersytet Medyczny
Pl. Traugutta 2
41-800 Zabrze
POLAND
Tel: +48 32 37 05 280
Website: http://www.sum.edu.pl/
dziekan-wlz@sum.edu.pl

Dentists graduating each year: 77
Number of students: 518

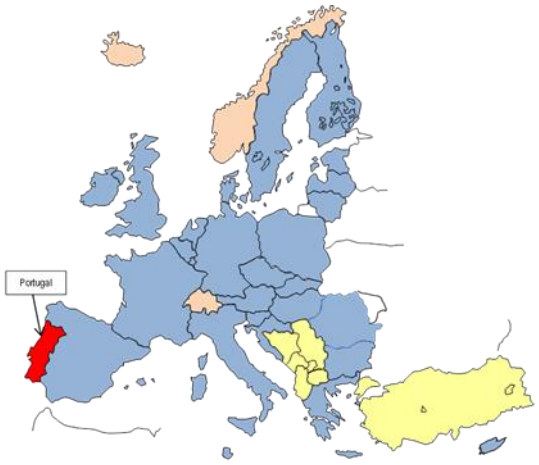
City: *Warsaw*
The Dean
prof. dr hab. n. med. Elżbieta Mierzwińska-Nastalska
Wydział Lekarsko-Dentystyczny
Warszawskiego Uniwersytetu Medycznego
ul. Żwirki i Wigury 61 pok. 213
02-091 Warszawa, POLAND
Tel.: +48 022 572 02 13
Fax: +48 022 572 02 66
Website: www.wum.edu.pl
elzbieta.mierzwinska-nastalska@wum.edu.pl
Dentists graduating each year: 100
Number of students: 500

City: Szczecin
The Dean
Katedra i Zakład Stomatologii Ogólnej
Wydział Lekarsko-Stomatologiczny
Pomorski Uniwersytet Medyczny
ul. Rybacka 1
70-204 Szczecin,
POLAND
Tel: +48 91 48 00 812
Website: **www.pum.edu.pl**
Dentists graduating each year: 86
Number of students: 439

City: *Wroclaw*
The Dean
dr hab. Beata Kawala, prof. nadzw.
Wydział Lekarsko - Stomatologiczny
Uniwersytetu Medycznego we Wrocławiu
ul. Krakowska 26
50-425 Wroclaw, POLAND
Website: http://www.stomatologia.umed.wroc.pl
ds@umed.wroc.pl
Tel: +48 717840356
Fax: +48 717840118
Dentists graduating each year: 85
Number of students: 406

City: *Poznań*
The Dean
prof. dr hab. Zbigniew Krasiński
Wydział Lekarski
Collegium Stomatologicum
Uniwersytetu Medycznego im. Karola Marcinkowskiego
w Poznaniu
ul. Bukowska 70, 60-812 Poznań
Tel. +48 61 854 71 31
Fax. +48 61 854 71 33
Website : http://www.ump.edu.pl/
dwl2@ump.edu.pl
Dentists graduating each year: 83
Number of students: 460

Portugal



Date of last revision: 27th January 2014

In the EU/EC since	1986
Population (2013)	10,487,289
GDP PPP per capita (2012)	€17,746
Currency	Euro
Main language	Portuguese

The National Health service is largely funded through general taxation. Dentists work mostly in the private sector. Only a few regional health centres and hospitals include oral health professionals. There is a the Portuguese Public Oral Health Programme (PPOHP) that provides assistance to certain vulnerable groups.

Dentists, stomatologists & odontologists:	9,097
Population ratio (active workers):	1,153
Membership of the OMD by dentists:	100%

The specialties of Oral Surgery and Orthodontics were implemented only in 1999; six further specialties have now been approved.
Continuing education for dentists has been mandatory since January 2009.
The competent authority and regulatory body is the Ordem dos Médicos Dentistas (OMD) - the Portuguese Dental Association, to which all dentists must belong.

Government and healthcare in Portugal

Portugal is a parlamentary democratic republic, with Lisbon, the nation's largest city, as its capital. The constitution grants the division, or separation, of powers among legislative, executive, and judicial branches. The four main institutions as described in this constitution are the President of the Republic, the Parliament, known as the Assembleia da República (English: Assembly of the Republic (Portugal)), the Government, headed by a Prime Minister, and the Courts. Both the President and the Parliament are elected by means of universal suffrage, through national elections.

The President of the Republic is elected by direct universal suffrage for a five-year term. He/she has a supervisory non-executive role with a threefold role: executive power supervisor, armed forces Supreme Commander and international representative of the State. **The Parliament** (Assembly of the Republic) is a chamber composed of 230 deputies elected, by popular vote for legislative terms of four years from the country's twenty-two constituencies, eighteen in mainland Portugal corresponding to each district, one for each autonomous region, Azores (Portuguese: Açores) and Madeira, one for Portuguese living in Europe and a last one for those living in the rest of the world, according to a system of proportional representation and the highest average method (Hondt method). The Portuguese Parliament has the legislative competence, as well as political and fiscal power above the government.

The President of the Assembly of the Republic is the second hierarchical figure in the Portuguese state, after the President of the Republic.

The government, whose head is the Prime Minister, is the leader of the party with most votes in each election, appointed by the President on the basis of the election results and after consultation with the political parties. The President also appoints the other members of the government under the recommendation of the prime minister.

The Courts are organized into several levels. The Supreme Courts are institutions of last resort/appeal. The Constitutional Court oversees the constitutionality of the laws.

The administrative system comprises 5 regions (North, Centre, Lisbon, Alentejo and the Algarve), 18 districts and 2 autonomous regions (the Azores and Madeira). The districts are further divided into municipalities (concelhos), which have their own level of elected government and boroughs (freguesias). The islands (Azores and Madeira) have their own political and administrative structures.

Healthcare is controlled by a Minister of Health.

The **Ministry of Health** is responsible for developing health policy as well as managing the National Health Service (Serviço Nacional de Saúde). Five regional health administrations are in charge of implementing the national health policy objectives, developing guidelines and protocols and supervising health care delivery. Decentralisation efforts have aimed at shifting financial and management responsibility to the regional level. In practice, however, the autonomy of regional health administrations over budget setting and spending has been limited to primary care. In the Autonomous Regions of Azores and Madeira, there is an effective autonomy on regional health strategy and administration over budget setting and spending.

Under the scope of the Constitution, the NHS is by definition and universal and "tendentiously free". Taking into account the economic and social conditions of the user and chronically ill patients, about 40 % of the population are exemptof any extra co-payment when using the Service.

Beneficiaries pay a "taxa moderadora" [co-payment] for each appointment or treatment provided in the SNS. A regular appointment in a Health Centre, for example, costs €5, while an emergency appointment in a hospital costs from €15 to €20, plus the costs of any other clinical procedure.

The **Health Centre and** the **Health Family Unit (HFU)** are the basic units of the National Health Service (SNS).Distributed throughout geographic areas, who provide essential health care of both preventive and curative nature. For general practice and family medicine, public healthcare, nursing, immunisation and some diagnostic tests the Health and the HFU are the primary care contact points. Centre is the first place to go. Under the Portuguese healthcare system, patients are assigned a general practitioner/family doctor (medico de familia) at their local health centre or health family unit.

Aside from administrative staff, family and general medical doctors, there are public health doctors (public health authority) and nurses in some Health Centres. There are also other professionals working there, such as social workers, oral hygienists, environmental health workers, nutritionists and psychologists. Only a small number of stomatologists and a very few dentists (médicos dentistas) work in Health Centres and HFU.

Hospitals services include ambulatory (specialist appointments), internal and emergency patients. There are different kinds of Hospitals with specific target intervention. There are also some private hospitals.

The NHS pays part of the cost of most medicines, though some are totally subsidised, particularly those which are vital for treating certain illnesses.

The Portuguese health system is characterized by three coexisting systems:

The National Health Service (Sistema Nacional de Saúde - SNS), which is funded largely through general taxation. The NHS provides universal coverage, even to the groups below.

Special social health insurance. In addition to NHS schemes, there is health subsystems for certain professions, for example for lawyers, banks, military and public servants, covering about 25% of the population. Each fund has its own administrative structure and each one pays a different level of benefit as a contribution towards the cost of care.

Voluntary private health insurance - In addition to NHS, about 20% of the population is covered by private insurance schemes or mutual funds.

The Parliament decides the level of health expenditure each year.

Oral healthcare

Publicly funded oral healthcare

The Portuguese Public Oral Health Programme (PPOHP) began in 2005, after the guidelines for fluoride intake were revised and implemented by the Ministry of Health.

Until 2008 the main purpose of the PPOHP was to promote oral health in the kindergartens and public schools of the first cycle, as well as take some preventive actions such as promoting tooth brushing at the schools. This part of the program still is held by hygienists that do some fissure sealing, and nurses from the public health system.

Since 2008 the Portuguese government, together with PDA, introduced in the PPOHP the "dental voucher". This programme presents a new complementary public strategy to control oral diseases, focused on dentist and hygienist action. For the first time ever, some specific groups of the population have access to oral health promotion, prevention and treatment of oral diseases integrated in a public program. There is a specific budget of €16 million for this program (2013) and is defined by the government for each year. About half a million people is enrolled in PPOHP.

		Year	Source
% GDP spent on health	10.2%	2011	OECD
% of this spent by government	65.0%	2011	OECD

This is a programme where every private dentist who is interested to join, can do so freely and gives the chance for the patients to choose freely to whom to go, from a list of private enrolled dentists. The dentists attend to the patients in their own clinics or offices.

Each of the vulnerable selected groups has a specific program to be fulfilled by the patient and the dentist.

There is a programme for the people over 65 years old, identified as a low income specific group that benefit from the public *Solidarity Complement for Seniors*, who can access the dentist every year for a group of identified basic dental treatments. This group can also have a public co-payment for removable prostheses up to €250 (2013).

Another group that benefits from this programme is pregnant women who are followed up by the public health system. They have also right to a specific group of basic treatments during pregnancy and until 3 months after the birth of the child.

Patients with Human Immunodeficiency Virus have also a group of basic treatments that they can access. The treatment

needs of this group are known to be greater, so the programme takes that in account.

Children and adolescents (from 3 to 16 years old) have a specific programme with particular emphasis at the ages of 7, 10, 13 and 16 years old, where everybody is observed for diagnosis, a treatment plan and basic treatments or fissure sealing.
The programme data of the "dentist voucher" are registered in software specially developed for this purpose and contains the diagnosis, treatment plan and treatments performed for each patient. This software has also other functionalities including all the procedures related to the payments to dentists.

Another publicly funded oral health care system is called ADSE (Social Protection for Public Workers) and considers a public co-payment for dental treatments delivered by dentists in their clinics or offices for these public workers and their families. It also includes prosthodontic rehabilitation.

There are other public systems that consider a co-payment, but may disappear. It also includes prosthodontic rehabilitation that, in some cases, might need prior approval.

Most of oral health care is provided in private (liberal) practices. Few public hospitals and health centers from the National Health Service have stomatologists and a few dentists. Some private hospitals also have dentists.

Domiciliary dental care is not offered in the public health system.

There is no data about the frequency of attendance by patients for their routine oral healthcare.

		Year	Source
% GDP spent on oral health	0.36%	2004	OMD
% of OH expenditure private	40%	2004	OMD

Private insurance for dental care

Almost all insurance companies include dentistry in their scope. These insurances are often expensive and can have three options: reimbursement, convention and a combined solution.

In the first system, the patient pays the total cost of treatment to the dentist and then ~~re~~claims reimbursement, as appropriate from the company. Prior approval applies through reports from the dentist and sometimes, partial reimbursement may happen in advanced prosthodontic rehabilitations. In the second system, the cheaper and the most common, for each treatment the dentist earns a certain amount defined by the insurance company. Besides the amount paid by the company, the patient may have to make a direct co-payment to the dentist that varies depending upon the contract established between the company and the patient.

Most private insurance provide limited coverage, as all "insurance products" assume a supplementary nature relative to the NHS coverage. In 2013, approximately 20% of the population had taken out some form of VHI. About half of the policies are group insurance provided by the employer, and half are individual policies.

These insurances are mostly for high or upper middle *class* and business executives. The private insurance policies which people can purchase provide a range of medical benefits including or not dental care. The last ones are the most expensive. Only dental insurance is not available.

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.

There is also a market product nominated by dental plan which is not subject to a proper regulation - often a source of controversy due to its confundibility aspect to consumers, when compared with traditional insurance products.

In the two political-administrative autonomous Regions, the health systems are also autonomous. In the *Região Autónoma da Madeira* (Madeira) there is a public insurance plan providing reimbursement for dental care with some exclusions. A few dentists are salariad in hospital primary care. In the *Região Autónoma do Açores* (Azores) most of all of the nine isles of the archipelago are equipped with dental care in health centres - about eighteen regional health centres in total.

The Quality of Care

The quality of the care provided is monitored by the OMD and in most of the cases fraud or illegal practice is identified and pursued by the joint action of several public health authorities. Complaints from patients are dealt with in two different ways, by the Order or/and by the Courts.

The OMD issues on a regular basis several clinical and professional regulatory guidelines and the Manual of Good Practice

Health data

		Year	Source
DMFT at age 12	1.50	2007	CECDO
DMFT zero at age 12	44%	2007	CECDO
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 artificial water fluoridation areas in Portugal. In Azores and Madeira you can find some places (mainly in Azores) wher you can find natural water fluoridation. The PPOHP recommends the use of fluoridated toothpaste for children included in 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 public and private University. Then the candidates are selected after consideration of the average classification obtained on the secondary school and on the national exams.

Year of data:	2012
Number of public schools	3
Number of private schools	4
Student intake	716
Number of graduates	553
Percentage female (2006)	66%
Length of course	5 yrs
VT mandatory?	No

The public dental schools are located in university faculties of Medicine (*Coimbra*) and in faculties of Dental Medicine (*Porto* and *Lisbon*). The private schools are in Institutes of Health (North - CESPU and South - Egas Moniz), in the Fernando Pessoa University and in the Catholic University. Some students in private schools receive scholarships, but not all.

Until the entry into the EU in 1986, many dentists qualified as "Stomatologists" who are medical practitioners with an additional, two or three years of dental training. They are trained in public hospitals of the National Health Service. Portugal EU membership has caused a growth of the number of dentists (Médicos Dentistas) whose curriculum meets the requirements of the Professional Qualifications Directive and a dramatic reduction of the number of stomatologists. By 2013, only a handful of stomatologists were being trained per year.

The students who entered university in 2005 or after have study plans of five years, which includes theoretical education and practical training. Before 2005 the courses were of 6 years' duration.

Qualification and Vocational Training

Primary dental qualification

The *Bologna Declaration* was adopted by Portugal and reformed the structures of the higher education system. Before the Bologna process the main degree which could be included in the register was the *Carta de curso de licenciatura em medicina dentaria.* After Bologna, its official designation is *Carta de curso de mestrado integrado em medicina dentária,* Master's degree. (diploma conferring official recognition of completion of studies in dentistry).

Vocational Training (VT)

In 2013, there iwas no requirement for post-qualification vocational training, although its implementation could be considered by the OMD (*Ordem dos Médicos Dentistas)* due to a special disposition related to future mandatory vocational training. So it is compatible with the choice of *law rules contained* in the OMD Statute.

Distinctively and complementary, there are also several State-run youth employment programmes applicable for qualified professions such as dentists.

Registration

To obtain registration an applicant must hold a degree or Diploma in Dentistry (Dental Medicine) ~~or~~ meet the requirements of the Professional Qualifications Directive.

Applications are exclusively addressed to the OMD, which also holds the register. The OMD Statutes define 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 (2012)*	€250+
*€250 to €1,000	

The variable registration fee depends on the extension of administrative procedures for the analysis of each request.

Language requirements

Migrants must have basic knowledge of Portuguese, the official language necessary for practising the profession in Portugal. Nevertheless, this disposition needs further development in order to be completely transposed into an official control.

Further Postgraduate and Specialist Training

Continuing education

Continuing education is regulated by the OMD. There is an internal rule which regulates continuing education that already foresees conditions and the terms of mandatory CPD.

The OMD offers an annual continuing education programme; this includes one annual multidisciplinary scientific, social and professional congress (3 days). There are also several courses such as: short courses, usually at the end of the-day; mini-courses (half-a-day courses) and practical courses. Dentists who attend may pay a registration fee and receive a Certificate of Attendance (most of it are being freely offered by OMD to its members).

Specialist Training

OMD holds the exclusive and public competencies for implementing and recognising dental specialties.

Specialist training in Portugal, in the recognised specialties of orthodontics and oral surgery, is at least 3 years in length, takes place in the OMD recognised higher education centres, and is followed by a clinical cases presentation examination to a jury nominated by the OMD. Students receive no remuneration during training.

In 2013, the OMD approved the specialties of paediatric dentistry, periodontology, endodontics, prosthodontics, dental public health, and of hospital dental medicine.

Boards of the new specialties are running for full implement-ation by the OMD.

The titles awarded for specialist qualification (provided by OMD) are:

- Orthodontics (*especialista em ortodontia*)
- Oral surgery (*especialista em cirurgia oral*)
- Paediatric dentistry (*especialista em ondontopediatria*)
- Periodontology (*especialista em periodontologia*)
- Endodontics (*especialista em endodontia*)
- Prosthodontics (*especialista em prostodontia*)
- Dental public health (*dental public health*)
- Hospital dental medicine (*especialista em medicina dentária hospitalar*)

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). All dentists now trained and qualified in Portugal since then are recognised under the Professional Qualifications Directive, and may work in any EU/EEA country

Dentists

Dentists ("Medicos Dentistas"), in Portugal, work almost exclusively in private practice.

Year of data:	2012
Medicos Dentistas registered	8,568
Medicos Dentistas in active practice	7,779
Population to dental worker ratio*	1,153
Percentage female	57%
Qualified overseas	840
Stomatologists	650

Odontologists	668

** active dentists, stomatologists & odontologists*

"Odontologists"

The former group of "technicians", designated as odontologists, are recognised only in Portugal. They were introduced in the early 1980s, but are no longer being trained. Their qualification is insufficient to be recognised as dentists, even under Acquired Rights, as their training does not comply with the Professional Qualifications Directive.

There is no specific body to register odontologists, although they do need to register at the Ministry of Health. There is also a disciplinary body working to regulate and produce an ethical code for them, called CEPO.

"Stomatologists"

Stomatologists are regulated and registered as members of a college of the Portuguese Medical Association.

Movement of dentists across borders

There is a significant cross border movement, which the OMD report as increasing significantly.

Specialists

The specialties of Orthodontics and Oral Surgery were introduced in 1999. Oral Maxillo-facial surgery is a medical specialty.

Year of data:	2012
Orthodontics	51
Oral Surgery	4
OMFS	93

Dental specialists work in private practice, only.

New specialties recognised by the OMD are currently (in 2014) in the implementation phase.

Auxiliaries

Other than Dental Assistants, for whom there is no organised formal education, or training requirements, there are two other recognised technical professions in Portugal. They are:

- Dental hygienists
- Dental technicians

Year of data:	2012
Hygienists	520
Technicians	546
Denturists	0
Assistants	No data
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 course certificate.

There are four higher education institutions providing such training: the Faculdade Medicina Dentária da Universidade de Lisboa; ISAVE - Instituto Superior do Alto do Ave; CESPU – Norte; Escola Superior de Saúde de Portalegre.

To work dental hygienists have to be registered. The registration is administered by the Ministry of Health. Hygienists must work under the supervision of a dentist, who must be present at the office when they are working. Their fields of action are oral hygiene education and screening, oral examination, clinical record data and prophylaxis (scaling), the application of topical products and sealants, clinical assistance to the dentist and care of dental equipment. They are not allowed to do local anaesthetics.

Dental Technicians

Most dental technicians do not have academic (degree) qualifications. However, 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).

As with hygienists, there are four higher education institutions in such area: Faculdade Medicina Dentária da Universidade de Lisboa, ISAVE - Instituto Superior do Alto do Ave, CESPU – Norte, Instituto Superior de Ciências da Saúde Egas Moniz-Almada.

They must register at the Ministry of Health. Those who are responsible for manufacturing the prosthesis (medical devices) must be registered at the Competent National Authority for Medical Devices (INFARMED)

Technicians work in dental laboratories and cannot offer services to the public. They earn their fees from dentists for the work they provide to them. However, OMD have reported that there is illegal practice of dentistry, which is being pursued by the public authorities.

Dental Assistants

There is no available information about the number of 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

The figures for hospitals refer to stomatologists who practise only in hospitals. The remainder are in general (private) practice. Approximately 50% of the population has no acess to dental care, due to financial reasons, amongst others.

Year of data:	2012
General (private) practice	9,007
Public dental service	43
University	446
Hospital	90
Armed Forces	16
General Practice as a proportion is	94%

Working in General Practice

More than 90% of dentists work in private practice and claim payment directly from patients.

There are also public and private illness funds. In these situations the dentist claims his fees directly from the fund and there is no patient charge in most cases, except for treatments that are not covered. Sometimes, a patient may have to make a co-payment.

Fee scales

As outlined above, in private practice, where patients pay 100% of fees, the dentist sets the fees. For work with patients included in publicly funded health care system, each fund is self regulating, setting the fees and the OMD have no part in the process.

Specialists receive the same fees as the generalists, when they are paid by the publicly funded health care system or by private insurance companies.

The control on the quality of care provided in private practice is under the OMD ethical code and its guidelines and regulation.

Joining or establishing a practice

For establishment ~~of~~ dental practices there is a need for licensing. The law regulates the operation of dental clinics 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.

It also regulates the licensing process and establishes the supervising bodies, and the tools for the practice of dentistry at national and regional levels. The licence is issued by one of the five Health Regional Administrations.

Dentists in private practice are free to join individually the Portuguese Public Oral Health Programme (PPOHP). Mixed practices also exist and are increasing. No government funding is available for the purchase of dental practices.

OMD negotiated with the Ministry (Direcção Geral de Saúde) healthcare for children and other target groups. Progress had already been made with the Portuguese Public Oral Health Programme (PPOHP) on children and teenagers and then with pregnant, aged people and HIV patients. This programme is also held in Health Centres.

The PPOHP has a primary strategy for intervention, based on oral health promotion, oral disease prevention and basic dental treatment

Working in the Public Clinics

There are about 400 Public Health Centres (Centros de Saúde) and some HFU (Unidades de Saúde Familiar): few dentists work in these units.

Working in Hospitals

Only Stomatologists work in the approximately 80 Public hospitals in Portugal, and there are very few dental services. The number of private hospitals is growing and some dentists work there. There is no data available.

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.

Working in the Armed Forces/Military Health Services

There are dentists working in the military health services. In 2012 this included 7 in the Army (1 female), 4 in the Navy (2 females) and 5 in the Air Force (4 females).

Professional Matters

Professional associations

The national dental association is the Portuguese Dental Association (*Ordem dos Médicos Dentistas* (OMD), which is the Public Authority that administers the dentists' (Médicos Dentistas) register. All dentists are members - it is mandatory to be a member to practise.

	Number	Year	Source
Ordem dos Médicos Dentistas	8,568	2012	OMD

The OMD is also represented at the 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 (Azores 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

Stomatologists are members of a college of the Portuguese Medical Association.

There is no specific body to register odontologists, although they do need to register at the Ministry of Health. There is also a disciplinary body working to regulate and produce an ethical code for them, called CEPO.

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.

The OMD has also issued quality rules within the profession, such as the Manual of Good Practice.

Fitness to Practise/Disciplinary Matters

If *prima facia* evidence is found to support any complaint, it may be referred to the Ethical Council of OMD for investigation.

The Council has the power to reprimand the dentist, suspend the activity for up to five years or expel him or her from the OMD. 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. 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 some specific regulation about health services advertising in Portugal. There is an internal national rule according to the general law and also according to the Ethical Code for Dentists. The general Law does not allow absolute restrictions to advertising.

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.

All OMD members' can benefit from the professional basic indemnity insurance plan, free of charge.

Corporate dentistry

According to the Deontological Code of the OMD, dentists may form into companies.

Non-dentists can own a company, but according to the law and the Deontological Code, companies must have a clinical director, who must be a dentist.

Tooth whitening

Portugal has implemented the EU legislation that restricts the free sale of products that contain more than 0.1% hydrogen peroxide concentration, whilst no specific national legislation exists on tooth whitening products. The regulating national authority is the *INFARMED.*

Health and Safety at Work

Vaccines, such those as for 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. This is also a requirement for licensing the health unit.

Amalgam separators

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	Laboratory of Radiological Protection and Safety and the National Institute of Engineering, Technology and Innovation
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

General health care is funded largely throught general taxation, as explained. The NHS provides universal coverage tendentiously free.

Insurance Scheme Social Security benefits apply to Portuguese nationals, qualifying European Union nationals, and those legally resident in Portugal as well as their spouses and dependents. Social Security provides benefits for retirement, unemployment, sickness, work-related accidents, disability, death and old age, maternity, paternity and adoption

The retirement age is 65 years, but it will be extended to 66 years starting in 2014. It is possible to defer the pension until the age of 70.

The social security system has three basic schemes:

- There is a contributory scheme for employed individuals and their families (Employees pay premiums of about 11% of earnings - with employers contributing 23.75% of earnings).
- There is a contributory scheme for self-employed individuals. They one can choose to pay the obligatory rate of 25.4%, based on the previous year's income, that gives compulsory cover only (retirement, disability, death and old age, maternity, paternity and adoption), or a voluntary 32% rate that also covers sickness and other family benefits
- There is also a non-contributory scheme for those who do not meet the minimum income requirements to belong to either of the first two schemes (for disability, retirement, death and family).

Dentists can practice beyond 66 if they wish, as there is no age limit. The retirement earnings estimation is the best salary of the10 out of the final 15 years. However, this base is being extended, such that it will reach lifetime average earnings from 2017.

Taxes

Income Tax

There is a national income tax (dependent on salary). The lowest rate is 14 %, for an annual gross income below €7.000 and the higher is 45 % at incomes above €40,000.

VAT/sales tax

A reduced rate of 6% (applies to general to basic food products, pharmaceutical products, water, medical, newspapers, hotels, passenger transport). Anesthesia and prosthetic devices are charged at this 6% rate. An intermediate rate of 13% (applies to general to other food products, wine, agricultural supplies, cultural events)

A standard rate of 23% applies to remaining goods and services not subject to the above rates. Dental materials and equipment are charged at this 23% rate.

The cost of dental health care (and other health care too) is VAT free.

Various Financial Comparators

Lisbon ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	68.5	58.6
Wage levels (net)	25.1	32.2
Domestic Purchasing Power at PPP	37.7	45.8

Source: UBS August 2003 & November 2012

Other Useful Information

Competent Authority:

Ministério da Saúde
Departamento de Recursos
Humanos da Saúde
Avenida Miguel Bombarda, 6
1000-208 Lisboa
Tel: + 351 21 798 4200
Fax: + 351 21 798 4220
E-mail: drhs@drhs.min-saude.pt
Website: http://www.min-saude.pt

Publications:

Revista da OMD
Av. Dr Antunes Guimarães, 463
4100 - 080 Porto
Portugal
Tel.: +351 22 619 7690
Fax: +351 22 619 7699
Email: omdsede@omd.pt
Website: www.omd.pt

Os Números da Ordem – Estatísticas
Av. Dr Antunes Guimarães, 463
4100 - 080 Porto
Portugal
Tel.: +351 22 619 7690
Fax: +351 22 619 7699
Email: omdsede@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: omdsede@omd.pt
Website: www.omd.pt

Lisbon Delegation
Campo Grande, 28 – 7º B
1700-093 Lisboa
Portugal
Tel: + 351 21 794 1344
Fax + 351 21 799 3551
Email: omdlisboa@omd.pt
Website: www.omd.pt

Madeira Delegation
Conjunto Habitacional do Amparo S. Martinho
Avenida do Amparo nº 147
9000-276 Funchal
Tel.: +351 291 761 178
Fax: +351 291 768 252
Email: omdmadeira@omd.pt
Website: www.omd.pt

Azores Delegation
Angra Office Center Palmeiras Park
Rua Dr. Aníbal Bettencourt nº 242 – D
9700 - 240 Angra do Heroísmo
Email: omdacores@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 in 2012/2013= 103
Number of students: 425

Faculdade de Medicina Dentária de Lisboa
Cidade Universitária
1600 Lisboa
Tel: + 351 21 7922600
Fax: + 351 21 7957905
Email: correio@fmd.ul.pt or secretario@fmd.ul.pt
Website: www.fmd.ul.pt

Dentists graduating in 2012/2013 = 46
Number of students: 284

Faculdade de Medicina da Universidade de Coimbra
Licenciatura de Medicina Dentária
Av. Bissaya Barreto
3049 Coimbra
Tel: + 351 23 9400 578
Fax: + 351 23 9402 910
Email: md@fmed.uc.pt
Website: www.fmed.uc.pt

Dentists graduating in 2012/2013 = 43
Number of students: 233

Private Faculties:

Instituto Superior de Ciências da Saúde do Norte
Rua Central de Gandra,
1317 - 4858-116 Gandra PAREDES
Tel.: 22 415 71 00
Fax: 22 415 71 02
E-mail: info@cespu.pt
Website: www.cespu.pt

Dentists graduating in 2012/2013= 94
Number of students: 635

Instituto Superior de Ciências da Saúde Egas Moniz
Quinta da Granja
Travessa da Granja
2825 Monte da Caparica
Tel: + 351 21 294 6700
Fax: + 351 21 294 6768
Email: iscsem@egasmoniz.edu.pt
Website: www.egasmoniz.edu.pt

Dentists graduating in 2012/2013= 100
Number of students: 613

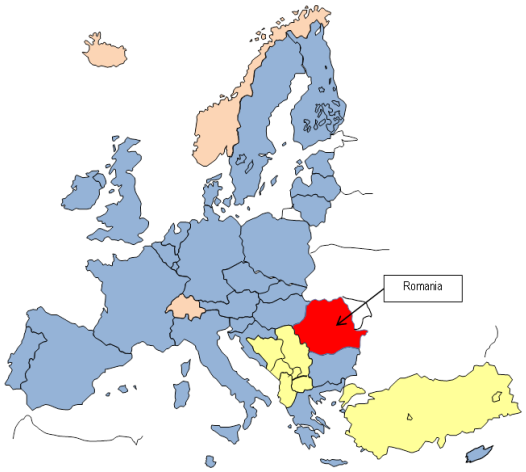
Universidade Fernando Pessoa
Rua Carlos da Maia, 296
4200-150 Porto
Tel: + 351 22 507 4630
Fax: + 351 22 507 4637
Email: reitoria@ufp.edu.pt
Website: http://www.ufp.pt/

Dentists graduating in 2012/2013= 123
Number of students: 588

Universidade Católica Portuguesa
Centro Regional das Beiras
Estrada da Circunvalação,
3504-505 Viseu
Tel: +351 23 241 9500
Fax: +351 23 242 8344
Email: info@crb.ucp.pt
Website: www.crb.ucp.pt

Dentists graduating in 2012/2013= 44
Number of students: 257

Romania



In the EU/EEA since	2007
Population (2011)	20,057,458
GDP PPP per capita (2012)	€9,796
Currency	Romanian New Lei (RON) 4.44 RON = €1.00 (2013)
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:	15,500
Population to (active) dentist ratio:	1,393
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 (RCDP), to which all dentists must belong.

Last amended: 21st December 2013

Warning: this section was prepared with the assistance of a former senior officer of the Romanian Collegiums, and the use of the internet, but without any cooperation from the official authorities or academic institutions. Some of the data may not be entirely consistent with the current (in 2014) situation.

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 41 ~~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	5.8%	2011	World Bank
% of this spent by government	80.2%	2011	World Bank

There is no more up to date available information

Oral healthcare

There is no up to date available information

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

Almost 90% of dentists are private; they have fiscal code and all kinds of legal authorisations for liberal 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, for an annual fee of aprox. €50, set 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 20% of Romanian dentists, owners or non-owners of their dental offices, work within the CSHIH. The other 80% 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.

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.

In 2013, due to the economic and financial crisis which affected Europe and had also consequences and effects in Romania, the budget for dental care was transferred to patients who suffer from cancer. It was an unprecedented political measure taken by the Ministry of Health.

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 based on dentist's experience, competence and self-evaluation of expertise. A real free dental market was established between 1990 to1998, with prices regulated by the principles of the market economy.

Approximately 75% of dentists have private patients only.

Private health insurance companies are not yet functioning in Romania (in 2013).

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 1,000 to 1,500 patients who he would count as his "list".

There is no form of domiciliary dental care.

Health data

		Year	Source
DMFT at age 12	3.30	2007	WHO
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.

In October 2013, a study showed that caries experience in schoolchildren in Bucharest was 75 percent, and 64 percent had untreated caries. The mean DMFT value for the entire sample was 2.8, and its highest component was decayed teeth (mean DT 2).

Parental education level had the strongest influence on the caries scores; 70 percent of children whose parents had not completed a university degree had untreated caries (%DT) compared to only 49 percent of children whose parents had a higher level of education ($P < 0.05$).

Children with access to school-based dental care had significantly better dental health ($P < 0.05$).

http://www.ncbi.nlm.nih.gov/pubmed/?term=Caries+experience+in+schoolchildren+in+Bucharest%2C+Romania%3A+The+PAROGIM+study

Fluoridation

There are no water or other fluoridation schemes in Romania.

Education and Training

Undergraduate Training

To enter dental school a Romanian (citizenship) student needs to be a high school graduate and pass an entry examination. There is no need for vocational entry.

It is possible for non-nationals to study dentistry in Romania in English, French or Romanian. Admission is based on application file selection or on an examination. The main dentistry entry requirement is a high school diploma.

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:	2013
Number of public schools	10
Number of private schools	3
Student intake	1,800
Number of graduates	1,700
Percentage female	70%
Length of course	6 yrs

Publicly funded schools: Bucharest, Cluj-Napoca, Iași, Timișoara, Târgu-Mureș, Craiova, Constanța, Sibiu, Oradea, Galați.

Privately funded schools: București, Iași, Arad

Students have to pay no contribution for the state-funded faculties and the full costs for the privately funded faculties. As for all medical studies in Romania, the tuition fee amount for dentistry study depends varies within each university. The minimum tuition fee is €2,000 (for Romanian students) and the maximum is €5,000 a year (for a non- Romanian citizen) (2013).

Every state funded faculty also has the right to manage a limited number of private places for students each year,for both budgeted and fee-paying students.
.
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 Romanian Collegiums of Dental Physicians (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 RCDP registers all Dental Physicians and all specialists.

Language requirements

It is mandatory 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 evaluation test, for which they must pay 500 RON (€111.10), in addition to the relevant registration fee.

Cost of registration (1)	€ 11.10
Cost of registration (2)	€ 111.10

(1) Romanian citizens
(2) Non-Romanian citizens

Further Postgraduate and Specialist Training

Continuing education

Continuing education is compulsory for all dentists. Every dentist must undergo 200 hours of continuing education in every 5 year period. If they do not achieve this the Romanian Collegiums of Dental Physicians (RCDP) has the legal obligation to end the right of the dentist to practise.

The regulation of Continuing (Medical) Education is based on the following mechanism: the RCDP authorises annually the dental professional associations and the lecturers. A lecturer is allowed to provide courses and or hands-on demonstrations credited by the RCDP, on specific subjects only, under the organisational supervision of a professional dental association.

Each kind of scientific event (one-day course, symposium, conference or congress) is credited with a number of credits of CME value.

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 6 specialties:

- Orthodontics: 3 years training,
- Oral-maxillofacial surgery: 5 years training,
- Dento-alveolar surgery: 3 years training.
- Endodontics: 3 years training.
- Periodontology: 3 years training.
- Prosthetics: 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;
- physician specialist endodontist;
- physician specialist periodontologist;
- physician specialist prosthetician

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:	2013
Total Registered	15,500
In active practice	14,400
Dentist to population ratio*	1,393
Percentage female	68%
Qualified overseas	450

** active dentists*

The active dental work force is known by the RDAPP to be increasing. More then 40% of dentists are younger than 40 years.

There is no information about whether there are unemployed dentists.

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	

More up to data has not been supplied.

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 charged with the registration of all specialists.

Auxiliaries

There are limited numbers of clinical dental auxiliaries in Romania.

Year of data:	2013
Hygienists (2008)	100
Technicians	4,500
Denturists	8
Assistants*	2,000
Therapists	0
Other	0
* estimated	

Dental Hygienists

In 2008, the RCDP provided data which showed that there were about 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.
http://www.otdr.ro/files/rutd.pdf

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 (page unchanged since 2008)

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	88%

There is no further up to date information about these numbers.

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 have said 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 workis 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 anintegrated 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

	Number	Year	Source
Romanian Collegiums of Dental Physicians (RCDP)	14,000	2007	RCDP
Romanian Dental Association of Private Practitioners (RDAPP)	700	2012	FDI
Romanian Soc of Stomatology	200	2012	FDI

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 Collegiums of Dental Physicians". The RDAPP was consulted by the Parliament and 70% of the RDAPP's proposals were included in the Law about Romanian Collegiums of Dental Physicians

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 theLaw 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

Despite the 2011 EU Directive, in 2013 there were still some beauty salons which offered a whitening service to their customers. This is not a legal practise, but it was said to be happening due to the passive attitude of the Romanian authorities, who had not taken any action by then.

Health and Safety at Work

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.

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.

Financial Matters (2013 data)

Retirement pensions and Healthcare

The set age for retirement is 60 years old for females and 64 years old for males. Dentists and dental auxiliaries can work after the retirement only in the private liberal system.

The compulsory deductions for Social Security are as in this table:

	Employer	Employee
Social Security	20.8%	10.5%
Health Fund	5.2%%	5.5%
Unemployment Fund	0.5%	0.5%
Risk Fund	0.25%	--
Accidents Fund	0.15%-0.85%	--
Medical Leave	0.85%	--

There are also optional private pensions. In compulsory general social pensions, the level of pensions was €2,100 per year (in 2013), but in optional private pension schemes the level depends upon the contributions made.

Taxes

The unique rate of tax is 16%, which is applied to income, corporate and capital gains.

VAT

The standard is 24%. There are reduced rates of 9% and 5%.The reduced 9% rate applies to hotel services, books, newspapers and medicines. The reduced 5% rate applies to buildings supply.

Medical and dental services, insurance companies, banks and financial services in Romania are exempt.

For dental materials, instruments and equipment, VAT is the same as for general goods, 24%.

Various Financial Comparators

Bucharest ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	29.9	33.9
Wage levels (net)	11.9	10.2
Domestic Purchasing Power at PPP	31.4	27.3

Source: UBS August 2003 and November 2012

Other Useful Information (2008 data)

Competent and Legal Authority:	***Dental Associations:***
Romanian Collegiums of Dental Physicians No headquarters in 2013 Bucharest Romania Tel: +40 21-222 5671 Fax: +40 21-222 5671 E-mail: secretariat@cmdr.ro Website:www.cmdr.ro	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 MirceaVulcănescu 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: http://www.ortodontie-caroldavila.ro/anro/
Romanian Society of Stomatology (Academic Association) IonelPerlea 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: "ViaţaStomatologică" (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: This information was taken from the internet in October 2013 and may not be accurate, as there was no response from any of the emails sent to every school with an email address.

There is no information about the number of students in each university, or the numbers graduating annually (except for BUCUREŞTI).

City: IAŞI UNIVERSITY OF MEDICINE AND PHARMACY "G.T. POPA"– FACULTY OF DENTAL MEDICINE Prof. dr. Norina Consuela Forna, decanFacultatea de MedicinaDentara Tel: +40 232-301-618 Fax: +40 232-211-820 Email:ncforna@CITEpi.umfiasi.ro Website: www.umfiasi.ro Intake 2013: 70 overseas students Language of teaching:	***City: TIMIŞOARA*** UNIVERSITY OF MEDICINE AND PHARMACY « VICTOR BABEŞ » FACULTY OF DENTAL MEDICINE Tel: +40 256-220480 Fax: +40 256-220480 Email : stoma@umft.ro Website: www.umft.ro Intake: 2013: Language of teaching: ::
City: TÎRGU- MUREŞ UNIVERSITY OF MEDICINE AND PHARMACY – FACULTY OF DENTAL MEDICINE Tel: +40-265-21 55 51 Fax:+40-265-21 04 07 Email: rectorat@umftgm.ro Website:www.umftgm.ro/en/the-faculty-of-dentistry.html Intake: 2013: Language of teaching: Romanian and English	***City: CLUJ-NAPOCA*** UNIVERSITY OF MEDICINE AND PHARMACY « I. HAŢIEGANU » FACULTY OF DENTAL MEDICINE Tel: +40-264-406-844 Fax: +40-264-597-257 Email: decanat_stoma@umfcluj.ro Website:www.meddent.umfcluj.ro/index.php/en/ Intake: 2013: Language of teaching: :
City: CONSTANŢA UNIVERSITY "OVIDIUS" FACULTY OF DENTAL MEDICINE Tel: +40 241 545697 Fax: +40 241 545697 Email: Website: www.ovidunivconstanta-edu.org/academic.php Intake 2013: Language of teaching: English	***City: CRAIOVA*** UNIVERSITY OF MEDICINE AND PHARMACY – FACULTY OF DENTAL MEDICINE Tel: +40 251 524 442 Fax: +40 251 593077 Email: dentistry@umfcv.ro Website:www.umfcv.ro/en/faculty-of-dentistry Intake: 2013: Language of teaching:
City: BUCUREŞTI UNIVERSITY OF MEDICINE AND PHARMACY « CAROL DAVILA » FACULTY OF DENTAL MEDICINE Tel: +40 21 3155217 Fax: +40 21 3126765 Email: Website: www.umfcaroldavila.ro Intake 2013: Dentists graduating each year: 250 Number of students: 1500 Language of teaching: Romanian	***City: SIBIU*** UNIVERSITY OF SIBIU FACULTY OF DENTAL MEDICINE Tel: +40 269 436777 Fax: +40 269 212320 Email: medicina@ulbsibiu.ro Website:www.ulbsibiu.ro/en/facultati/medicina/ Intake: 2013: Language of teaching:
City: GALAŢI (2013 information) FACULTY OF MEDICINE AND PHARMACY Str. Al. I. Cuza Nr. 35 , Galati Tel: 0336 130 217 Fax: 0236 412 100 E-mail: secretar.med@ugal.ro Website: http://www.fmfgl.ro/ Intake 2013: Dentists graduating each year: Number of students: Language of teaching:	***City: ORADEA*** FACULTY OF MEDICINE AND PHARMACY Tel: +40 259-412834 Fax: +40 259-418266 Email: medas@rdsor.ro Website: www.oradeauniversity.com/facultyofmedicine.htm Intake 2013: Dentists graduating each year: Number of students: Language of teaching:

PRIVATE FACULTY

City: BUCUREŞTI

UNIVERSITY OF MEDICINE AND PHARMACY
« TITU MAIORESCU » FACULTY OF DENTAL MEDICINE
Tel: +40 21 3251416
Fax: +40 21 3251415
Email :
Website:
Intake: 2013:

PRIVATE FACULTY

City :IAŞI

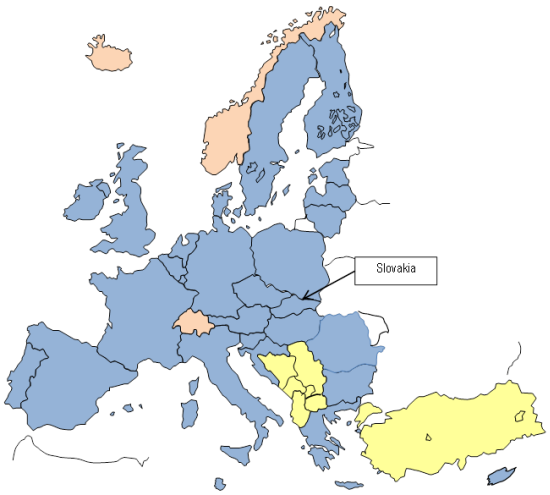
UNIVERSITY « APOLLONIA »
FACULTY OF DENTAL MEDICINE
Tel: +40 232 215922
Fax: +40 232 215900
Email :
Website:
Intake: 2013:
:

PRIVATE FACULTY

City: ARAD

WESTERN UNIVERSITY « VASILE GOLDIŞ »
FACULTY OF DENTAL MEDICINE
Tel: +40 257 228081
Fax: +40 257 228081
Email: medicina@uvvg.ro
Website: www.medicina.uvvg.ro/en/contact.html
Intake: 2013:
Dentists graduating each year:
Number of students:
Language of teaching: ::

Slovakia



In the EU/EEA since	2004
Population (2013)	5,410,728
GDP PPP per capita (2012)	€18,672
Currency	Euro
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:	3,357
Population to (active) dentist ratio:	1,641
Membership of the Dental Chamber::	87%

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. Whilst membership of the Chamber is voluntary, it is mandatory to register with the Chamber.

Date of last revision: 29th January 2014

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 km^2. 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 3 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	7.9%	2011	OECD
% of this spent by government	64.5%	2010	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 Slovak Chamber of Dentists 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. However, by 2013 the contribution for elderly people for a total prosthesis from the insurance company is 100%.

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	0.15%	2007	CECDO
% of OH expenditure private	50%	2007	CECDO

Private Practice

There is a relatively low percentage (about 15%) 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 economic and social environment – which includes relatively low average wages (€9,660 per annum), and 14% unemployment (2012).

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 Chamber 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, who work with an agreement with insurance company, 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 a "*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 was 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 about 1,800 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	1.80	2011	OECD
DMFT zero at age 12	26%	2007	CECDO
Edentulous at age 65	9%	2007	CECDO

"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

The DMFT data from 2010 referred to about 2.0 at 12 years of age, but the data were evaluated by a statistics institute obtaining it from dentists. This means that only children who visit a dentist entered into the sample. According to a local study, nearly 34% of children between 0-14 years have never visited a dentist, so the DMFT data are skewed by the sample being selective.

Fluoridation

There is no water fluoridation, or fluoridation of milk. Only fluoridated salt is available. There are no free toothpaste schemes for children.

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 4 medical faculties, which are known as *lekárska fakulta,* within Slovakian universities, all which are state owned and financed. All of them also offer a dental study program.

Year of data:	2013
Number of schools	4
Student intake	117
Number of graduates	101
Percentage female	60%

The Slovak Medical University in Bratislava opened a general medicine programme in 2006 and a dentistry programme in 2013.

The Jesenius medical faculty in Martin started a dentistry program in 2012. Both schools are public. The intake is low, 29 students altogether in 2013.

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. Were in 2009. These graduates - with MDDr - are entitled to open their own practice, and have not needed to undertake the 3 years' vocational training.

Vocational Training (VT) – known as "Stomatology" in Slovakia.

Following qualification prior to 2009, there was a programme of vocational postgraduate training for 36 months, under the guidance of skilled dentists, which was a prerequisite for obtaining a licence (the right to practise the profession of dental surgeon). After the training the dentist had to pass an interview in front of a Commission, to obtain a practice certificate. Only then was a dentist able to lead his own dental practice.

Registration

All dentists in the private sector work under a licence issued by the state authority. The dentist has to be registered in the register of the Slovak Chamber of Dentists and he/she has to substantiate to the state authority the confirmation of his/her professional and ethical eligibility, issued by the Slovak Chamber of Dentists.

The steps are as follows:

1. Certificate of professional competence- 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.
3. Certificate of medical fitness
4. Copy of criminal records certificate

Language Testing

A potential registrant must pass an examination of the ability to speak and understand the Slovak language. The language tests are administered, for example, by the Comenius University, department for foreign languages. 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. The responsible person in this matter is the employer.

Cost of first registration	€ 13
Cost of annual registration in 2013	€ 4

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 60 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 five years after the first registration of a dentist and every consecutive

evaluation is done after five years from the last evaluation. The condition of continuing education is fulfilled, if the dentist can prove 250 credits for the evaluated period.

Specialist Training

Slovakia has 3 specialties for dentists:

- Orthodontics
- Maxillo-facial Surgery
- Paediatric Dentistry

Dental surgeons are also entitled to specialist education and training. Study is for 2 years in Paedodontics, 3 years in Orthodontics and Maxillo-facial surgery lasts 4 years. From 2013, dentists are entitled to join training for a new specialisation - in Health Management and Finance, that lasts 1 year.

Specialist training is conducted according to a given specialisation programme, as determined by the Ministry of

Health. This institution also determines the form, length and course of the studies. The dentist's participation in study is recorded by the Medical Faculty of the University, which has

the accreditation for specialisation programme. Training takes place in University dental clinics, or at the Department of Medical Faculty of the University, or in accredited dental practice, under supervision of a specialist.

The titles upon completion of the courses are:

- Specialist in orthodontics (čeľustný ortopéd)
- Maxillofacial surgeon ("maxilofaciálny chirurg")
- Specialist in paedodontics ("detský zubný lekár")

The specialist training for periodontics and prosthodontics ceased in 2003, 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:	2013
Total Registered	3,357
In active practice	3,298
Dentist to population ratio*	1,641
Percentage female	61%
Qualified overseas	198

*Active dentists only

Over 80% of active dentists work in private practice (85% with an agreement, and 15% with no agreement with insurance companies).

Movement of dentists across borders

The Chamber registered 41 requests for a "certificate of good standing" from dentists planning to leave Slovakia to work, during the period 2009 – 2013. This certificate is among the conditions to be registered abroad.

Specialists

Year of data:	2013
Orthodontics	193
Endodontics	
Paedodontics	39
Periodontics (2008)	95
Prosthodontics (2008)	64
Oral Radiologists	
Oral Surgery	192
OMFS (2008)	26
Dental Public Health	

There is a specialist register held by the Chamber.

Patients do not go directly to specialists and are always referred.

Auxiliaries

There are two kinds of clinical auxiliaries in Slovakia – Dental Hygienists and Dental Technicians. Additionally, there are dental nurses, dental assistants and receptionists.

Every medical employee has a lawful obligation to undertake continuing education.

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.

Year of data:	2013
Hygienists	187
Technicians	1,392
Denturists	0
Nurses and Assistants	3,610
Therapists	0

Dental Hygienists

Training for dental hygienists is conducted only at the Faculty of Medical Study in Presov. The study program lasts for 3 years, and leads to a "BSc Dental Hygienist". Training for hygienists at secondary schools was abolished in 2012.

They register 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 BPI, 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

The training for dental technicians at secondary schools was abolished in 2012. It is possible to study for "BSc Dental Technician" at two medical schools (Bratislava, Martin). The study program lasts for 3 years. They register at the Slovak Chamber of Dental Technicians.

Technicians can work in commercial laboratories, or be an employee of a clinic. In 2012 half of all registered dental technicians worked in independent dental laboratories and a quarter were employed by the public dental service.

The independent practice of denturists is illegal in Slovakia.

Dental Assistants and 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. Dental nurses (chairside assistants) are registered in the section for Nurses working in Dentistry, of the Chamber of Nurses and Midwifes. This section was created in 2007.

There is a now a new profession - dental assistant. They are educated in secondary school for 4 years and specially trained for dental practice. Graduates are registered in the Chamber of Other Health Professionals.

Practice in Slovakia

Year of data:	2013
General (private) practice	3,135
Public dental service	80
University	120
Hospital (2008)	29
Armed Forces	22
General Practice as a proportion is	95%

Of general practitioners, 1,616 work for themselves in private practice, 673 dentists work as employed in a private practice or clinic, and 976 are guarantors in a private company As in many countries, many dentists are in practice in more than one sector, hence the numbers above amount to more than the number of active dentists, through "double counting".

Working in Liberal (General) Practice

About 85% 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 budget.

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 waiting room in 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 establishing 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, medical fitness certificate, 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 410/2008.

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. Graduates since 2009, with a MDDr. are entitled to open their own practice without the need to have completed 3 years vocational training.

Patient lists must be kept - this means that the dentist has to 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 four 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.

	Number	Year	Source
Slovak Chamber of Dentists	2,906	2013	Chamber

To be registered at the Chamber is mandatory for active dentists, as the Chamber administers the Register. If a dentist retires, he/she should de-register.
Membership of the Chamber as a professional organisation is voluntary. Membership in 2013 was €360 per annum, entitling a monthly dental journal and various benefits, such as a discount on educational activities organised by the Chamber, access to lawyers, consultations and cheaper insurance etc. Unsubscription from membership 6 weeks before the end of calendar year does not affect practice as dentist.

The Chamber 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 €300 or up to €1470 for 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.

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 €24,000. When the dentist provides surgical services also, it can be over €24,000. 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.

Nevertheless, each dentist may freely choose the insurance and make an individual contract with the insurance company, which is often the case.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 a 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 €500,000 for a non-specialist would be about €2,257 for one year in 2013.

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

Slovakia has fully adopted the 2011 EU Cosmetics Directive. Nevertheless, the Chamber reports some illegal practice continues, as there is advertising of bleaching by non-dental cosmetic studios or other non-dentists, but the trend is decreasing.

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, pass an exam and will be placed on the register of persons professionally qualified for work with ionising radiation.

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 zdravotníctva)
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 zdravotníctva)
Infection control	Institut of public health (Urad verejného zdravotníctva)

Financial Matters

Retirement pensions and Healthcare

The legal retirement age is 62 for men and will gradually increase to 62 for women by 2015 (the retirement age for women with 5 or more children could be as low as 53 years in 2013).

The earnings related, public pension scheme is similar to a points system, with benefits that depend on individual earnings relative to the average. Pension eligibility depends on making at least 10 years of contributions. Low income workers are protected by a minimum amount of earnings on which pension is calculated. All pensioners are eligible for social assistance benefits. Defined contribution plans were introduced at the beginning of 2005

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

The Income Tax rate in 2013 was 19% up to a tax base of €34,401.74 of taxable income - adjusted on annual basis – and then at 25% above that amount.

VAT

The standard rate of VAT is 20%, with a reduced rate of 10% applying to certain pharmaceutical and medical products. Certain supplies (for example, financial and insurance service, and dental treatment) are exempt.

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Various Financial Comparators (*Source: UBS August 2003 & November 2012)*

Bratislava ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	38.9	45.6
Wage levels (net)	9.8	20.6
Domestic Purchasing Power at PPP	26.2	41.3

Other Useful Information

Competent authority:		***Details of indemnity organisations:***
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 Website: www.minedu.sk	Všeobecná zdravotná poisťovňa The General health insurance Tel: +421 2 67 27 71 11 Fax: +421 2 62 41 26 31 E-mail: petra.balazova@vszp.sk Website: www.vszp.sk
Major Specialist Associations:	***Main Professional Journals:***	***Main information centre:***
Slovenská ortodontická spoločnosť The Slovak Orthodontic Society Poliklinika Karlova Ves, Líščie údolie 57, 842 31 Bratislava Tel: +421 2 65 42 23 05 Fax: none E-mail: alex1@netax.sk Website: www.ortho.sk President: Dr. Irena Klímová Contact person: Dr. Gabriela Alexandrová Name: Slovenská lekárska spoločnosť Cukrová 3, 813 22 Bratislava Tel: +421 2 5263 5603 Fax: +421 2 5263 5611 E-mail: secretarysma@ba.telecom.sk Website: www.sls.sk	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: strecha@medima.sk Website: www.skzl.sk	Ministerstvo zdravotníctva 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

Dental Schools (all Medical Faculties with a 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: 30
Number of students: 200

Košice

Name of University: Univerzita Pavla Jozefa Šafárika
Univerzita P. J. Šafárika v Košiciach
Lekárska fakulta
Trieda SNP č.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: 60
Number of students: 235

Bratislava

Name of University: Slovenská Zdravotnícka Univerzita
Lekárska fakulta Slovenskej Zdravotníckej Univerzity
Limbová 12
83303 Bratislava
Tel: +421 2 59370 111
e-mail: dekanat.lf@szu.sk
Website: www.szu.sk

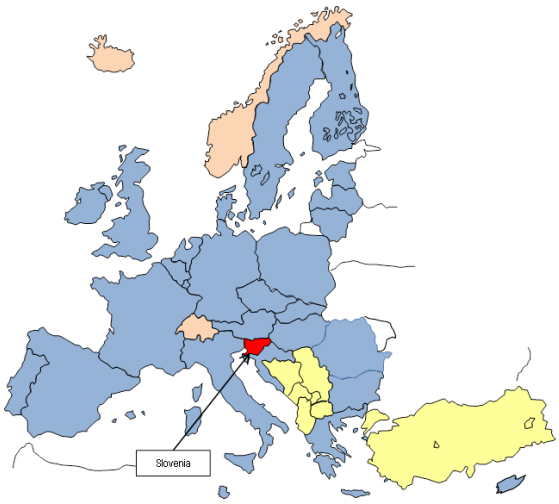
Number of students: 20

Martin

Name of University: Jesseniova lekárska fakulta Univerzity Komenského
Malá Hora 10701/4A
03601 Martin-Slovenská republika
Tel: +421 43 2633310
Fax: +421 43 2633309
e-mail: sdek@jfmed.uniba.sk
Website: www.jfmed.uniba.sk

Number of students: 16

Slovenia



In the EU/EEA since	2004
Population (2013)	2,060,253
GDP PPP per capita (2012)	€21,710
Currency	Euro
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:	1,789
Population to (active) dentist ratio:	1,517
Membership of the Chamber::	100%

Specialists are widely used, but there were clinical dental auxiliaries are limited to the use of hygienists.
Continuing education for dentists is mandatory, and is administered by the Slovenian Medical Chamber, to which all dentists must belong.

Date of last revision: 21st November 2013

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 Slovene 83.1%, Serb 2%, Croat 1.8%, Bosniak 1.1%, other or unspecified 12%.

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. 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 three more health insurances, for non-compulsory health insurance. Their titles are the Mutual Health Insurance (*Vzajemna zdravstvena zavarovalnica*), the Adriatic Insurance Company (*Adriatic zavarovalna družba*) and 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	8.9%	2011	OECD
% of this spent by government	72.8%	2010	OECD

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.

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.

		Year	Source
% GDP spent on oral health	0.14%	2007	HIIS
% of OH expenditure private	35%	2007	SDA

Private care

In fully liberal practice (about 10% of Dentists), 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 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	1.90	2013	Local*
DMFT zero at age 12	36%	2013	Local*
Edentulous at age 65	9%	2007	CECDO

* Local means Professor Vrbič

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. 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:	2012
Number of schools	1
Student intake	70
Number of graduates	50
Percentage female	70%
Length of course	6 yrs

Whilst 6 years is the target length of the course, 6.5 years is the average length of study.

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 Health is responsible for the supervision of this. The trainees are paid a salary of €1,309 per month (gross income in 2013), from the Health Insurance Institute of Slovenia.

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.

Diplomas from other EU countries have been recognised without the need for vocational training since May 2004.

Registration

The Medical Chamber of Slovenia registers all physicians and dentists. EU/EEA dentists need to contact the Chamber with details of their qualification in order to register. There is no fee payable for registration.

Dentists who qualified outside the EU/EEA have to seek the official recognition of their diploma from the Ministry of Education (Faculty of Medicine). After the diploma has been accepted, they can register with the Chamber.

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 practise. 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 Oral surgery
- Specialist of Maxillofacial surgery
- Specialist in Jaw and Dental Orthopaedics (Orthodontics)
- Specialist of Dental Ddiseases and Endodontics
- Specilist for Stomatological Prosthetics
- Specialist for Child and Preventive Dentistry
- Specialist in Oral Medicine and Periodontology

The Medical Chamber of Slovenia is responsible for the registration of specialists.

Workforce

Dentists

Year of data:	2013
Total Registered	1,762
In active practice	1,358
Dentist to population ratio*	1,517
Percentage female	63%
Qualified overseas	144

The Chamber reports that the dental workforce is increasing in 2013, after the decrease reported in 2008.
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:	2013
Orthodontics	84
Endodontics inc Dental Diseases	24
Paedodontics inc Preventive	36
Periodontics inc Oral Medicine	16
Prosthodontics	24
Oral Radiologists	
Oral Surgery	24
OMFS	34
Dental Public Health	
Others	

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:	2011
Hygienists	15
Technicians	251
Denturists	0
Assistants	870
Therapists	0
Other	

The figure for dental assistants is estimated by the Chamber. Normally, there is at least one assistant per dentist, but there is no special register for them to measure numbers.

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:	2013
General (private) practice	804
Public dental service	523
University	27
Hospital	31
Armed Forces	0
General Practice as a proportion is	59%

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

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.

There are limitations on the treatment that can be provided, mainly for adult population: they pay only for amalgam filings on posterior teeth, with limitations also for prosthetic dentistry, with no implants possible.

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.

Joining or establishing a practice

There are no stated regulations which specifically aim to control the location of dental practices or 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 in the 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. About 40% of 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

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. They provide all types of treatment, but mainly only the more difficult cases.

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
Medical Chamber of Slovenia	1,789	2013	MCS

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 is 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 €350 per year (2013) - it is possible to choose the level of cover. It is compulsory, by law, for every practising dentist to be insured. 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 under the latest EU Cosmetics Directive (2011), and application is limited to dentists. There is some illegal practice, but it is not a huge problem.

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 retirement age is being raised (in 2013) to 65 for men and women. The change will be implemented gradually: reaching age 65 will be a condition for retirement only in the year 2021 (men) and 2025 (women).

For healthcare arrangements, see the first part of this section.

Taxes

The annual taxable base is computed after compulsory social security contributions and certain allowances are deducted. Net active income is taxed according to a progressive tax rate. There are four tax brackets in the annual tax schedule for active income. The progressive tax rates are 16%, 27% and 41%. The top rate of income tax is 50% and is charged on incomes above €69,315 per year.

VAT

The standard rate of VAT in Slovenia is 22%, starting from July 1, 2013 (increased from the previous 20% rate). Dental materials, instruments and equipment are charged at this rate.

There is a reduced rate of 9.5% (increased from the previous 8.5% rate).

Various Financial Comparators

Ljubljana ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	59.1	53.8
Wage levels (net)	17.6	24.2
Domestic Purchasing Power at PPP	31.4	39.6

Source: UBS August 2003 & November 2012

Other Useful Information

Competent and Legal Authority:	**The Medical Chamber of Slovenia**
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 Dunajska cesta 162 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/

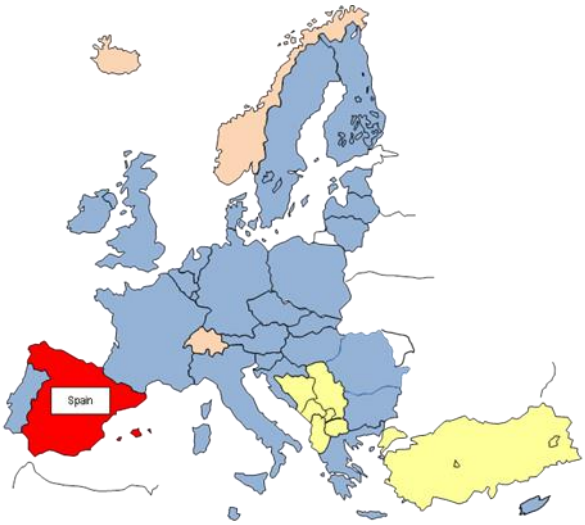
Dental School:

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: 10th February 2015

In the EU/EEA since	1986
Population (2013)	47,059,533
GDP PPP per capita (2012)	€23,529
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:	31,261
Population to (active) dentist ratio:	1,623
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	9.5%	2012	OECD
% of this spent by governm't	73.0%	2012	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		
% of OH expenditure private	85%	2007	CECDO

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, in 2013 only 19.3% of the population were using 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. The dental association indicated in 2013 that there is a mean 2.2 years between visits to dentists by the population.

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	1.12	2010	CGCOE
DMFT zero at age 12	55%	2010	CGCOE
Edentulous at age 65	17%	2010	CGCOE

"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

Source CGCOE is the Spanish Dental Council

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. Indeed, about 11% of the Spanish population lives in an artificial fluoridated area.

The Canary Islands have naturally fluoridated water.

Education, Training and Registration

Undergraduate Training

Year of data:	2012
Number of public schools	12
Number of private schools	5
Student intake (approximate)	1,400
Number of graduates	1,379
Percentage female	67%
Length of course	5 yrs

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.

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 Odontología* (1986 onwards)
- *Médico Especialista en Estomatología* (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. No more have been trained since then.

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 was not compulsory in 2013.

The current system of continuing education is organised 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 from 2001 no more stomatologists have been trained. In 2008 less than one third of the dentists practising in Spain are stomatologists.

Year of data:	2012
Total Registered	31,261
In active practice*	29,000
Dentist to population ratio**	1,623
Percentage female	52%
Qualified overseas*	6,300

* estimated
** in active practice only

Many dentists in private practice also work part-time in other spheres.

The dental association believes that Spain has an excess of supply over need in 2013.

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 have reduced. The entry examinations for these dentists have become progressively more difficult. The dental association reported that 70 to 100 a year were still passing the entrance examination in 2013. 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 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:	2013
Hygienists	13,200
Technicians	11,135
Denturists	0
Assistants	37,000
Therapists	0
Other	0

All figures estimated

Dental Hygienists

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 resulted in a rapid increase in the number of "recorded" hygienists (there is no registration) from 1,000 to over 13,000.

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.

Dental technicians may only work in commercial laboratories. In 2013 the Supreme Court announced a judgement that dental technicians are health care professionals, but cannot take part in clinical acts performed on patients, being the taking of dental impressions and recordings – these being reserved exclusively to dentists.

Dental Assistants (Nurses)

Dental assistants work at the chairside. There is no formal training or qualification.

Practice in Spain

Year of data:	2012
General (private) practice	28,839
Public dental service	1,300
University	864
Hospital	350
Armed Forces	340
General Practice as a proportion is	99%

Many dentists in private practice also work part-time in other spheres, hence the imbalance in the numbers above.

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.

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.

A dentist on average will look after 664 patients 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 but is not recorded how many are female.

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	31,260	2013	Colegios

Membership is mandatory, so the figures represent 100% 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. However, non-dentists usually use products without carbamide peroxide.

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

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.

There are two types of contributory schemes in the Spanish social security system: a general scheme applicable to all employed persons who are not covered by special schemes such as one for the self-employed. There is also a Non-contributory system for persons who face a specific situation of need, and whose income is below a certain legally prescribed level.

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.ublic 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.

Taxes

Income taxes are progressively increased from 12.75% of taxable income after allowances, to 30.5% on incomes over €300,000. Each Autonomous Community has to approve its own scale of rates. In general, the rates are 12% to 21%. Investment income, such as dividends and interest arising from bank deposits, any gains on sales of shares, and so on, are taxed at a rate of 21% for amounts up to €6,000, 25% for income between €6,000 and €24,000 and 27% for amounts exceeding €24,000.

VAT

The standard VAT rate is 21% (since Sept 2012). There is a reduced rate of 10% (from Sept 2012) for: passenger transport; hotel and restaurant services; and others. There is also a 4% VAT rate for: food and drink; goods from chemists; construction work; and some newspapers.

No medical procedures, including laboratory prostheses attract VAT. The VAT rates are 10% on dental equipment and 21% on materials.

Various Financial Comparators

Madrid ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	67.5	60.1
Wage levels (net)	39.2	43.5
Domestic Purchasing Power at PPP	55.4	60.6

Source: UBS August 2003 & November 2012

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

Dental Schools

2013	Number of Undergrads	Annual Graduates
Private		
Madrid: El Sabio	1,829	312
Madrid: Europea	811	201
Catalunya	287	57
Valencia	449	96
San Pablo CEU, Madrid	241	48
	3,617	**714**
Public		
Madrid	347	95
Barcelona	404	96
Valencia	298	55
Granada	391	71
Vizcaya	199	44
La Coruna	220	41
Sevilla	279	61
Murcia	195	45
Oviedo	140	34
Salamanca	155	36
Madrid Rey Juan Carlos	246	61
Huesca	121	26
	2,995	**665**
Overall total	**6,612**	**1,379**

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: 312
Number of students: 1,829

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: 201
Number of students: 811

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: 57
Number of students: 287

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: 48
Number of students: 241

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: www.uch.ceu.es/principal/inicio.asp
Dentists graduating each year: 96
Number of students: 449

Public Dental Schools:

Madrid
Facultad de Odontología
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: 95
Number of students: 347

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: 96
Number of students: 404

Madrid

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: 61
Number of students: 246

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: 55
Number of students: 298

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: 71
Number of students: 391

Huesca
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: 26
Number of students: 121

Vizcaya (Bilbao)
Facultad de Vizcaya
Universidad del País Vasco
Facultad de Medicina y
Odontología
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: 44
Number of students: 199

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 coieinf1@usc.es
Website:
http://www.usc.es/coies/
Dentists graduating each year:
41
Number of students: 220

Oviedo
Facultad de Medicina.
Clínica Universitaria de
Odontología.
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: 34
Number of students: 140

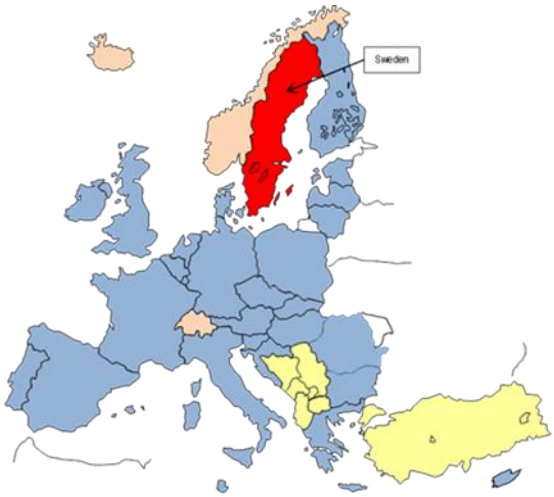
Sevilla
Facultad de Sevilla
Facutad de Odontología
C/ Avicena s/n, 41009 Sevilla
Tel: +34 95 448.11.03
Fax: +34 95 448.11.04
Email: fodonjsec@us.es
Website: www.us.es
Dentists graduating each year: 61
Number of students: 279

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: 45
Number of students: 195

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: 36
Number of students: 155

Sweden



In the EU/EEA since	1995
Population (2008)	9,580,424
GDP PPP per capita (2012)	€31,717
Currency (1 July 2013)	Kronor (SEK)
	8.69 = €1
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:	14,454
Population to (active) dentist ratio:	1,273
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.

Date of last revision: 28th January 2015

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. In 2013 there were eight political parties represented in the Riksdag.

Many aspects of government, including healthcare, are delegated to the county or municipality level (290 municipalities and 20 counties/regions in 2013). Both the counties and municipalities have elected councils which may levy taxes. Liberal immigration policies have given Sweden a multicultural population. About 17% of the population was foreign-born.

Most healthcare is provided through a national social insurance system, which also provides sick pay, child benefits, disability allowances and pensions. The national social insurance system operates through the Swedish Social Insurance Agency (*Försäkringskassan*). Every person 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 81 % (2013) of healthcare costs including dentistry are funded by government.

On 1 June 2013, the Health and Social Care Inspectorate (IVO) was created as a new government agency to take over the supervisory activities of the National Board of Health and Welfare. It is thus the Health and Social Care Inspectorate that now supervises health and medical care, social services and services under the Act concerning Support and Service for Persons with Certain Functional Impairments. The Inspectorate is also responsible for the consideration of permits in these areas. The main task of the Health and Social Care Inspectorate is to check that the public receives safe, good quality health and social care in accordance with laws and other regulations. The Health and Social Care Inspectorate took on the staff of the National Board of Health and Welfare supervision division, and therefore also the skills and experience tied to its activities. It is the same legislation, but with improved analysis and guidance.

Since July 1st 2013, Sweden has new legislation regarding health care for undocumented people/migrants. The legislation states that adult undocumented migrants are entitled to necessary health and dental care, as well as maternity care, pre and post abortion care and medication at a reduced cost. Children under the age of 18 are entitled to full healthcare, regular dental care and medications at no cost.

There is no up to date health data in 2013, but previously published data was as follows:

		Year	Source
% GDP spent on health	9.5%	2011	OECD
% of this spent by government	81.6%	2011	OECD

For the majority of the Swedish population general health care is paid for through general taxation, plus a small fee for each visit to a doctor (€20 in 2013).

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	0.67%	2010	SDA
% OH expenditure private	78%	2005	NBHW

Public Dental Healthcare

Dental care for children and adolescents

All dental care for children and adolescents is free of charge up to the age of 19 (some county councils have decided to extend this to include general dental care for young people also over 20). Care is provided on a regular basis and is individually targeted. Approximately 95% of children and adolescents have contact with dental care over a two year period. Additionally, preventive dental care is provided to children in schools or child healthcare centres in terms of health promotion, information or offering preventive fluoride treatments. The dental care up to the age of 19 also includes specialist dental treatment. The dental care is provided and financed through the counties and carried out either by dentists within the Public Dental Service (PDS) or private practitioners (PP). Parents/legal guardians choose the dentist or dental clinic they want to be responsible for the dental care of their children. The majority of dental care for children and adolescents is carried out within the PDS. Specialist treatment, foremost orthodontics and specialist paediatric dental care is provided mainly by specialist employed within the PDS, but in some counties/regions there are also specialists in PP who provide care that is financed by the county/region.

Dental care for the adult population

Dental care for the adult population is provided by dentists from both PDS and PP. Adults pay a large part of their dental care themselves. However, for the majority of dental care there is a social insurance system that covers parts of the costs and this system reimburses the patient on the same premises, regardless of whether the dental care is carried out within the PDS or the PP.

The framework for social insurance for dental care (*Tandvårdsstödet*) changed in 2008 with a new national insurance scheme, consisting of the following components:

A dental care voucher or dental grant of €15 is given to everyone aged 30 to 74 every year. For those aged 20 to 29 and 75 or older, the sum is €30 per year. The grant can be saved for a period of two years, resulting in either €30 or €60 for dental care over a two year period as a part-payment for a dental care check-up at any dentist or dental hygienist, or as a part-payment for subscription dental care.

A high-cost protection scheme provides compensation equal to 50% of the dental care costs between €321 to €1590, and 85% of costs exceeding €1590. The compensation levels are based on "reference prices". These have a price-steering effect on prices and enables patients to compare dental prices more easily. The dentist's individual price list can differ from the reference price list. If the dentist's price is higher than the reference price, the patient pays the difference. The first €320 (reference price) is always paid by the patient.

Dentists in PP settle their prices themselves, and for the PDS the prices are decided by the county councils.

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 medical diagnoses or special needs owing to disabilities, there are additional systems subsidising dental care. This is based on individual assessments of the patients and may include extra support for preventive dental care or dental treatment at the same fee as for medical care.

In 2010, adult patients' co-payments were around two thirds, for oral health carried out in the national insurance scheme.

It is easier to access dental care in and around bigger cities than in the countryside. During a two-year period (2010-2011), 73 % of the adult population accessed dentistry at least once. In any one-year period, approximately 60% of the whole adult population access dentistry.

Private Insurance

This 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 and good dental health on equal conditions. The standards are monitored by the Regional Departments of the National Board of Health and Welfare (NBHW or *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

There is no up to date health data in 2013, but previously published data was as follows:

		Year	Source
DMFT at age 12	0.76	2011	NBHW
DMFT zero at age 12	65%	2011	NBHW
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 or collaborate with the Faculties of Medicine of the respective universities. To enter dental school, students must have completed secondary education. There is no mandatory entrance examination. The universities/dental faculties can use complementing tools like interviews or manual tests when accepting students for undergraduate training.

Year of data:	2012
Number of schools (public)	4
Number of schools (private)	0
Student intake	339
Number of graduates	200
Percentage female	63%
Length of course	5 yrs
VT mandatory?	No

The intake of students has increased over the years. The student intake in 2012 was considerably higher than the intake in 2007, which explains the large difference between "Student intake" and "Number of graduates" in the chart above.

Quality assurance for the dental schools is provided by the Swedish Higher Education Authority.

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.

Dentists do not need to re-register annually.

The Swedish Social Insurance Agency (*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 it.

Cost of registration (2013)	€77.00
Cost of diploma for specialisation	€ 265

Further Postgraduate and Specialist Training

Continuing education

Continuing education is optional. The Swedish Dental Association offers continuing education (programme printed and sent to all members twice a year). Further, almost all Public Dental Service (PDS) and some of the bigger private dental corporations/companies also arrange continuing education activities. Courses are also provided by the dental industry and 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. In 2013 there were 170 dentists undertaking specialist training. 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 2010 52% of the specialists were 55 years or older and it is anticipated that there will be a shortage in some disciplines.

There is training in 8 recognized specialties:

- Orthodontics
- Endodontics
- Paedodontics
- Periodontology
- Prosthodontics
- Dentomaxillofacial radiology
- Oral and maxillofacial surgery
- Stomatognathic physiology

There are a limited number of positions for post graduate/specialist training. 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

The Swedish Dental Association reports that the number of active dentists is decreasing. The number of dentists in active practice per 100 000 inhabitants has decreased with 8% between 1995 and 2010. Retirement is increasing due to the dispersion of age. In the mid-1990s the Government reduced undergraduate numbers by 40%. The number of students admitted to the dental schools increased from 247 in 2006 to 339 in 2012.

Year of data:	2010
Total Registered	14,454
In active practice	7,528
Dentist to population ratio*	1,273
Percentage female	52%
Qualified overseas**	656
* active dentists	
** dentists in active practice 2010	

There is almost no unemployment amongst Swedish dentists in 2013.

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, the trend of a great movement out of Sweden appears to be ending, as during 2009 and 2010 the net immigration of dentists was positive.

Specialists

e specialties are:

Year of data*:	2010
Orthodontics	265
Endodontics	47
Paedodontics	83
Periodontics	101
Prosthodontics	134
Dentomaxillofacial radiology	43
Oral Surgery	
OMFS	145
Dental Public Health	
Stomatognathic pathology	34
* figures refer to active specialists	

In 2010 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 although the number of specialists working in private practice is increasing. 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:	2010
Hygienists	3,749
Technicians*	1,500
Denturists	0
Assistants	12,000
Therapists	0
Orthodontic assistants*	360
* estimated by SDA 2008	

These figures are for “active” dental auxiliaries.

Dental Hygienists

To become a dental hygienist requires 2-3 years of undergraduate academic education, in oral health science, at one of several University Colleges in Sweden.

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 250 were self-employed in 2013. They take legal responsibility for their work and charge fees to patients, which may vary from what dentists charge. About 40 of the 250 self-employed hygienists own their own private practice.

Dental Technicians

To become a dental technician requires 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 2013, 65 dental technicians were qualified.

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

Approximately 60% of dental nurses are employed by the Counties. About 35% of dental nurses are 55 year or older.

There is no common national education for dental nurses; however, the curriculum is similar across the country.

Practice in Sweden

Year of data:	2010
Private (general) practice	3,463
Public dental service	4,065
University	431
Hospital	N/R
Armed Forces	N/R
General Practice as a proportion is	46%

Working in Private Practice

In Sweden, dentists who are not employed within the Public Dental Service (PDS) or dental faculties are said to be in *Private Practice (PP)*. Dentists in PP include both those with a practice of their own, those running a small practice together with one or a few other dentists, or even dentists employed by bigger private companies. The term 'general practice' or 'general practitioner' refers to any dental practitioner who does not have a license as a specialist.

There is no accurate data on number of private clinics and clinics in Public Dental Service in Sweden

The majority of dentists in private practice are self-employed and are remunerated mainly by charging fees for treatments, supplemented by social insurance subsidies. The most common way of remunerating a dentist is to pay a fee for each treatment (item of service).

In 2010, very few dentists (less than 1%) accepted only private fee-paying patients, i.e. not any subsidy from the social insurance system.

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. This has to be approved by the local municipality.

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 and see their patients every 12 to 18 months, normally.

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 (PDS) with responsibility for planning comprehensive dental care free of charge to children and adolescents up to 19 years of age. However, the dental care for this age group is carried out by both the PDS and the PP. Approximately 80 % of the dental care for children and adolescents is carried out within the PDS. Apart from children and adolescents, the service also provides dental care for adults as stated earlier. The Public Dental Service is funded by the counties, and provides the same types of dental treatments for adults as the PP for which national social insurance subsidies are available.

The service employs about 55 % of all practising dentists, and approximately 80% of specialists. Specialists receive referrals of patients from dentists in PP and the PDS.

Besides the dental degree, the only formal qualification required to work in the PDS is for specialists, who should have received recognised additional training.

The monitoring of dentists in the PDS is the same as that for dentists in private practice.

Working in Hospitals

In Sweden, dentists who work in hospitals are also employed by the PDS. Special care dentistry is not a recognized speciality in Sweden, though many of the dentists working in this field have extra training in medical and psychological aspects related to the dental care they provide. The dentists provide conventional dental treatment to adult medically compromised patients or patients with disabilities. Dental treatment under general sedation and/or nitrous oxide-oxygen is also available. General anaesthesia is provided by medical doctors, while dentists can use nitrous oxide-oxygen sedation after special training. There are also many clinics situated outside the hospital that provide treatments for patients with medical conditions or disabilities that affect the dental treatment.

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 PP or within the PDS outside the faculty. Academic titles within a Swedish dental faculty are: *professor* (responsible for education and research), *associate professor/senior lecturer* (teaching and research), and *assistant professor/lecturer* (teaching). There are formal requirements regarding pedagogic training and scientific research as well as regarding specialist training. The requirements differ, depending on type of academic position and area/subject for lecturing.

Working in the Armed Forces

There is no information available regarding the number of dentists working in the Swedish Armed Forces.

Professional Matters

Professional associations

The Swedish Dental Association (SDA) has four member associations:

- SOL – Sveriges Odontologiska Lärare (the Swedish Association of Dental Teachers)
- STUD – Studerandeföreningen (the Swedish Association of Dental Students)
- TEV – Tandläkare egen verksamhet (the Swedish Association for Dentists in Private Practice – enrolling dentists within the private sector who are not employees)
- TT – Tjänstetandläkarna (the Swedish Association of Public Dental Officers – enrolling all dentists employed in both private and public sectors)

Through the membership in one of these associations, the dentist automatically gets a membership in the SDA as well.

Until 2011 private practitioners were members of the Swedish Association of Private Practitioners, which was also a member of the Swedish Dental Association (SDA). However, from 2012 the Swedish Association of Private Practitioners no longer has dentists as members. Instead they enrol companies within the private dental care sector as members and are therefore no longer associated to the SDA. They have also changed their name in English to the Association for Private Dental Care Providers in Sweden.

	Number	Year	Source
Swedish Dental Association	5,138	2013	SDA

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.

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. The other way is for the patient to make a complaint to the Health and Social Care Inspectorate (IVO). The IVO investigates complaints within the whole Health and Social care sector and if needed, the IVO can forward the matter to the Medical Responsibility Board (HSAN).

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

The Patient Data Act applies to all care providers regardless of who is the manager and 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.

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. 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

In October 2012, Sweden implemented the EU Directive stating that all tooth whitening products are cosmetic products. There

is still the matter of tooth whitening products incorrectly classified as medical products and CE labelled as such

products. The Medical Products Agency in Sweden has produced regulations with detailed information on the new EU regulation and the Agency is also responsible for the surveillance regarding tooth whitening products.

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 regulations from the Swedish Radiation Safety Authority. Continuing education and training is not mandatory.

To be able to buy and use equipment for panoramic radiography, 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 have been *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 Safety Authority, SE-171 16 Stockholm +46 8 799 40 00
Electrical installations	The county authorities
Infection control	National Board of Health and Welfare (IVO), SE-106 30 Stockholm +46 75 247 30 00
Medical devices	Medical Products Agency, P.O. Box 26, SE-751 03 Uppsala +46 18 17 46 00
Waste disposal	Swedish Environmental Protection Agency, SE-106 48 Stockholm +46 10 698 10 00

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 a new system and part according to the old system. Anyone born after 1954 will receive pensions according to the new system only.

The normal retirement age is between 65 and 67. There is 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 57% on earnings over about €69,585 (2013) 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 restaurants, hotels and provisions etc.) and 6% (on for example public transportation, newspapers and cinema tickets).

Various Financial Comparators

Stockholm ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	88.1	79.7
Wage levels (net)	56.5	59.0
Domestic Purchasing Power*	59.9	66.9

(* relative to net income)

Source: UBS August 2003 and November 2012

Other Useful Information

Main National Associations and Information Centres:

Swedish Dental Association
Sveriges Tandläkarförbund
P.O. Box 1217, SE – 111 82 Stockholm
Tel: +46 8 666 15 00
Fax: +46 8 662 58 42
Email: kansli@tandlakarforbundet.se
Website: www.tandlakarforbundet.se

The Swedish Association for Dentists in Private Practice
TEV – Tandläkare egen verksamhet
Tel: +46 8 666 1530
Fax: +46 8 662 5842
E-mail: info.tev@stlf.se
Website: http://tandlakare-egenverksamhet.se/

The Swedish Association of Public Dental Officers
TT – Tjänstetandläkarna
Tel: +46 8 545 159 80
Fax: +46 8 660 34 34
E-mail: kansliet@stf-tt.org
Website: www.stf-tt.org

The Swedish Association of Dental Teachers
SOL – Sveriges Odontologiska Lärare
Per Vult von Steyern
E-mail: per.vult@mah.se

The Swedish Association of Dental Students
STUD – Studerandeföreningen
Tel: +46 8 666 1500
E-mail: kansli@tandlakarforbundet.se

Journal of the Swedish Dental Association
Tandläkartidningen
Swedish Dental Journal
(the scientific journal of the SDA), both at:
P.O. Box 1217
SE – 111 82 Stockholm
Tel: +46 8 666 15 00
Fax: +46 8 666 15 95
E-mail: redaktionen@tandlakarforbundet.se

The National Board of Health and Welfare
Socialstyrelsen
Rålambsvägen 3
SE – 106 30 Stockholm
Tel: +46 75 247 30 00
Fax: +46 75 247 32 52
Email: socialstyrelsen@socialstyrelsen.se
Website: www.socialstyrelsen.se

The Swedish Association of Local Authorities and Regions
Sveriges Kommuner och Landsting
Tel: +46 8 452 70 00
E-mail: info@skl.se
Website: www.skl.se

The Association for Private Dental Care Providers in Sweden
Privattandläkarna
Tel: +46 8 555 446 00
E-mail: info@ptl.se
Website: www.ptl.se

The Dental Association has chosen to delete the usual data on “annual intake”, “dentists graduating each year” and “number of students” in the table of dental schools, since they cannot provide data that they are certain is correct.

Dental Schools

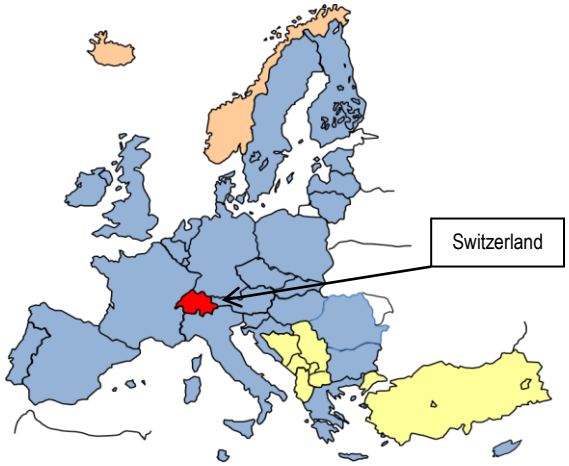
Huddinge
Karolinska Institutet
Institutionen för Odontologi
P.O. Box 4064, SE – 141 04 Huddinge
Tel: +46 8 524 800 00
Email: info@ofa.ki.se
Website: www.ki.se/dentmed

Göteborg
Göteborg University
Institutionen för Odontologi
P.O. Box 450, SE – 405 30 Göteborg
Tel: +46 31 786 00 00
Email: info@odontologi.gu.se
Website: www.odontology.gu.se

Malmö
Malmö Högskola
Odontologiska Fakulteten, SE – 205 06 Malmö
Tel: +46 40 665 70 00
Email: info@mah.se
Website: www.mah.se/od

Umeå
Umeå Universitet
Institutionen för odontologi, SE – 901 85 Umeå
Tel: +46 90 785 60 00
Email: info@odont.umu.se
Website: www.odont.umu.se

Switzerland



Associate of the EEA	
Population (2013)	8,058,100
GDP PPP per capita (2012)	€34,545
Currency	Swiss Franc (CHF)
	1.225 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 (€2,449). Most oral healthcare is provided by independent private practitioners and paid for directly by individual patients.

Number of dentists:	4,850
Population to (active) dentist ratio:	1,679
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.

Date of last revision: 30th January 2014

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 (€2,419). 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 subsidised by 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 500 CHF (€625) 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 (€565) in 2013.

		Year	Source
% GDP spent on health	11.3%	2012	OECD
% of this spent by government	61.7%	2012	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, 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.

		Year	Source
% GDP spent on oral health	0.20%	2012	SSO
% of OH expenditure private	90%	2012	SSO

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 about 1,500 regular patients.

Private insurance for dental care

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*	0.82	2010	WHO
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
* The DMFT figure is based on Canton of Zurich only (not national)

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:	2013
Number of schools (public)	4
Number of schools (private)	0
Student intake	128
Number of graduates	103
Percentage female	60%
Length of course	5 yrs

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 post-qualification vocational training of two years, which is mandatory to qualify to provide treatments covered by the health insurance system.

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 exper-ience 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

Since 1994, there has been a minimum level of compulsory participation in continuing education (CE), 10 days per year. Every year 10% of dentists are approached and must submit documents to show the CE they have undertaken.

More than 75% do fulfil the requirements. Those who do not achieve the requirements are ordered to increase their hours of CE.

If they do not complete 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:	2013
Total Registered	4,850
In active practice	4,800
Dentist to population ratio*	1,679
Percentage female	28%
Qualified overseas	3,500

**active dentists only*

The total number of practitioners is stable. It was reported by the SSO that there were a small number of unemployed dentists in 2013.

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. By 2013 the Swiss authorithy had recognised approximately 3,500 diplomas from EU countries, which corresponds to about 70% of all dentists in Switzerland.

Specialists

Year of data:	2013
Orthodontics	370
Endodontics	
Paedodontics	
Periodontics	112
Prosthodontics	72
Oral Radiologists	
Oral Surgery	185
OMFS	
Dental Public Health	

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:	2013
Hygienists	1,600
Technicians	1,800
Denturists	50
Assistants	6,500
Therapists	280
Other	0

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' labor-atories. 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

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 1.5 Chairside Assistants for every dentist.

Practice in Switzerland

Year of data:	2013
General (private) practice	4,300
Public dental service	200
University	300
Hospital	50
Armed Forces	0
General Practice is about	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 2013, no dentists served full-time in the Armed Forces.

Professional Matters

Professional association

	Number	Year	Source
Société Suisse des médecines-dentistes	4,130	2013	SSO

There is a single main national dental association, the *Société Suisse des médecines-dentistes* 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 (2013).

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 compan-iies. A general practitioner pays approximately 2,200 CHF (€1,775) 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 to 20% of earnings for national and professional schemes.

Men, at 65, and women, at 64, are entitled to an old-age pension. Payments may be taken out earlier by one or two years, but a fee per each year advanced is charged. Payments can also be postponed by one to five years, which gives an increase in payments depending on the number of months postponed. Dentists are allowed to practice beyond pension age.

A second pillar is based on occupational pension plans and accident insurance. Employees who earn more than 20,520 CHF (€16,550) a year are automatically insured by the second pillar pension fund. Pension plans and accident insurance have been mandatory for all employees for more than 25 years. The self-employed can join on a voluntary basis. When combined with the first pillar benefits, a person could expect to earn about 60 per cent of their final salary to help maintain their previous standard of living.

A third pillar is a private, individual option that workers can use to help make up the remainder of their income not covered by the first two pillars. Such schemes are also protected by law and often offer tax advantages.

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 3,000CHF (€2,420) per year.

Taxes

There is a national income tax, social security tax, and cantonal taxes. 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 42% and is levied to on incomes above approximately CHF 200,000 (€128,000).

VAT/sales tax

Switzerland introduced a value added tax system in 1995. Basically, the Swiss VAT system is in line with the 6th Directive of the European Union (although Switzerland is not a member of the European Union).

The VAT rates in Switzerland are: 8.0% standard rate, 2.5% reduced rate (for food, medicine, newspapers, books and feed) and 3.8% for lodging services

VAT is 8% on most dental equipment and consumables. Costs for dental treatment are not subject to VAT.

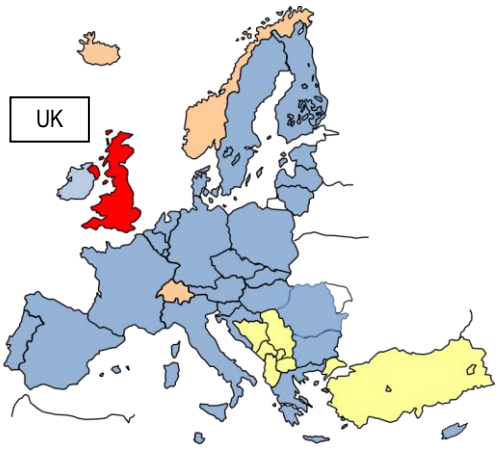
Other Useful Information

Dental Association (and competent authority):	*Publications:*
Schweizerische Zahnärzte-Gesellschaft Société Suisse des médecines-dentistes (SSO) Società Svizzera Odontoiatri Münzgraben 2 CH-3000 Bern 7 SWITZERLAND Tel: +41 313 31 31 Fax: +41 313 31 40 Email: sekretariat@sso.ch Website: www.sso.ch	SWISS DENTAL JOURNAL 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: +41 313 56 20 20 Fax +41 313 56 20 30 Email: office@gdk-cds.ch Wesite: www.gdk-cds.ch	Stellenvermittlung SSO Münzgraben 2 CH-3000 Bern 7, SWITZERLAND Tel: +41 313 31 41 Fax: +41 313 31 40 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 02 e-mail: firstname.name@unige.ch website: www.smd.unige.ch Dentists graduating each year: 15 Number of students: 100	**Zürich** Universität Zürich Zentrum für Zahnmedizin Plattenstrasse 11 Postfach, CH – 8028 Zürich Tel: +41 01 634 33 11 Fax: +41 01 634 43 11 e-mail: firstname.name@zzm.uzh.ch website: www.zzm.uzh.ch Dentists graduating each year: 44 Number of students: 232
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.zahnkliniken.unibas.ch Dentists graduating each year: 19 Number of students: 110	**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.zmk.unibe.ch Dentists graduating each year: 25 Number of students: 125

The United Kingdom



Date of last revision: 22nd January 2014

In the EU/EEA since	1973
Population (2013)	63,887,988
GDP PPP per capita (2012)	€28,158
Currency	British Pound £
	€1.20 = £1.00 (2013)
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.
Each country of the UK has its own variation of the arrangements for NHS care.

Number of dentists:	38,934
Population to (active) dentist ratio:	1,936
Membership of the Dental Association::	50%

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, with a small proportion of members being 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 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. The systems for implementation vary. In England, a statutory body called NHS England and its area teams take forward commissioning of healthcare, while in Scotland, Northern Ireland and Wales, this is done through regional heatlh boards.

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.

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	9.4%	2011	OECD
% of this spent by governm't	83.2%	2010	OECD

Oral healthcare

National Health Service (NHS)

Oral healthcare in the UK is available from the NHS or privately. As with 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 as described earlier. GDS contracts are "open-ended", having no fixed term. There are different contractual arrangements, in general dental practice, in the four countries of the UK.

In England and Wales, some practitioners provide NHS care through a different form of contract, known as "*Personal Dental Services*". Typically, for example, NHS orthodontic care is provided by practitioners with these types of contracts, which have different terms and are time limited.

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 2013, they ranged from £18.00 (€21.60) for routine treatments such as check-up, scale and polishing, to £214 (€257) for complex treatment, such as crown and bridgework.

The detail of the contract was in the process of being reviewed at the time of writing.

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 continuing care and capitation fees, allowances and direct reimbursement of expenses also occur.

Most patients who receive dental treatment under the National Health Service (NHS) (Scotland) or the Health Service (HS) (Northern Ireland), are charged a percentage co-payment of a set 'NHS/HS fee' (80% in 2013); there is also a maximum charge payable in one course of treatment (about €445 in 2013).

In Scotland, the registration period for both adults and children treated under the NHS is "open-ended", which means that patients are permanently registered until they go elsewhere. Continuing care and capitation payments are paid on a monthly basis for all patients registered with a dentist. Where a patient has not attended the dentist for three years or more and the dentist has not submitted a payment claim form (GP17) for the patient, the continuing care or capitation payment reduces to 20%.

In the HS in Northern Ireland adults and children are registered for twenty-four months. In both cases, the arrangement can 'roll on' for as long as both parties agree.

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 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 lower than those that would be paid privately.

Access to an NHS 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 majority of dentists in the UK do have some commitment to the NHS, but an increasing number accept only private fee-paying patients. Dentists contracted to provide care under NHS terms will negotiate their commitment with the commissioning authority. They may provide as much or as little NHS care, and as much private care as they wish, subject to their individual NHS contract.

There is also a Salaried Primary Dental Care Service (SPDCS). This provides public health dentistry by salaried dentists for groups who have poor access to other dental services, for example children and adults with disabilities, 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 SPDCS are free.

All four services - the GDS, SPDCS, 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 the government, with advice from a quasi-independent committee, the Doctors' and Dentists' Review Body (DDRB). Newly qualified dentists work as salaried Vocational GDPs ('Foundation Dentists'), and are salaried at national rates.

Traditionally, patients attended six-monthly for their routine re-examinations, but in 2013 fewer adults are now keeping to this timetable, because of improvements in oral health. Many now attend only annually.

Figures from the Health and Social Care Information Centre, published in September 2013, show that about 56% of the adult population visited a dentist in the two years to June 2013, and

just 70% of the child population in the same period. List sizes are typically around 2,000 patients.

		Year	Source
% GDP spent on oral health	0.50%	2007	CECDO
% of OH expenditure private	55%	2012	BDA

Private care

Most GDPs will provide some private care – either in a fully private contract with their patients, or by providing individual items of private treatment during a course of NHS care – known as "mixing". This is permissible provided the patient has given fully informed consent.

If a patient is not on an insurance plan, private treatment is usually charged to the patient by way of fees, which will be individually set by the dentist, who must publish a list of fees, or his/her hourly rate.

Most specialist dental care is provided outside the NHS, in private practice, although there is some limited specialist care provided within the NHS – either in publicly run clinics and hospitals, or by general practitioners with contracts with the NHS.

Private insurance plans

In the UK, only a small proportion 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 recent 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. In Scotland 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.

Each 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/HS 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/HS. 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.

In all UK countries, a dental professional may be referred to the General Dental Council (GDC), for professional conduct issues. The GDC may censure a dental professional 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	0.70	2011	WHO
DMFT zero at age 12	62%	2007	CECDO
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, local health authorities 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.

Education, Training and Registration

Undergraduate Training

There are 16 UK dental schools, all part of medical faculties of state-funded universities. The newest school, in Aberdeen, Scotland, opened in September 2008.

Year of data:	2013
Number of schools	16
Student intake (approximate)	1,100
Number of graduates (2012)	1,052
Percentage female	56%

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.

Universities set their own fees and students have to pay these fees, up to £9,000 per year (2013). Student loans are available for tuition fees. In Scotland, Scottish students will not pay fees but they may claim a low-interest student loan from the state – which is repayable after graduation when earnings have passed a minimum threshold.
Many of the schools have expanded their intake in the last 10 years. All schools are public and there were no privately funded schools in 2013. For more information about numbers in each school, please see the final page of the UK section.

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 were re-introduced in 2010, although they are no longer available as a stand-alone dental qualification. They are now mostly an option for non-EEA qualified dentists to obtain a UK qualification.

Vocational Training (VT) and Dental Foundation Training (DFT)

VT and DFT are post-qualification. Dentists may practise outside the NHS system without undertaking VT/DFT, but competition for dental jobs both within and outwith the NHS is high at the time of writing.

In order to practise in the NHS in the UK a dentist must normally complete a period of supervised vocational training, in a practice or public health clinic. GDP and Community DFT are based on clinical practice for 4 days a week and day release courses for one day a week. A certificate of completion of the training must be obtained before independent, unsupervised NHS practice is possible.

EU nationals who have graduated from an EU dental school are exempt from the VT/DFT requirement, although they may undertake this if they wish. Graduates from outside the EU are required either to undertake VT/DFT or, if they have substantial experience in general dental practice, to undergo 'competency training' (formerly called equivalence training). In England and Wales, the process works by arrangement with an employing practice, an NHS England Area Team, and the dental section of the Local Training and Education Board (previously the regional postgraduate dental 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/DFT or competency training are dentists able to be included in the "performer" list without conditions 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 'contractor' in Scotland or 'principal' in Northern Ireland, 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.

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, the dental care professionals register, and the specialist lists.

Cost of registration (2013)	€ 685

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 certificate of current professional status 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 may be asked to undergo additional training. In most cases, dentists in this situation 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, the GDC's Standards document (ethical code) issued in September 2013 makes it a requirement that a dental professional "must be sufficiently fluent in written and spoken English to communicate effectively with patients, their relatives, the dental team and other healthcare professionals in the UK".

For working in NHS general dental practice (see below), there is a requirement to pass an English language test (the IELTS or one of a list of other qualifications), at a set standard,

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

Continuing education

All dentists (including specialists and non-practising 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. Dental care professionals also must undertake CPD with different hourly requirements. The scheme is administered by the GDC and was under review in 2013. It is expected that the required number of hours will change and that the requirement for core subjects will be discontinued. Instead, requirements for annual CPD declarations and formal personal development plans for every registrant are likely to be introduced.

There are two schools of postgraduate dentistry (London and Edinburgh) and also postgraduate institutes attached to many undergraduate schools. Continuing education can also be provided by professional associations and independent organisations.

Specialist Training

The training for all specialties takes place in recognised hospital training posts, is supervised by the Medical Royal Colleges and lasts from 3 to 5 years, following a minimum period of two years of postgraduate training (which includes the year of VT/DFT). So, depending upon the specialty, it may take 5 to 7 years post-graduation 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 2014:

- Oral Surgery
- Endodontics
- Orthodontics
- Periodontics
- Restorative dentistry
- Prosthodontics
- Dental Public Health
- Oral Medicine
- Paediatric dentistry
- Oral Microbiology
- Oral Pathology
- Dental and Maxillofacial Radiology
- Special Care Dentistry

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

Year of data:	2014
Total Registered	38,934
In active practice*	33,000
Dentist to population ratio**	1,936
Percentage female	45%
Qualified overseas***	10,273

The well-publicised shortage of dentists in the UK has been alleviated over recent years to a large extent, although there may still be pockets in rural areas where more dentists are needed. Competition is rising for jobs in dentistry in many areas, and a workforce review was ongoing in 2013.

* estimated

** active dentists only

*** 2013 data

The above numbers include those in the islands of the UK, shown at the end of this section.

In April 2013 a new statutory body, Health Education England (HEE) took on the responsibility for workforce planning and funding appropriate training in England. Local Education and Training Boards (LETBs) are reporting directly to this organisation and are including the function of the former postgraduate dental deaneries.

Non-active dentists will include those who are retired but remain on the Dentists Register, those who undertake full-time administrative work and other similar activities.

Newly qualified dentists are required to undertake vocational training/dental foundation training in the NHS before they can work unsupervised (in the NHS). Competition for training places is high.

There were anecdotal reports of unemployment in 2013, amongst (especially) newly qualified dentists who had failed to obtain VT/FD places. Underemployment, in particular of young dentists, is also increasing.

Movement of dentists into and out of the UK

UK qualified	29,136
Irish (primary qualification)	747
Other EU/EEA qualified	5,868
Non-EU: Qualified by examination	2,531
Qualified others	1,874

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. Most of those described above as "Qualified others" are dentists who trained in South Africa and Australia, whose qualifications were formerly recognised by the UK for registration and who have maintained their registration since this ruling was abandoned.

Specialists

Year of data:	2014
Orthodontics	1,338
Endodontics	255
Paediatric Dentistry	236
Periodontics	334
Prosthodontics	421
Restorative Dentistry	308
Dental Maxillo-facial Radiology	24
Oral Surgery	728
OMFS*	
Dental Public Health	114
Oral Medicine	69
Oral and Maxillofacial Path	31
Oral Microbiology	7
Special Care Dentistry	314
* OMFS is medical specialty	

Some Specialists are known as Consultants and work in hospitals. However, Consultants in Dental Public Health are employed by a central body called Public Health England 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.

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 five types of dental auxiliary:

- Dental Hygienists
- Dental Therapists
- Orthodontic Therapists
- Dental Technicians
- Clinical Dental Technicians

All DCPs have to be registered with the General Dental Council (or in a formal training programme). They 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. The CPD system was under review in 2014.

Year of data: 2014	Male	Female	Total
Hygienists	224	6,150	6,374
Technicians	6,283	1,373	6,323
Clinical Dental Technicians	233	18	251
Dental Nurses	599	50,110	50,709
Therapists	113	2,144	2,257
Orthodontic Therapists	8	345	353
Other	3		3
Total number of DCPs	7,463	60,140	66,270
Actual no of DCPs	5,771	57,297	63,068

Note: some DCPs are registered with more than one title, so the total is less than the sum of the individual numbers. Also, these numbers include those in the islands of the UK, shown at the end of this section.

There is some illegal dental practice by non-registered persons, who are routinely prosecuted in the courts upon the instigation of the GDC.

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.

Until April 2013, dental hygienists could only work under the direction of a dentist, who prepared the treatment plan, but need not be on the premises during treatment. Then the GDC amended their rules such that hygienists can now provide treatments within their scope of practice directly to patients, without a prescription. This is called 'direct access'. From the outset some practices started using direct access arrangements, while others continue to offer hygiene services only on prescription of a dentist. Direct access can currently only be provided in a private setting, not on the NHS. A hygienist's scope of practice includes:

- provide dental hygiene care to a wide range of patients obtain a detailed dental history from
- patients and evaluate their medical history
- carry out a clinical examination within their competence
- complete periodontal examination and charting and use indices to screen and monitor periodontal disease
- diagnose and treatment plan within their competence
- prescribe radiographs
- take, process and interpret various film views used in general dental practice
- plan the delivery of care for patients
- give appropriate patient advice
- 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 surface debridement
- using manual and powered instruments use appropriate anti-microbial therapy to manage plaque related diseases
- adjust restored surfaces in relation to periodontal treatment
- apply topical treatments and fissure sealants
- give patients advice on how to stop smoking
- take intra and extra-oral photographs
- give infiltration and inferior dental block analgesia
- place temporary dressings and re-cement crowns with temporary cement
- place rubber dam
- take impressions
- care of implants and treatment of peri-implant tissues
- identify anatomical features, recognise abnormalities and interpret common
- pathology: carry out oral cancer screening
- if necessary, refer patients to other healthcare professionals
- keep full, accurate and contemporaneous patient records
- if working on prescription, vary the detail
- but not the direction of the prescription according to patient needs

Additional skills which a dental hygienist might develop during their career:

- tooth whitening to the prescription of a dentist
- administering inhalation sedation
- removing sutures after the wound has been checked by a dentist

Dental hygienists do not:

- 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

Most dental therapists undertake a degree qualification. They often also train as hygienists at the same time. Qualified hygienists can attend a specific training programme to become dental therapists.

Dental therapists have a wider scope than hygienists. The permission to provide services directly to the public applies to them for their full scope of practice. Their type and amount of earnings is similar to hygienists.

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

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 training, which is a minimum of a year and leads to a diploma, is being offered by eight universities and training providers – Bristol, Cardiff, Edinburgh, Glasgow, Leeds, Manchester , Preston 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 removable appliances activated or adjusted by a dentist
- remove fixed appliances, orthodontic adhesives and cement
- identify, select, prepare and place auxiliaries
- 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
- take intra and extra-oral photographs
- place brackets and bands
- prepare, insert, adjust and remove archwires previously prescribed or, where necessary, activated by a dentist
- give advice on appliance care and oral health instruction
- fit tooth separators
- fit bonded retainers
- carry out Index of Orthodontic Treatment Need (IOTN) screening either under the direction of a dentist or direct to patients
- make appropriate referrals to other healthcare professionals
- keep full, accurate and contemporaneous patient records
- give appropriate patient advice

Additional skills which orthodontic therapists could develop during their career:

- applying fluoride varnish to the prescription of a dentist
- repairing the acrylic component part of orthodontic appliances
- measuring and recording plaque indices
- removing sutures after the wound has been checked by a dentist.

Orthodontic therapists do not:

- modify prescribed archwires
- give local analgesia
- remove sub-gingival deposits
- re-cement crowns
- place temporary dressings
- diagnose disease
- treatment plan

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 or clinical dental technician.. They may:

- review cases coming into the laboratory to decide how they should be progressed
- work with the dentist or clinical dental technician on treatment planning and outline design
- give appropriate patient advice
- design, plan and make a range of custom-made dental devices according to a prescription
- modify dental devices including dentures, orthodontic appliances, crowns and bridges according to a prescription
- carry out shade taking
- carry out infection prevention and 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 helping to fit attachments at chairside.
- Working with a dentist or a clinical dental technician in the clinic, assisting with treatment by:
- taking impressions
- recording facebows
- carrying out intra-oral and extra-oral tracing
- carrying out implant frame assessments
- recording occlusal registrations
- tracing cephalographs
- carrying out intra-oral scanning for CAD/CAM
- taking intra and extra-oral photographs

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 most now work in commercial dental laboratories which charge fees to dentists, health authorities. Some work as salaried employees in hospitals.

Clinical Dental Technicians (CDTs)

Until 2008 there were no courses available within the UK to achieve this qualification. Training courses are available (in 2013) in Edinburgh, Preston and Kent Postgraduate Deanery. 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.

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:

- prescribe and provide complete dentures direct to patients
- provide and fit other dental devices on prescription from a dentist
- take detailed dental history and relevant medical history
- perform technical and clinical procedures related to providing removable dental appliances
- carry out clinical examinations within their scope of practice
- take and process radiographs and other images related to providing removable dental appliances
- distinguish between normal and abnormal consequences of ageing
- give appropriate patient advice
- recognise abnormal oral mucosa and related underlying structures and refer patients to other healthcare professionals if necessary
- fit removable appliances
- provide sports mouth guards
- keep full, accurate and contemporaneous patient records vary the detail but not the direction of a prescription according to patient needs

Additional skills which a CDT could develop during their career:

- oral health education
- re-cementing crowns with temporary cement
- providing anti-snoring devices on prescription of a dentist
- removing sutures after the wound has been checked by a dentist
- prescribing radiographs
- replacing implant abutments for removable dental appliances on prescription from a dentist
- providing tooth whitening treatments on prescription from a dentist

They must be qualified to register with the GDC, which they must do before they can work. Their type of earnings is unknown and they are subject to the same 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 prevention and control procedures to prevent physical, chemical and microbiological contamination in the surgery or laboratory
- record dental charting and oral tissue assessment carried out by other registrants
- prepare, mix and handle dental bio-materials
- provide chairside support to the operator during treatment
- keep full, accurate and contemporaneous patient records
- prepare equipment, materials and patients for dental radiography; process dental radiographs
- monitor, support and reassure patients
- give appropriate patient advice
- support the patient and their colleagues if there is a medical emergency
- 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
- further skills in assisting in the treatment of orthodontic patients
- intra and extra-oral photography
- pouring, casting and trimming study models
- shade taking
- tracing cephalographs

Additional skills under prescription or direction from another registrant:

- taking radiographs
- placing rubber dam
- measuring and recording plaque indices
- removing sutures after the wound has been checked by a dentist
- constructing occlusal registration rims and special trays
- repairing the acrylic component of removable appliances
- applying topical anaesthetic to the prescription of a dentist
- constructing mouthguards and bleaching trays to the prescription of a dentist
- constructing vacuum formed retainers to the prescription of a dentist
- taking impressions to the prescription of a dentist or a CDT

Dental nurses do not diagnose disease or treatment plan. All other skills are reserved to one or more of the other registrant groups. Since 2013, they have been able to participate in public health programmes without patients seeing a dentist first.

Dental Receptionists and Practice Managers

It is usual for dental practices to have one or more dental receptionists, who manage appointments for patients and other front desk administrative work. Often the receptionists are dental nurses, who can also assist inside the clinical areas at times of shortage of the regular dental nurses.

Many practices also have practice managers, who handle the "backroom" affiars of the practice, which might include personnel matters, equipment maintenance and dental supply ordering, amongst many other duties. They are often recruited from outside dentistry.

Neither receptionists nor practice managers need be qualified, or registered with the General Dental Council. They have their own professional association.

It is estimated that there may be more than 15,000 receptionists and practice managers (in 2014).

Practice in the United Kingdom

Year of data:	2013
General (private) practice	31,615
Public dental service	1,800
University	566
Hospital	2,084
Armed Forces	244
Administrative	250
General Practice as a proportion is	92%
Number of general practices	12,000

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 (2013). All must be registered with the Care Quality Commission in England or equivalent organisations in the other countries (see below). Practitioners work without another dentist in the same practice in about one fifth of practices. However, most practices have two or more dentists working together and with dental hygienists and/or dental therapists.

Some practices are owned and run by clinical dental technicians, to provide dental protheses to patients. However, these practices are not 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. All dental care professionals are permitted to own and run dental practices, but most are not (in 2013) able to contract with the NHS.

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 2013.

NHS Practice (General Dental Services)

To be able to work in unsupervised practice in the NHS all dentists need to demonstrate that they understand English. Those qualified in the EU have to undertake an examination (IELTS or equivalent) 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 bring a police check showing 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.

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).

The contract system was under review in 2013.

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 Practitioner Services Division (Dental) or Business Services Organisation, respectively), is required for complex treatment which costs more than €405/€325 respectively (2013).

In addition there are allowances paid to GDPs/practices to recognise and reward their level of health service commitment.

Private Practice (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. BDA figures (in 2013) show that an increasing number of dentists are increasing the proportion of their practices to provide private-only care, independent of the NHS.

Joining or establishing any 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.

Before opening a practice in England, the prospective provider of dental services must register with the Care Quality Commission (CQC), a quasi-autonomous government body. Certain conditions must be fulfilled and the practice inspected before it opens for patients. It will then be inspected regularly, at least once every 3 years. The CQC has the power to close down a practice, if it considers it to be unsafe and a risk to the public.

Similar organisations exist in the other countries of the UK: Health Inspectorate Wales, Health Improvement Scotland (not operational at the time of writing), and the Regulation and Quality Improvement Authority in Northern Ireland. All organisations have similar, but slightly different objectives to those of the Care Quality Commission.

In Scotland there are incentive schemes to persuade dentists to open practices in certain areas. Some individual dentist's allowances may also not be available depending on the area.

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.

For sedation services, and for a new practice, the local health authority has the right to inspect the premises first (before 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/DFT, if they are working in the GDS. 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.

Working in the Public Clinics

The public dental service is known as the 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 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.

Some 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. 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.

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

About a third of the full-time dentists in the Armed Forces are female. Number of dentists in 2013:

Army	142
Royal Air Force	54
Royal Navy	48

Professional Matters

Professional association

The main dental organisation for dentists in the UK is the *British Dental Association* (or *BDA*).

	Number	Year	Source
British Dental Association	19,736	2012	FDI

About 50% of dentists (57% 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 Standards document produced by the registration body, the *General Dental Council* (GDC). As mentioned earlier, the latest ddocument was introduced in September 2013 and is mandatory for dental professionals to follow. It includes information about what is expected in relation to professional standards, patient expectations, overarching principles of professionalism and has detailed guidance on individual situations in some aspects. The overarching principles are:

- Put patients' interests first
- Communicate effectively with patients
- Obtain valid consent
- Maintain and protect patients' information
- Have a clear and effective complaints procedure
- Work with colleagues in a way that is in patients' best interests
- Maintain, develop and work within your professional knowledge and skills
- Raise concerns if patients are at risk
- Make sure your personal behaviour maintains patients' confidence in you and the dental profession

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 around 150 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 FTP panel a registrant whose fitness to practise has been deemed to be impaired might have sanctions placed upon them ranging from being admonished, put on restricted practise, 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 misleading 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. The General Dental Council has published guidance about advertising as part of its standards documents.

Indemnity Insurance

Liability insurance is compulsory for all dentists working in the NHS, and will become a legal requirement of GDC registration in due course, as a result of the EU cross-border directive provisions. It is already a requirement under the GDC standards. Professional indemnity or 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 €2,330 annually. Prices are determined on an individual level.).

The indemnity may cover the dentist for working overseas.

Corporate Dentistry

Until 2006, only dentists were able to own dental practices. Since then, 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. In 2010, the corporate dentistry market had an estimated 800 dental practices with 3,100 dentists, or 10.5% of all primary care dentists. 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

The EU Cosmetics Directive (and the subsequent Cosmetics Regulation replacing it in July 2013) has been fully implemented in the UK, reflecting the requirements for products between 0.1 and 6% hydrogen peroxide to be only sold to dentists.

The GDC believes that tooth whitening is the practise of dentistry and regularly prosecutes non-registrants in the courts for illegal practice. A legal precedent for this was set in 2013.

Health and Safety at Work

Dentists and those who work for them must be inoculated against Hepatitis B and TB and be checked regularly for sero-conversion. The employer is required to pay for inoculation of the dental staff, although in some parts of the UK this is 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 1999 and the Ionising Radiation (Medical Exposure) Regulation 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 required undertake regular audits 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 available and regular inspections carried out.

Hazardous waste

Clinical waste is considered "hazardous" under the Hazardous Waste (England and Wales) Regulations 2005. Similar regulations cover Scotland and Northern Ireland. 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 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 and national healthcare regulators such as the CQC
Electrical installations	Health and Safety Executive at local level
Waste disposal	Environment Agency at local level
Medical devices	Medicines and Healthcare products Regulatory Agency
Infection control	Local health authorities and national healthcare regulators such as the CQC

Financial Matters

Dentists who work in the NHS are usually members of the NHS superannuation scheme, a retirement pension scheme. The dentist contributes between 5% and 13.3% of net income (after practice expenses) and the NHS 14%, to produce a retirement fund (which is uprated each year, for inflation).

A change of rules means that there are two sections to the Scheme. At the normal retirement age of 60 or 65 (depending on which section of the scheme they are in) salaried members can take a pension based on 1/80th of the total pensionable pay for the 1995 section and 1/60th for the 2008 section. Practitioners benefits are calculated on their career averaged earnings. Members of the scheme can retire earlier than the normal retirement age on a reduced pension from age 50 if they joined the scheme before 1st April 2006 or age 55 if they joined after that date or are a member of the 2008 section. 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 75. Dentists in private practice have no fixed retirement age.

Taxes

Income Tax

There is a national income tax (dependent on salary), and a local council tax.

Using 2013 figures, an employed person or self-employed person working in the UK is allowed a basic personal allowance of £9,440 – this is the amount a person can earn during a tax year without having to pay any tax. Earned income above the personal allowance is taxed at the appropriate percentage rate:

Basic	£0 to £32,010	- 20%
Higher	£32,011 to £150,000	- 40%
Additional	over £150,000	- 45%

Self-employed workers pay Class 2 national insurance contributions (NICs), which are set at a flat rate of £2.70 per week. They also have to pay the following Class 4 NICs on the annual profit they make from their business: 9% between £7,755 and £41,450, and 2% on all profits above £41,450.

Employees pay Class 1 NIC at 12% on earnings above £149 and 2% on earnings above £797.

Value Added Tax

Generally, VAT must be applied if a business's annual sale of qualifying goods and services either has exceeded the VAT threshold of £79,000 or its taxable supplies are set to exceed £79,000 within the next 30 days.

VAT is charged at three different rates and goods and services are banded into these different categories. Most goods and services provided in the UK fall into the standard-rated category of 20% of the retail price but some goods can have a reduced rate of 5% or be zero rated.

Dentistry which is performed to restore, protect or maintain oral health is exempt from VAT.

Various Financial Comparators

London ***Zurich = 100***	**2003**	**2012**
Prices (including rent)	111.4	66.0
Wage levels (net)	63.9	56.8
Domestic Purchasing Power at PPP	63.6	66.0

(Source: UBS August 2003 and November 2012)

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
Publications: British Dental Journal Editorial Office 64 Wimpole Street London W1G 8YS UK Tel: +44 20 7535 5842 Fax: +44 20 7535 5843 Email: bdj@bda.org Website: www.bdj.co.uk	*For advertising:* BDJ Classified Advertising Department The Macmillan Building 4 Crinan Street London N1 9WX Tel: +44 20 7843 4729 Fax: +44 20 7843 4996 Email: bdj@nature.com Website: www.bdjjobs.co.uk

Dental Schools:

Aberdeen
The University of Aberdeen
University Office
King's College Aberdeen AB24 3FX
Tel: 01224 273 504
Fax: 01224 272 034
Email: sras@abdn.ac.uk
Web: www.abdn.ac.uk/sras

Birmingham
The University of Birmingham
Edgbaston Birmingham B15 2TT
Tel: 0121 415 8900
Fax: 0121 414 7159
Email: admissions@bham.ac.uk
Web: www.bham.ac.uk

Cardiff
Cardiff University
PO Box 927
30-36 Newport Road
Cardiff
CF24 0DE
Tel: 02920 879 999
Fax: 02920 876 138
Email: admissions@cardiff.ac.uk
Web: www.cardiff.ac.uk

Glasgow
University of Glasgow
The University of Glasgow
The Fraser Building
65 Hillhead Street
Glasgow
G12 8QF
Tel: 0141 330 6062
Fax: 0141 330 2961
Email: student.recruitment@glasgow.ac.uk
Web: www.glasgow.ac.uk

Liverpool
The University of Liverpool The Foundation Building
Brownlow Hill
Liverpool
L69 7ZX
Tel: 0151 794 2000
Fax: 0151 708 6502
Email: ugrecruitment@liv.ac.uk
Web: www.liv.ac.uk

Queen Mary, University of London
Mile End Road
London
E1 4NS
Tel: 020 7882 5555
Fax: 020 7882 5500
Email: admissions@qmul.ac.uk
Web: www.qmul.ac.uk

Newcastle
Newcastle University
King's Gate
Newcastle upon Tyne
NE1 7RU
Tel: 0191 208 3333
Fax: 0191 222 6143
Web: www.ncl.ac.uk

Belfast
Queen's University Belfast
University Road
Belfast
BT7 1NN
Tel: 02890 973 838
Fax: 02890 975 151
Email: admissions@qub.ac.uk
Web: www.qub.ac.ukBirmingham

Bristol
University of Bristol Undergraduate Admissions Office
Senate House
Tyndall Avenue
Bristol
BS8 1TH
Tel: 0117 928 9000
Fax: 0117 925 1424
Email: ug-admissions@bristol.ac.uk
Web: www.bristol.ac.uk

Dundee
University of Dundee
Dundee
DD1 4HN
Tel: 01382 383 838
Fax: 01382 388 150
Email: ContactUs@dundee.ac.uk
Web: www.dundee.ac.uk/admissions/undergraduate

Leeds
University of Leeds
The University of Leeds
Woodhouse Lane
Leeds
LS2 9JT
Tel: 0113 343 3999
Email: admissions@leeds.ac.uk
Web: www.leeds.ac.uk

King's College London (University of London)
Strand
London
WC2R 2LS
Tel: 020 7848 5454
Fax: 020 7848 7171
Email: prospective@kcl.ac.uk
Web: www.kcl.ac.uk

Manchester
The University of Manchester
Oxford Road Manchester M13 9PL
Tel: 0161 275 2077
Fax: 0161 275 2106
Email: admissions@manchester.ac.uk
Web: www.manchester.ac.uk

Plymouth
Peninsula College of Medicine & Dentistry
The John Bull Building Tamar Science Park Research
Way Plymouth
PL6 8BU
Tel: 01752 437 333
Fax: 01752 517 842
Email: pcmd-admissions@pcmd.ac.uk
Web: www.pcmd.ac.uk

Preston
University of Central Lancashire,
Preston,
Lancashire
PR1 2HE
Dentists graduating each year:
Tel: 01772 201 201
Web: http://www.uclan.ac.uk/

Sheffield
The University of Sheffield
9 Northumberland Road
Sheffield
S10 2TT
Tel: 0114 222 8030
Fax: 0114 222 8032
Web: www.sheffield.ac.uk

Edinburgh (postgraduate only)

The University of Edinburgh
4th Floor, Lauriston Building
Lauriston Place
Edinburgh EH3 9HA
Tel: +44(0)131 536 4970
Fax: +44(0)131 536 4971
Email: epdi@ed.ac.uk
Web:www.dentistry.ed.ac.uk/contact-us#sthash.M7QHfaw9.dpuf

London (postgraduate only)

London
Eastman (postgraduate only) Eastman Dental Hospital
256 Gray's Inn Road
London
WC1X 8LD
Tel: 020 3456 1038
Web: http://www.ucl.ac.uk/eastman

	Number of Undergrads 2013	Graduates 2012
Aberdeen	73	13
Belfast	234	36
Birmingham	375	71
Bristol	371	72
Cardiff	365	74
Dundee	331	59
Glasgow	459	84
Leeds	447	91
Liverpool	324	64
London*	941	195
Manchester	390	71
Newcastle	436	88
Plymouth	235	68
Preston**		
Sheffield	407	79
	5,388	**1,052**

* 2 dental schools in one university

** included in Liverpool numbers

British Dependencies and Overseas Territory in Europe

There are three island jurisdictions in the UK, with their own parliaments and a very limited amount of self-government: the Isle of Man, Guernsey and Jersey.

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.

Dentistry in all three Dependencies is regulated by the General Dental Council.

The Channel Islands

Year of data: 2014	Male	Female	Total
Dentists	107	59	166
Hygienists	0	31	31
Technicians	12	6	18
Clinical Dental Techs	2	1	3
Dental Nurses	0	174	174
Dental Therapists	0	3	3
Orthodontic Therapists	0	1	1

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 declined on previous levels but now remain stable. Light taxes and no death duties make them popular offshore tax centres (taxes are relatively low and there is no VAT or GST levied on goods and services in Guernsey, however Jersey now has a 5% GST.).

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 Health and Social Services Department (Guernsey) and the UK General Dental Council (both), whose ethical rules must be followed.

Guernsey

Guernsey has a land area of 78 sq km and a population of 65,605 (July 2013). Its capital is St Peter Port. The GDP was €70,400 PPP per capita in 2011 (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, although referred secondary medical and surgical specialist care and hospital administions are free.

The registered dentists in 2013 in Guernsey included 1 orthodontist, 2 surgical dentists, 1 periodontist and 1 visiting endodontist (one day per week). Oral healthcare is normally provided in private practice, by the general practitioners who are in 13 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), 2 of whom are clinical dental technicians and one dental nurse for each dentist (it is thought that about 30 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 those referred being entitled to free treatment. Orthodontics (excluding referred IOTN class V cases) 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 and Social Services Department registers all dentists, hygienists and CDT’s in the Bailiwick of Guernsey and monitors numbers with the GDA. All dental professionals must also be registered with the GDC in London. 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 95,732 (July 2013). Its capital is St Helier. The GDP was €57,000 (PPP) per capita in 2011 (latest figures) 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 2 resident orthodontists, 2 oral surgeons, 1 restorative specialist and 1 community dental officer. The island also has 1 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 10 dental hygienists and 3 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.

Dentists and dental hygienists are required to register with the Royal Court of Jersey, as well as with the UK General Dental Council, whose ethical rules must be followed

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 2013 there were 61 registered dentists on the island. Whilst the island does have a local dental association, the number of members is not available. Many dentists are also members of the BDA and are attached to an English Branch based around Liverpool.

Oral Healthcare in the Island includes private care delivered by General Practitioners in 19 practices. They 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. In 2013, 40 dentists were providing such care.

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.

Gibraltar

Gibraltar is a British Overseas Territory located on a small peninsula of land connected by an isthmus to the southern coast of Spain, in South-western Europe, and separated from the African continent by the Strait of Gibraltar, which links the Mediterranean Sea and the North Atlantic Ocean.

Gibraltar was ceded to Great Britain by Spain in 1713 and was formally declared a colony in 1830. Since 1967, Gibraltar has been a self-governing overseas territory of the UK, under Queen Elizabeth 2nd as the monarch. A governor is appointed by the monarch; following legislative elections, the leader of the majority party or the leader of the majority coalition is usually appointed chief minister by the governor. There is a unicameral Parliament (18 seats: 17 members elected by popular vote, 1 for the speaker appointed by Parliament; members serve four-year terms).

Gibraltar is self-sufficient and benefits from an extensive shipping trade, offshore banking, and its position as an international conference centre. Tax rates are low to attract foreign investment.

The population at July 2013 was 29,111 and languages are English (used in schools and for official purposes) and Spanish. The currency used is the Gibraltar Pound (parity with Sterling).The GDP at Purchasing Power Parity per capita was $43,000 in 2011. Health expenditure was expected to exceed £90m in 2013 [source Ministry for Health] – about 10% of GDP.

There are no dental schools in Gibraltar and education and training takes place abroad, usually in the UK. Dental Practitioners have to register with the Medical Registration Board of Gibraltar. There is no post-qualification vocational training or mandatory continuing education.

Dental hygienists train abroad, usually in the UK as there is no training in Gibraltar. The hygienists work in private practice under direct supervision.

Dental Technicians train overseas, usually in the UK, receiving degrees or diplomas as appropriate. The title is not protected, they also do not need to register and continuing education is not mandatory. Chairside assistance may be provided by Nursing Auxiliaries, Nursing Assistants or Dental Nurses. The title is not protected and training, which is not formal, is provided at the workplace. Currently, registration is not necessary, nor is continuing education mandatory.

The Gibraltar government advised (in 2013) that regulation of the professions of Dental Hygienist, Dental Technician and Dental Therapist was under consideration and if effected, these titles will become protected.

There is a social insurance Scheme which entitles residents to healthcare; the dental aspect of this is a core but largely age-limited service. The Scheme provides a full range of treatment options, including orthodontics, but only for the under-18s and students. There is a limited service provided for 'social cases', and a very basic emergency only/extraction service for everyone else.

Many employers provide private insurance to assist with the cost of dentistry.

Dentists employed by the Government are salaried. Those that are not salaried are funded entirely by the patients.

There is no separate Dental Association, but dentists are members of the Medical Association.

The Medical Registration Board has statutory responsibility for ensuring that dentists are fit to practise. However, there have been no serious cases against dental practitioners since the middle 1990s.

Health and Safety is handled by the relevant government departments. Dental practitioners' use of imaging equipment is regulated by statute.

Numbers in Gibraltar in 2013	
Registered dentists	33
Active Dentists	32
Specialists:	
Orthodontics	1
Oral surgery	1
Restorative Dentistry	1
Active dentists who are female	46%
Working in General Practice	77%
Working in public salaried service	23%
Number of dental hygienists	3

This data for Gibraltar is not included in UK figures

Smaller Countries Associated with the EU

There are three independent countries geographically situated wholly within the borders of the EU, but which are not members of the EU or EEA. However, all three countries have associated arrnagements with the EU.

Andorra

The landlocked Principality of Andorra is one of the smallest states in Europe, situated high in the Pyrenees Mountains between the French and Spanish borders. For 715 years, from 1278 to 1993, Andorrans lived under a co-principality, ruled by French and Spanish leaders (from 1607 onward, the French chief of state and the Spanish bishop of Seu d'Urgell).

In 1993, this feudal system was modified, with the titular heads of state retained, but the government transformed into a parliamentary democracy. In the late 20th century, Andorra became a popular tourist destination. An estimated 10 million people visit each year drawn by the winter sports, summer climate, and duty free goods. Andorra has also become a wealthy international commercial center because of its banking facilities, low taxes, and lack of customs duties. However, recent economic hardships have required Andorra to start taxing foreign investments and to implement stricter economic policies.

Andorra is not a member of the European Union, but enjoys a special relationship with it and uses the Euro as its national currency. Its population is 85,293 and languages spoken are Catalan (official), French, Castilian and Portuguese.

Andorra's GDP per capita at PPP in 2011 was €27,281 (estimated – CIA) and health spending was €2,254 per capita (WHO).

There is no available information about health services.

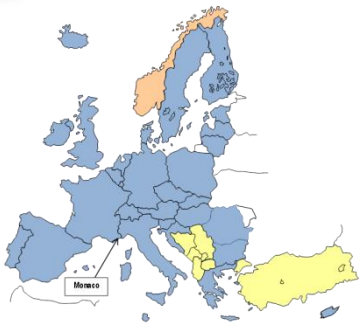
Monaco

Further information about Monaco is on the next pages.

San Marino

Further information about San Marino is later on.

Monaco



Monaco is a small country in Western Europe, bordering the Mediterranean Sea on the southern coast of France, near the border with Italy.

The ruling Grimaldi family has governed securely since 1297 – in 1997 Monaco celebrated 700 years of ruling. Economic development was spurred in the late 19th century with a railway linkup to France and the opening of a casino. Since then, the principality's mild climate, scenery, and gambling facilities have made Monaco world famous as a tourist centre.

There is a unicameral National Council or Conseil National (24 seats; 16 members elected by list majority system, 8 by proportional representation to serve five-year terms) and a Minister of State who is appointed by the monarch.

The population at 2012 was 37,579 (including 8,675 Monegasque nationals).

Spoken languages are French (official), English, Italian and Monegasque.

The GDP at Purchasing Power Parity per capita was €46,000 in 2011. Health expenditure was 4.3% of GDP in 2010.

Relations between Monaco and the European Union (EU) are primarily conducted through France. Through that relationship Monaco directly participates in certain EU policies. Monaco is an integral part of the EU customs territory & VAT area and applies most measures on VAT and Excise duties (particularly relating to free movement in the EU).

However this relationship does not extend to external trade. Preferential trade agreements between the EU and third countries apply only to goods originating from the customs territory - Monaco may not claim EU origin in this respect.

Monaco is a *de facto* member of the Schengen area (its borders and customs territory are treated as part of France) and it officially uses the Euro as its sole currency. It uses the Euro via an agreement with the EU and France and is allowed by the EU to mint its own coins. Monaco uses the Euro as it previously had its currency tied 1:1 with the French franc.

There is agreement on the application of Community legislation to pharmaceuticals, cosmetic products and medical devices (this entered into force on 1 May 2004); and on savings taxation (in force since 1 July 2005).

Healthcare

Monaco has its own social insurance system which is different from that of France in several aspects.

There is private insurance, as in any other country when a patient does not benefit from the social insurance system, or when the patient wants to have an improved coverage (complementary insurance) that will be added to the social insurance benefit.

Oral healthcare

All qualifications in dentistry are achieved outside of Monaco. Registration takes place with the Ministry of Health, at the *"Department de Direction de l'Action Sanitaire et Sociale"* (DASS).

In 2013, there were 37 registered dentists (including 3 orthodontists) in Monaco, all of them are in private practice.This gives a Dentist to Population ratio of 1:1,016.

Dentists' fees are paid directly by patients. Those patients who have social security insurance or private insurance can get reimbursement from those insurances, in accordance with the insurance plan.

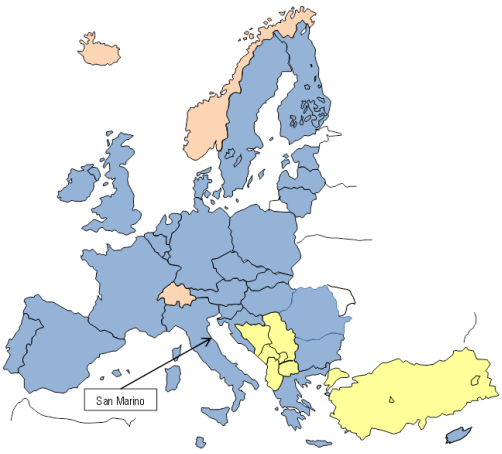
There is no available information about the number of dental auxiliaries employed in Monaco. Most auxiliaries train in France, but training from other countries is accepted. Dental hygienists are not allowed to work in Monaco. Therefore, the only dental auxiliaries allowed are dental assistants. They do not have to register, but they must be declared, as any other employee.

Monaco does not have any Dental Association. The College des Chirurgiens-Dentistes de la Principauté de Monaco, which is the equivalent of the Order in France, handles disciplinary and ethical matters.

For more information, visit: www.gouv.mc (the official Monaco website) or www.imsee.mc (for statistics).

(Date of last revision: October 15th 2013)

San Marino



Not a member of the EU/EEA	
Population (2013)	32,448
GDP PPP per capita (2012)	€26,840
Currency	Euro
Main language	Italian

There is availability of state-funded oral healthcare, limited to ages 0-16 and some "vulnerable" people. There is good access for private practice. The Dental Department at the State Hospital closed on December 31st 2013.PDS is entrusted to the private sector.

Number of dentists:	64
Population to (active) dentist ratio:	507
Membership of the Dental Association::	Not relevant

Orthodontics and Oral Surgery are the only specialties. The use of dental auxiliaries is also limited
Continuing education is not mandatory.

Date of last revision: 31st January 2014

Government and healthcare in San Marino

An enclave in central Italy, geographically the third smallest state in Europe (after the Holy See and Monaco), San Marino also claims to be the world's oldest republic. According to tradition, it was founded by a Christian stonemason named Marinus in A.D. 301. San Marino's foreign policy is aligned with that of the European Union, although it is not a member. Social and political trends in the republic track closely with those of its larger neighbour, Italy.

San Marino is a Parliamentary Republic with a unicameral Grand and General Council or *Consiglio Grande e Generale* (60 seats; members elected by popular vote to serve five-year terms). The co-Chiefs of State (Captains Regent) are elected by the Grand and General Council for a six-month term.

The spoken language is Italian and the currency used is the Euro.

By law in San Marino all citizens and long term residents permitted to live in country are entitled to equal public healthcare services.

The National Healthcare System (*Istituto di Sicurezza Sociale - ISS*). The system is a mandatory state-funded healthcare. Employers and employees working in San Marino need to make regular contributions through salaries, which funds the country's public healthcare services.

Citizens and long-term residents receive a health card and a unique number which they are required to use to access healthcare services. Vulnerable groups such as old age pensioners and the chronically ill receive free healthcare services, without the need to make contributions to the state-healthcare fund. The scheme covers the majority of healthcare services and medical treatments such as hospitalisation, specialist treatment and rehabilitation. Doctors can refer patients to a consultant free of charge.

Healthcare is provided at a low cost to residents and nationals through a network of clinics and a small hospital - .the state hospital called the San Marino Hospital. Treatment options are limited and certain procedures must be conducted in hospitals outside of the country. The Institute for Health and Social Security (ISS) administer the country's healthcare system on behalf of the national government.

Health centers and clinics in San Marino are capable of providing outpatient care and some are capable of offering a variety of specialist services.

Emergency care is available free for everyone including those without state health insurance. Emergency treatments are provided at the emergency room of the state hospital and are of a high standard. Emergency care is also available in the network of clinics throughout the country. The emergency rooms are known as pronto soccorso.

The GDP at Purchasing Power Parity per capita was €26,840 in 2012. Health expenditure was 9.4% of GDP in 2012. The per capita health expenditure was €2,525 (at PPP) – source the World Bank.

Oral healthcare

In principle, there is a comprehensive oral health care system, which functions within the National Health Service (ISS). Some dental treatments are available through the state healthcare system.

Such national regulations state that the oral health care, on NHS charge, is limited to:

4. Dental health care programmes dedicated to the age of development (0-16 years) which include the monitoring and treatment of cavities and the diagnosis of malocclusions.
5. Dental and Prosthetic care to subjects with particular conditions of vulnerability (social and sanitary).

Treatments:

- Dental visits: to all subjects in the age group (0-16 years), without limit of frequency, for diagnosis
- Other treatments, including extractions, periodontal surgery, reconstructive oral surgery, scaling, etc.
- Dental and Prosthetic care to people with particular conditions of vulnerability.

Similarly to the Italian LEA, two different categories of 'vulnerability' are 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.

Private insurance for dental care

There are no private healthcare insurance plans.

Education, Training and Registration

Undergraduate Training

There is no dental school In the Republic of San Marino and so all study is abroad (usually in Italy). During the academic year 2012/13 four students in dentistry and one student in dental hygiene were noted.

Qualification and Vocational Training

Primary dental qualification

A dentist is a professional holding a university degree in medicine and surgery, or in dentistry and prosthetics. A dentist is responsible for the prevention, diagnosis and treatment of diseases of the teeth, mouth, jaws and associated tissues.

In 2013, the legal practice of dentistry is permitted by (Article 5-6 Decreto 32/1996 Titolo 2) by:

- graduates in Dentistry
- graduates in Medicine and Surgery enrolled in a university course before January 28th 1980, with or without a specialisation in dentistry (EU Citizens)
- graduates in Medicine and Surgery enrolled in the university course after 28 January 1980, holding the diploma of specialisation in dentistry or authorised to practise dentistry (EU Citizens)
- graduates in Medicine and Surgery enrolled in a university course before 31th December 1995 (San Marino Citizens or Residents)

Vocational Training (VT)

Vocational training is not mandatory.

Registration

To register as a dentist, an applicant must have a degree or diploma in Dentistry or in Medicine and Surgery (as explained before). It is not possible to be registered in both Dental and Medical Registers. The prerequisite for professional practise is the registration as a dentist at State Chamber.

The registration list is held by the *Ordine dei Medici Chirurghi e degli Odontoiatri della Repubblica di San Marino* – ***Albo 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 in 2014 was €150 (€180 Euro for a first registration).

Workforce

Dentists

In December 2013, there were 28 San Marino Citizens registered in the *Albo Odontoiatri*. Altogether, there were 64 Dentists working in San Marino. About these:

Graduated in dentistry	36	Working using the Albo Odontoiatri	8
		Working using the Italian annotated in "Registro dei Consulenti")	28
Graduated in medicine and surgery, specialised in dentistry	10	Working using the Albo Odontoiatri	5
		Working using the Italian annotated in "Registro dei Consulenti")	5
Graduated in medicine and surgery and authorised to work as dentists	18	Working using the Albo Odontoiatri	10
		Working using the Italian annotated in "Registro dei Consulenti")	8

Specialists

In San Marino, two are specialties recognised: Oral Surgery and Orthodontics. There is also a medical specialty of Oral Maxillo-facial surgery. Three San Marino dentists are specialised in Orthodontics.

Auxiliaries

Dental Hygienists

In Republic of San Marino there is no dental school so it is necessary to study Dental Hygiene abroad. Education and training is provided by Universities and it lasts three years, leading to a diploma, which must be obtained before a dental hygienist may legally practise. There is no compulsory registration upon qualification. In academic year 2012/2013 there was a San Marino citizen studying Dental Hygiene abroad.

Dental Technicians

In Republic of San Marino there is no school for Dental Technicians. They are trained abroad (usually in Italy) in technical schools, in a three plus two year course, which is needed to get the diploma of a technician.

During the School Year 2012/2013 there were four students in dental technical schools.

Dental technicians are salaried or professionals who own their private laboratories, deriving their income from the provision of services to dentists.

Chairside Assistants

Dental chairside assistants' education and training is normally provided by individual dental practitioners.

There are no schools dedicated to chairside assistants in Republic of San Marino.

Practice in San Marino

In December 2013 there were 35 dental offices/dental clinics in Republic of San Marino. Until then there were 6 dentists worked in Dental Department inside the State Hospital, but this service was closed in January 2014. So, from 2014, all dentists work in private practice and the ISS has established private practice accreditation to provide public dental services.

Employment contracts for dental staff members are not agreed at national level. There are no dentists in the Public Dental Service, Hospitals and Armed Forces.

There is no minimum fee scale for dental services. Only dentists are registered in the "placement lists".

Annex 1 - Information collection and validation

The EU Dental Liaison Committee (DLC) commissioned the University of Wales to design and construct a manual of dental practice across the European Community, in 1995.

The original information, for the first edition of the Manual, was collected in early 1996, in three stages. Firstly, a questionnaire was circulated to the main dental associations in each of the 18 countries ie the 15 countries of the EU, plus Norway, Switzerland and Iceland.

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 in 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 3 and 7 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.

The first full edition of this review was published as a Manual of Dental Practice in the EU in 1997.

This process was repeated for the second edition, and the content was extended to include more information – such as information about women in dentistry, specialisation and remuneration trends, where appropriate and available. This was published in January 2000.

The DLC 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.

This third edition was revised and updated using two methodologies: for the 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 then authors, Dr Anthony Kravitz and Professor Elizabeth Treasure, 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 later in 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 were then validated with dental associations of the countries, many chief dental officers, and some dental councils and registration bodies, before publication.

The third edition, published in 2004, was presented in a new, modern style – a complete revamp of the two earlier editions.

The University of Wales became Cardiff University in 2005 and the DLC became the Council of European Dentists (CED) in May 2006. The CED commissioned Cardiff University in November 2007 to update the 2004 Manual and produce another version relevant to 2008 (edition 4) – to include Bulgaria (missing from the 2004 version) and Croatia, which was expected to join the EU in January 2009. The same process, with the same authors, was used for the 4th edition.

A further edition, 4.1 was produced in 2009, which embraced corrections of errors on 24 pages of the 405. All the data remained as supplied by 1st October 2008 and was not updated for edition 4.1.

For this 5th edition, Cardiff University was again commissioned. All the 32 countries involved with the 4th edition were approached in June 2013 (by email) and requested to provide new data – which all completed by November. For Romania the past Secretary-General of Collegiums contributed. No direct interviews were possible. Contacts in Italy (for San Marino), Monaco and Gibraltar were also approached with questionnaires in the Summer of 2013, and they are included here for the first time.

All countries were then invited in January 2014 to update any data or information. Four countries did not respond to this request.

Documentary sources of information used in 2013-14 are listed at the beginning of this Manual.

Annex 2 – EU Institutions

The major institutions of the EU include the seven institutions listed below, together with 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.

Summary of the important Institutions[28]

The **European Parliament** (elected by the peoples of the Member States);

The **European Council** (which has the role of driving EU policy-making, headed by the President.);

The **Council** (composed of representatives of each Member State at ministerial level, who may commit the government of the Member State in question and cast its vote);

The **European Commission** (the driving force and executive body);

The **Court of Justice** (compliance with EU law);

The **European Central Bank**

The **Court of Auditors** (sound and lawful management of the EU budget).

The European Parliament

The European Parliament is a directly elected body of members. The Lisbon Treaty has boosted its powers as regards law-making, the EU budget and approval of international agreements

After the European elections of May 2014, the number of MEPs from each country varies according to the size of the Member State, ranging from 96 from Germany to 6 from Cyprus, Estonia, Luxembourg amd Malta, (see table for numbers from each country). The total number was reduced from 766 to 751 in line with the Treaty, some Member States losing between 1 to 3 seats each. Members are elected for five years and form political rather than national groups.

The Parliament's powers increased with the Single European Act and the Lisbon Treaty. It now exercises democratic supervision over all EU 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. An EU 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 EU legislation.

The European Parliament and the Council now share the power of decision equally in a large number of areas such as legislation and the EU budget. The Parliament also supervises other EU institutions, such as the Commission.

Most of the detailed work in the Parliament is conducted by specialist committees, divided into 20 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 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.

	Number of members of the European Parliament				2014
	1999-2004	2004-2007	2007-2009	2013-2014	onwards
Austria	21	18	18	19	18
Belgium	25	24	24	22	21
Bulgaria	-	-	18	18	17
Cyprus	-	6	6	6	6
Croatia	-	-	-	12	11
Czech Rep	-	24	24	22	21
Denmark	16	14	14	13	13
Estonia	-	6	6	6	6
Finland	16	14	14	13	13
France	87	78	78	74	74
Germany	99	99	99	99	96
Greece	25	24	24	22	21
Hungary	-	24	24	22	21
Ireland	15	13	13	12	11
Italy	87	78	78	73	73
Latvia	-	9	9	9	8
Lithuania	-	13	13	12	11
Luxembourg	6	6	6	6	6
Malta	-	5	5	6	6
Netherlands	31	27	27	26	26
Poland	-	54	54	51	51
Portugal	25	24	24	22	21
Romania	-	-	36	33	32
Slovakia	-	14	14	13	13
Slovenia	-	7	7	8	8
Spain	64	54	54	54	54
Sweden	22	19	19	20	20
UK	87	78	78	73	73
TOTAL	**626**	**732**	**786**	**766**	**751**

[28] http://europa.eu/lisbon_treaty/glance/institutions/index_en.htm

Table 28: The European Parliament

There are two types of legislative procedures: Ordinary Legislative Procedure (or the co-decision procedure) and Special Legislative Procedure.

Ordinary Legislative Procedure

Ordinary Legislative Procedure applies to the majority of EU legislation including consumer rights, transport and environmental protection. Any laws passed are joint acts of the Parliament and the Council. In this procedure the Commission draws up a proposal which is adopted by the Parliament and the Council. Parliament's consent is needed in all international decisions under this procedure.

Special Legislative Procedures

In areas such as internal market exemptions and competition law, the Consultation Procedure may be used. In this procedure the Council *consults* Parliament regarding a proposal from the Commission but they do not need to accept Parliament's advice.

The Consent Procedure can apply for legislation such as the Accession of new Member States, association agreements with third countries, the right of residence for Union citizens, combating discrimination, accession of the Union to the European Convention of Human Rights or agreements with important budgetary implications. Parliament can accept or reject a proposal.

The Parliament has the ultimate power to dismiss the Commission as a whole, with a two-thirds majority.

The European Council

The European Council, which has the role of driving EU policy-making, has become a full EU institution. Although it does not gain any new powers in the Lisbon Treaty, it is headed by a President.

European Council meetings are essentially summits where EU leaders meet to decide on broad political priorities and major initiatives.

Its role is twofold – setting the EU's general political direction and priorities, and dealing with complex or sensitive issues that cannot be resolved at a lower level of intergovernmental cooperation. Though influential in setting the EU political agenda, it has no powers to pass laws.

Elected by the European Council for 2½ years, the main job of the President is to prepare the Council's work, ensure its continuity and work to secure consensus among Member States. The President cannot simultaneously hold any elected position or office nationally.

The European Council brings together the Heads of State or government of the Member States, the Commission President and the European Council President, who chairs the meetings. The EU's High Representative for Foreign Affairs and Security Policy also takes part.

The Council meets (usually in Brussels) twice every 6 months, though its President can convene a special meeting if needed. Meetings are chaired by the President.

The European Council decides by consensus, except if the Treaties provide otherwise.
The Presidents of the European Council and Commission, and the High Representative for Foreign Affairs and Security Policy do not have a vote.

The Council

Also informally known as the EU Council, this is where national ministers from each Member State meet to adopt laws and coordinate policies. It should not be confused with the **European Council,** or the **Council of Europe** – which is not an EU body at all.

The Council of the EU:

- Passes EU laws,
- Coordinates the broad economic policies of Member States.
- Signs agreements between the EU and other countries.
- Approves the annual EU budget
- Develops the EU's foreign and defence policies.
- Coordinates cooperation between courts and police forces of Member States.

Passing EU laws

The Council and Parliament share the final say on new EU laws proposed by the Commission.

Coordinating economic policies

Member States have decided they want an overall economic policy for Europe, coordinated by the economics and finance ministers of each country. A further objective is to create more jobs and improve education, healthcare and welfare systems. Although each country is responsible for its own policy, they can agree on common goals and learn from each other's experience.

Signing international agreements

The Council signs agreements on behalf of the EU – on subjects as diverse as the environment, trade, development, textiles, fisheries, science, technology and transport.

Approving the EU budget

The money the EU can spend every year is decided jointly by the Council and the European Parliament.

Foreign and defence policy

National governments have independent control in these areas, but are said to be working together to develop a joint foreign and defence policy (known as the 'Common Foreign and Security Policy'). The Council is the main forum for this cooperation.

The EU does not have an army. But to help it respond more quickly to international conflicts and natural disasters, some EU countries provide troops for a rapid reaction force, whose role is limited to humanitarian work, rescues and peace-keeping.

Justice

EU citizens should have equal access to justice anywhere in the EU. In the Council, justice ministers strive to ensure that court judgements in one Member State – on divorce cases, for instance – are recognised in all other Member States. Justice and interior ministers coordinate the policing of the EU's external borders, and the fight against terrorism and international organised crime.

The members of the Council

There are no fixed members as such. At each Council meeting, each Member State sends the minister for the policy field being discussed – for example, the environment minister for the meeting dealing with environmental matters. That meeting will then be known as the "Environment Council".

The foreign ministers' Council has a permanent chairperson – the EU's High Representative of the Union for Foreign Affairs and Security Policy.

Member States and the High Representative meet as part of the Foreign Affairs Council to define and implement policies with wider international objectives.

All other Council meetings are chaired by the relevant minister of the Member State holding the rotating EU Presidency.

The Council's role is largely unchanged, following the Lisbon Treaty. It continues to share law-making and budget power with the European Parliament and maintain its central role in common foreign and security policy (CFSP) and coordinating economic policies.

The main change brought by the Treaty concerns the decision making process. From November 2014, a new voting method is introduced - double majority voting. To be passed by the Council, proposed EU laws require a majority not only of the EU's Member States (55%) but also of the EU population (65%). It is to reflect the legitimacy of the EU as a union of both peoples and nations. It is intended to make EU law-making both more transparent and more effective. And it is being accompanied by a new mechanism (similar to the "Ioannina Decision") enabling a small number of Member States (close to the blocking minority provided for in the Lisbon Treaty) to demonstrate their opposition to a decision ("Ioannina-bis Mechanism"). Where this mechanism is used, the Council is required to do everything in its power to reach a satisfactory solution between the two parties, within a reasonable time period.

The Council is the EU's decision maker, adopting or amending the Commission's proposals, coordinating Member States' policies and defining the EU's foreign policy.

The term 'Council' is used to cover not only the meetings of ministers from the Member States (Council of Ministers) but also 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.

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.

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.

Finance ministers working within the Economic and Financial Affairs (Econfin) Council coordinate the national economic policies of the European Monetary Union (EMU). All Member States are part of the EMU, whether they have adopted the Euro or not.

The European Commission

The European Commission is the executive branch of the European Union and is the body responsible for developing and proposing EU policy and legislation. So, it is one of the main institutions of the European Union. It represents and upholds the interests of the EU as a whole. It drafts proposals for new European laws. It manages the day-to-day business of implementing EU policies and spending EU funds.

Taking into account elections to the European Parliament, the European Council, acting by a qualified majority, must propose to the European Parliament a candidate for President, who is then elected by the Parliament by a majority of its component members. If there is no required majority, there are rules for subsequent procedure.

The Council, by common accord with the President-elect, adopts the list of the other persons whom it proposes for appointment as members of the Commission. They are selected, on the basis of suggestions made by Member States, in accordance with designated criteria.

The President, the High Representative of the Union for Foreign Affairs and Security Policy and the other members of the Commission are subject as a body to a vote of consent by the Parliament. On the basis of this consent the Commission must be appointed by the European Council, acting by a qualified majority.

There are 28 Commissioners, one from each Member State, who provide the Commission's political leadership during their 5-year term.

Each Commissioner is assigned responsibility for specific policy areas by the President. He or 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 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.

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).

The day-to-day running of the Commission is taken care of by the Commission's staff, career officials recruited from the Member States, who are responsible for the technical preparation of the legislation and its implementation. – administrators, lawyers, economists, translators, interpreters, secretarial staff, etc. organised in the Directorates-General (DGs).

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 Commission represents and upholds the interests of the EU as a whole. It oversees and implements EU policies by:

- proposing new laws to Parliament and the Council
- managing the EU's budget and allocating funding
- enforcing EU law (together with the Court of Justice)
- representing the EU internationally, for example, by negotiating agreements between the EU and other countries.

Proposing new laws

The Commission has the 'right of initiative' – it can propose new laws to protect the interests of the EU and its citizens. It does this only on issues that cannot be dealt with effectively at national, regional or local level (subsidiarity principle).

When the Commission proposes a law, it tries to satisfy the widest possible range of interests. To get the technical details right, it consults experts through various committees and groups. It also holds public consultations.

The Commission's departments produce a draft of the proposed new law. If at least 15 of the Commissioners agree with it, the draft is then sent to the Council and Parliament. After debating and amending the draft, they decide whether to adopt it as a law.

Managing the EU's budget and allocating funding

With the Council and Parliament, the Commission sets broad long-term spending priorities for the EU in the EU 'financial framework'. It also draws up an annual budget for approval by Parliament and the Council, and supervises how EU funds are spent – by agencies and national and regional authorities, for instance. The Commission's management of the budget is scrutinised by the Court of Auditors.

The Commission manages funding for EU policies (e.g. agriculture and rural development) and programmes such as 'Erasmus' (student exchanges).

Enforcing European law

As 'guardian of the Treaties', the Commission checks that each member country is applying EU law properly. If it thinks a national government is failing to apply EU law, the Commission first sends an official letter asking it to correct the problem. As a last resort, the Commission refers the issue to the Court of Justice. The Court can impose penalties, and its decisions are binding on EU countries and institutions.

Representing the EU internationally

The Commission speaks on behalf of all Member States in international bodies like the World Trade Organisation. It also negotiates international agreements for the EU such as the Cotonou Agreement (on aid and trade between the EU and developing countries in Africa, the Caribbean and the Pacific).

The Commission is primarily based in the Berlaymont building of Brussels, but is also in Luxembourg and has offices (representations) in every EU country and delegations in capital cities around the world.

The present Commission (at January 2014) took office in late 2004 and (in 2014) was serving its second five-year term. Its internal working languages are English, French and German.

National Parliaments

The Lisbon Treaty, in 2009, gave the national parliaments of Member States greater powers at an EU level. Parliaments are now able to comment on draft legislations and other activities.

The power to enforce subsidiarity (ensuring acts are more effective at EU rather than national level) was introduced as part of the Treaty. National parliaments now monitor that this principle is being appropriately applied to decision-making. If a national parliament believes that a new proposal does not comply, then it can give a reasoned opinion why not. If a majority of national parliaments submit reasoned opinions then the Commission has the choice whether to maintain, adjust or withdraw it. If the Commission wishes to continue with the proposal it will have to explain its reasons to the European Parliament and Council.

National parliaments are also responsible for implementing EU legislation in their own Member State. EU directives are issued which outline expected outcomes that must be achieved within a specified timeframe. National parliaments have flexibility with regard to how they implement these directives within their Member States' national law.

The Court of Justice (ECJ) of the European Union

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[29].

The body was established in 1952 and is based in Luxembourg City — unlike most other Union institutions which are based in Brussels. The Court includes the Court of Justice, the General Court and specialised courts. It ensures that in the interpretation and application of the Treaties, the law is observed.

The court is composed of one judge per member state and, depending on the complexity or importance, cases are heard by 3-5 judges (around 80% of General Court cases), 13 (the 'Grand Chamber') or all 28 (the "Full Chamber"). The court is led by a president.

(i) It rules on actions brought by a Member State, an institution or an individual;

[29] http://eur-lex.europa.eu/resource.html?uri=cellar:d1b6b3e1-17dc-4d21-9a47-30b523bc1710.0023.02/DOC_1&format=PDF

(ii) It gives preliminary rulings, at the request of courts or tribunals of the Member States, on the interpretation of Union law or the validity of acts adopted by the institutions;
(iii) It rules in other cases provided for in the Treaties.

The Court of Justice sits in chambers or in a Grand Chamber, in accordance with the rules laid down for that purpose in the Statute of the Court of Justice of the European Union. When provided for in the Statute, the Court of Justice may also sit as a full Court.

The Court of Justice is assisted by eight Advocates-General; if the Court requests it, the Council acting unanimously, may increase the number of Advocates-General.

It is the duty of the Advocate-General, acting with complete impartiality and independence, to make, in open court, reasoned submissions on cases which, in accordance with the Statute of the Court, requires his involvement.

The Court should not be confused with the European Court of Human Rights in Strasbourg, which is part of the Council of Europe.

The European Central Bank

The European Central Bank, together with the national central banks, shall constitute the European System of Central Banks (ESCB). The European Central Bank, together with the national central banks of the Member States whose currency is the Euro, which constitute the Eurosystem,

The ECB is also responsible for framing and implementing the EU's economic and monetary policy. Its main purpose is to:

- keep prices stable (keep inflation under control), especially in countries that use the euro.
- keep the financial system stable – by making sure financial markets and institutions are properly supervised.

It also leads the close cooperation between central banks in the euro area – the Member States that have adopted the euro, also known as the "Eurozone". The cooperation between this smaller, tighter group of banks is referred to as the "Eurosystem".

The ECB's role includes:

- setting key interest rates for the Eurozone and controlling the money supply
- managing the Eurozone's foreign-currency reserves and buying or selling currencies when necessary to keep exchange rates in balance
- helping to ensure financial markets and institutions are adequately supervised by national authorities, and that payment systems function smoothly
- authorising central banks in Eurozone countries to issue Euro banknotes
- monitoring price trends and assessing the risk they pose to price stability.

The Court of Auditors

The European Court of Auditors audits EU finances. Its role is to improve EU financial management and report on the use of public funds. It was set up in 1975 and is based in Luxembourg. Its purpose is ensure that EU taxpayers get maximum value for their money. The Court of Auditors has the right to check ('audit') any person or organisation handling EU funds. The Court frequently carries out on-the-spot checks. Its findings are written up in reports submitted to the Commission and EU national governments.

The Court of Auditors has no independent legal powers of its own to determine legal issues. If auditors discover alleged fraud or irregularities they inform OLAF – the European Anti-Fraud Office.

One of the Court's most important jobs is to present the European Parliament and the Council with an annual report on the previous financial year (the 'annual discharge'). Parliament examines the Court's report thoroughly before deciding whether or not to approve the way in which the Commission has handled the budget. The Court also has to give its opinion on EU financial legislation and how to help the EU fight fraud.

Auditors frequently carry out inspections in EU institutions, Member Staes and countries receiving EU aid. While the Court's work mainly concerns money for which the Commission is responsible, in practice 80% of the income and expenditure is managed by national authorities.

To do its job properly, the Court of Auditors must stay completely independent of the other institutions but remain in constant touch with them.

The Court has one member from each EU country appointed by the Council for a six-year term (renewable). The members elect one of their number as President for a term of three years (also renewable).

The Court of Auditors has approximately 800 staff, including translators and administrators as well as auditors. The auditors are divided into 'audit groups'. They prepare draft reports on which the Court takes decisions.

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 members of the Committee are appointed for five years. The Council, acting by a qualified majority, adopts the list of members drawn up in accordance with the proposals made by

each Member State. The members are nominated by the EU governments but they work in complete political independence. The term of office of the members is renewable.

The Committee meets in Plenary Assembly, and its discussions are prepared by six subcommittees known as "'sections", each dealing with particular policy areas.

The Committee elects its own chairman and officers from its own members, for a term of two and a half years.

No. of EESC members (*)			
Italy	24	Portugal	12
Germany	24	Sweden	12
UK	24	Croatia	9
France	24	Denmark	9
Poland	21	Ireland	9
Spain	21	Finland	9
Romania	15	Lithuania	9
Austria	12	Slovakia	9
Belgium	12	Estonia	7
Bulgaria	12	Latvia	7
Czech Rep	12	Slovenia	7
Greece	12	Cyprus	6
Hungary	12	Luxembourg	6
Netherlands	12	Malta	5

(*) http://www.eesc.europa.eu/?i=portal.en.about-the-committee

Table 29: EESC membership

The Committee of the Regions

The Committee of the Regions is an advisory body representing local and regional authorities in the European Union. The role of the Committee of the Regions (CoR) is to put forward local and regional points of view on EU legislation. It does so by issuing reports ('opinions') on Commission proposals.

The Commission, the Council and the Parliament must consult the Committee of the Regions before EU decisions are taken on matters concerning local and regional government (for example on employment policy, the environment, education or public health).

The Committee of the Regions currently (in 2014) has 353 members (and as many alternate members) from all Member States.

Members and alternates are appointed for a five-year term by the Council, acting on proposals from the Member States. Each country chooses its members in its own way, but the delegations all reflect the political, geographical and regional/local balance in their country. The members are elected members of or key players in local or regional authorities in their home region.

The CoR holds five plenary sessions each year, to define general policy and adopt opinions. It chooses a President from among its members, for a term of two and a half years.

There are six 'commissions' to consider different policy areas and prepare the opinions to be debated in the plenary sessions:

- Territorial cohesion
- Economic and social policy

- Education, youth and research
- Environment, climate change and energy
- Citizenship, governance, institutional and external affairs
- Natural resources

The Committee also adopts resolutions on topical political issues.

Following implementation of the Lisbon Treaty, the European Commission now has to consult with local and regional authorities and their associations across the EU as early as in the pre-legislative phase. The CoR, as the voice of local and regional authorities, is deeply involved in this procedure.

Once the Commission has made a legislative proposal, it has to consult the Committee of the Regions again if the proposal concerns one of the many policy areas that directly affect local and regional authorities.

Other Institutions

The **European Ombudsman** can be found at:

http://www.ombudsman.europa.eu/home/en/default.htm

The **European Investment Bank** can be found at:

http://europa.eu/about-eu/institutions-bodies/eib/index_en.htm

The **European External Action Service** can be found at:

http://europa.eu/about-eu/institutions-bodies/eeas/index_en.htm

The **European Data Protection Supervisor** can be found at:

http://www.edps.europa.eu/EDPSWEB/edps/lang/en/EDPS

EU 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 – Acquired Rights; Freedom of Movement

Acquired Rights

General Acquired rights[30] in the Professional Qualifications Directives 2005 and 2013 (PQD)[31]

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 State nationals, does not satisfy all the training requirements referred to in the Articles of the PQD (2013), particularly (but not limited to) 25, 31, 34 and 35, each Member State has to recognise as sufficient proof evidence formal qualifications issued by those Member States. This is only insofar as such evidence attests to 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 holder has 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 3rd 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 20th August 1991,
(b) for Latvia, before 21st August 1991,
(c) for Lithuania, before 11th March 1990.

This applies 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 25th June 1991, or Croatia before 8th October 1991, where the authorities of these Member States 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 25, 31, 34 and 35 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 of the PQD.

Acquired Rights specific to dental practitioners

- Every Member State must, 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:
  - 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;
  - 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

[30] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:255:0022:0142:EN:PDF page 22

[31] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:255:0022:0142:EN:PDF page 1
and
http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2013:354:0132:0170:en:PDF

the Member State concerned as being equivalent to the training referred to in Article 34, are exempt from the three-year practical work experience referred to in the second subparagraph [b].

- With regard to the Czech Republic and Slovakia, evidence of formal qualifications obtained in the former Czechoslovakia is 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.

- Each Member State must recognise evidence of formal qualifications as a doctor issued in Italy to persons who began their university medical training after 28th January 1980 and no later than 31st December 1984, accompanied by a certificate issued by the competent Italian authorities. The certificate must show that the three following conditions are met:

  i. 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].

  ii. 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.

  iii. 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*] are exempt from the aptitude test referred to above.

- Persons who began their university medical training after 31 December 1984 are treated in the same way as those referred to above, provided that the abovementioned three years of study began before 31st December 1994.

- Member States must recognise evidence of formal qualifications as a doctor issued in Spain to professionals who began their university medical training between 1st January 1986 and 31st December 1997, accompanied by a certificate issued by the Spanish competent authorities. The certificate shall confirm that the following conditions have been met:

  i. the professional in question has successfully completed at least three years of study, certified by the Spanish competent authorities as being equivalent to the training referred to in Article 34 [of the PQD]

  ii. the professional in question was effectively, lawfully and principally engaged in the activities referred to in Article 36 in Spain for at least three consecutive years during the five years preceding the award of the certificate

  iii. the professional in question is authorised to engage in or is 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 Spain in Annex V.

Freedom of Movement for Family Members[32]

Directive 2004/38/EC (Freedom of Movement in the EU), legislated on the right of citizens of the European Union and their family members[33] to move and reside freely within the territory of the Member States. The Directive was implemented on 30th April 2006 and was effective from then.

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.

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32 http://ec.europa.eu/justice_home/fsj/citizenship/movement/fsj_citizenship_movement_en.htm

33 For interpretation, a "Family Member" is not himself, or herself a national of a Member State – which would otherwise offer them freedom of movement within the EU anyway

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 Member State to where the application is being made 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
- 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 person's child is considered to be a direct descendent.

Who is a direct relative in the ascending line?

A person's 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 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 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 4 – The four models of healthcare

There appear to be four models of provision of healthcare into which the 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 healthcare is subsidised as part of the national social security system (or health 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 30: Models of Healthcare

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, Denmark, Iceland, Ireland, Malta, Norway 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	Finland, Greece, Italy, Sweden and the UK
Social Insurance type ("Sick Funds")	
Compulsory public health insurance, maybe supplemented with voluntary supplementary insurance 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 groups (e.g. children) or for those who are unable to afford care from 'private practitioners'.	Germany
No Income ceiling There are other criteria for access – full access for the elderly and children, other medically compromised and low income adult groups. Part access (i.e. limited care) for adults above a low level of earnings	Austria, Belgium, Croatia, the Czech Republic, Estonia, France, Hungary, Latvia, Lithuania, Luxembourg, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, and Switzerland

Oral healthcare through social insurance

The essential features of a social insurance-based oral healthcare 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).

Seventeen countries have healthcare 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 17 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, disabled people, medically compromised, hospital inpatients or war veterans. Limited care may be offered for adults above a low level of earnings.

Annex 5 – 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 Health Strategy White Paper[34], "Together for Health: A Strategic Approach for the EU 2008-2013", which, according to the Commission, *"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 Health Strategy was reviewed in 2011 (see below).

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 period.

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 put forward a Structured Cooperation implementation mechanism (Commission).

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[35].

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.

34 http://ec.europa.eu/health/ph_overview/strategy/health_strategy_en.htm

35 http://ec.europa.eu/health/index_en.htm

Findings of the Mid-Term Evaluation of the EU Health Strategy 2008-2013 (2011)[36]

A mid-term review explored the implementation and impacts of the Health Strategy over the period 2008-2010. A series of stakeholder interviews, Member State questionnaires and desk-based research (review of mandates, mapping of outputs, comparison of Member States' health strategies with EU Health Strategy, etc) was undertaken. The report concluded that *"the EU Health Strategy has had varying success in influencing, guiding and encouraging different actors in the public health arena to adopt, adapt or revise policies, or undertake concrete actions".p10*

Implementation outputs

- There has been a high level of activity in relation to the principles and objectives of the EU Health Strategy at Commission and Member State levels. However, many of the outputs, especially those at MS level, cannot be attributed directly and exclusively to the EU Health Strategy.
- Instead, the high level of activity is mainly due to the fact that the EU Health Strategy captures a lot of what both the Commission and MS consider priorities in health policy.

Implementation: Coordination mechanisms

- The coordination mechanisms (namely the EU Health Policy Forum (EUHPF) and the Council Working Party on Public Health (SLWP) have been unable to fulfil their full potential. There is a need to review their working methods to provide them with more vitality and dynamism.

Impact

- There is relevance and coherence with other EU policies, activities and funding programmes, but the evaluation did not find a discernable direct impact of the EU Health Strategy on a number of these.
- In most Member States, the influence of the EU Health Strategy on national health strategies is limited. Any thematic or structural similarities identified were more likely to be a reflection of aligned properties than of significant influence.

Added value

- The EU Health Strategy's main value is that it acts as a guiding framework and, to some extent, as a catalyst for actions at the EU level.
- Most actors outside of the EU institutions do not see it as an invitation or an inspiration for them to become active.

Potential options for adjusting the strategy were suggested:

- No adjustments: status quo
- Adjustments: reinforcements
  - Increase multi-stakeholder action
  - Further prioritise policy areas where EU added value is greatest
  - Make the current coordination mechanisms more effective
- Adjustments: creating new tools or mechanisms for implementation and/or coordination
  - Devise a clearer framework for action
  - Employ a different means to implement/coordinate the EU Health Strategy.

Investing in Health: Towards Social Investment for Growth and Cohesion – including implementing the European Social Fund 2014-2020[37]

The Working Paper was published 20 February 2013 as part of the Social Investment Package for growth and cohesion. Based around the statement that health is a value in itself, it lays out plans for investment in health as "health expenditure is recognised as growth-friendly expenditure". The strategy does not necessarily mean spending more but spending in a more targeted way, investing in health-improving programmes and in health coverage as a way of reducing inequalities and tackling social exclusion.

The paper focuses on four targets:

Investing in sustainable health systems: Reform and innovation
This combines innovative reforms aimed at improving cost-efficiency and creating sustainable services.

Investing in people's health as human capital
Improving the health of the population, in general, contributes to a more productive work force. In turn, this aids economic growth by enabling the population to remain active and therefore work longer. This target includes reducing industrial accidents and promoting general health.

Investing in reducing health inequalities
Expenditure should contribute to fostering social cohesion and breaking the vicious spiral of poor health contributing to, and resulting from, poverty and exclusion.

Investing in health through adequate support from EU funds.

Action Plan for the EU Health Work Force

On 18 April 2012, the Commission Communication "Towards a job rich recovery" (SWD (2012) 100 final) identified the healthcare work force as one of three key sectors with potential to encourage employment and economic growth in Europe. With an aging population and social, epidemiological and cultural changes occurring as a result of migration, demand for healthcare will increase and evolve and there is concern that the healthcare work force may not be equipped to deal with demand. A working group on the European Work force for health has been established to bring together national governments and professional organisations.

The Action Plan for the EU Health Work force (SWD (2012) 93 final)[38] outlined a series of actions to protect against work force shortages:

36 http://ec.europa.eu/health/strategy/docs/midtermevaluation_euhealthstrategy_2011_report_en.pdf

37 http://ec.europa.eu/health/strategy/docs/swd_investing_in_health.pdf

Forecasting work force needs and improving work force planning methodologies

A three year **EU Joint Action on forecasting and planning** commenced on 11 April 2013, following support from a feasibility study[39] on forecasting health work force needs, planning and health work force tenders. The Joint Action consists of Member States and professional organisations who will operate under the Health Programme to develop ways to forecast health work force needs and work force planning, share good practice and improve EU-wide data gathering. The CED is an Associated Partner in the Joint Action.

Guidance on the exchange of education and training capacities in health professions will be developed by 2014. The CED is an Associated Partner in the Joint Action.

Anticipating future skill needs in health professions

Recent new demands in healthcare such as home-based care for elderly patients with multiple chronic conditions, new medical technologies and the expansion of e-health have required new skill sets from the healthcare work force. Forecasting future demands will aid the timely provision of an appropriately trained work force and avoid a lag in care while the work force adapts.

Sector skills councils were developed in 2013 to better analyse and anticipate skill needs in various professions. A study is exploring the feasibility of establishing a European Skills Council on nursing and care workers. Plans are also in force for the launch of a pilot Sector Skills Alliance in the healthcare sector.

A pilot healthcare assistants expert network and database, outlining recommendations for healthcare assistants training and support for informal carers, was due to be completed in 2014.

Share good practice on effective recruitment and retention strategies for health professionals

Retention of appropriately trained and experienced staff is also a concern in a competitive global market. The Communication outlines plans for mapping innovative and effective retention strategies in order to draw up a series of best practice guidelines to be adopted by all Member States.

One project, Nurse Forecasting in Europe is exploring the link between work environment factors and nurse job satisfaction. The European Social Dialogue in the hospital and healthcare sector has agreed a Code of Conduct on the Ethical Cross-Border Recruitment and Retention in the Hospital Sector and a Framework of Actions on Recruitment and Retention.

Addressing the ethical recruitment of health professionals

Healthcare work force migration from areas within and outside Europe has increased in recent years. This poses a challenge when migration occurs from lower income countries where healthcare systems may already be stretched. The WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted by the 63rd World Health Assembly on 21st May 2010 to promote ethical recruitment of healthcare workers.

The Treaty of Lisbon entered into force on 1st December 2009[40]. Health is addressed in several Articles; for example Article 9 on Public Health introduces a "horizontal social clause" meaning that all EU policies and actions must consider ways to fight against social exclusion and ensure a high level of education, training and protection of human health.

Article 168 (which replaced the previous EU Treaty Article 152) states that improving public health, preventing human illness and diseases, and obviating sources of danger to human health, should be a high priority within the definition and implementation of all EU policies.

Alongside setting high standards of quality and safety for medicinal products and medical devices, the Treaty reinforced the importance of cooperation and coordination between Member States on health services, particularly with regard to instances of monitoring and action against potential cross-border health threats. The Parliament and Council can implement incentive measures to further protect health from cross-border public health hazards, for example tobacco and alcohol misuse.

While coordination and cooperation across Member States is encouraged, the Article maintains the principle of subsidiarity in public health. Although the Union can develop actions to encourage coordination and cooperation, Member States retain control over how they define and implement health policies. The inclusion of the subsidiarity principle precludes any harmonization or regulation of public health laws across Member States.

38

http://ec.europa.eu/health/workforce/docs/staff_working_doc_healthcare_workforce_en.pdf

39

http://ec.europa.eu/health/workforce/docs/health_workforce_study_2012_report_en.pdf

40

http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0047:0199:en:PDF

Annex 6 – Directive on patients' rights in cross-border healthcare

On 24th November 2011, **Directive 2011/24/EU on patients' rights in cross-border healthcare**[41] entered into force.

The Directive arose out a number of principles with regard to rights of patients obtaining healthcare abroad having 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.

Right to treatment

Residents of the EEA are entitled to cross-border healthcare. Healthcare may be funded if it is available in the citizens' home state as part of their standard national healthcare package and if there is undue delay in provision of the same treatment in their home state. Undue delay is defined by the European Court of Justice as one that "exceeds the period which is acceptable in the light of an objective medical assessment". Therefore this time period is based upon medical assessment of need rather than an externally imposed time target.

Treatment may be refused if the treatment can be delivered within the home state without undue delay or if it poses a risk to the patient's health or to public health if the patient has a highly contagious or dangerous infection. Treatment may also be refused if it would disrupt either home state or MS healthcare provision, e.g. if it would threaten the running of small, highly specialised departments within the home state or if capacity is limited in the MS.

The Directive does not cover long-term care services, organ transplants or public vaccination programmes.

Major provisions:

- **Patients have the right to seek healthcare abroad and be reimbursed up to what they would have received at home**.

The Directive provides 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 are not allowed to profit from the reimbursement if the cost of treatment abroad is less than in the home state. Travel and accommodation costs are not refunded. Patients do not need prior authorisation for non-hospital care.

Hospital care is 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 was 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 Directive does not 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 provides 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.

41 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:en:PDF

- **Health technology assessment**

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" are 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 is a requirement for member states to provide information to patients on their rights and options through a national contact point.

Annex 7 – 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 allows personal data to travel across borders with great 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 are collected and exchanged more frequently, 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 were 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)**[42] 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, storage, disclosure, etc. The Directive applies to data processed by automated means (for example computerised 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. Dental practitioners would usually be the controllers of the data processed on their 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.

Proposal for a Regulation of the European Parliament and of the Council on the protection of individuals with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation)[43]

In January 2012, a proposal redrafting the current Data Protection Directive to create the General Data Protection Regulation (GDPR) was published. As of January 2014, no final decision had been made.

42 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31995L0046:en:HTML

43 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2012:0011:FIN:EN:PDF

The Commission proposed, among others, changes to the data subject's control over what data might be collected or retained and the right to appeal to their own National Data Protection Authority (NDPA), regardless of in which country the data was processed. Also proposed was the requirement of data protection officers, and data protection impact assessment for data processors, as well as substantial fines for non-compliance.

Healthcare stakeholders, including the Council of European Dentists, expressed significant concern at some of the proposals and called on the decision makers to ensure that the Regulation does not have a negative impact on patient safety or create an excessive administrative burden on healthcare providers

Annex 8 – Tooth Whitening

Regulation (EC) no 1223/2009 of 30 November 2009 on cosmetic products

In the early 1970s, 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. 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. Directive 92/86/EEC, prescribed that "oral hygiene products" should include a maximum concentration of 0.1% of hydrogen peroxide present or released.

The Directive regulates the use of hydrogen peroxide and other compounds or mixtures that release hydrogen peroxide in tooth whitening or bleaching products. According to the 1976 Directive on the approximation of the laws of the Member States relating to cosmetic products, the use of hydrogen peroxide and other compounds or mixtures that release hydrogen peroxide was limited to 0.1% of hydrogen peroxide present in oral hygiene products or released. Concentrations above this limit were prohibited. Indeed, under Article 4 of the 1976 Directive, marketing of cosmetic products which contained the substances listed in Annex III, beyond the limits and outside the conditions laid down, was prohibited in all Member States. Hence, only concentrations of 0.1 % of hydrogen peroxide were considered safe and were allowed to be freely available to the consumers on the market.

The New Cosmetic Products Regulation

On 30 November 2009, the new **Cosmetic Products Regulation 1223/2009** was adopted.

With the new regulation, Europe was described by the Commission as "having a robust, internationally recognised regime, which reinforces product safety taking into consideration the latest technological developments".

The Regulation[44] became law across the EU on 11th July 2013 and, being a regulation, made it directly applicable in all Member States, with no room for an MS interpretation through the process of transposition.

The 2009 regulation defines a "responsible person" and the obligations on that person relating to safety and transport of materials.

A **Council Directive 2011/84/EC** of 20th September 2011, introduced only limited changes to the Annex of the Regulation.

In 2007, the Scientific Committee on Consumer Products[45] gave an opinion on hydrogen peroxide, in its free form or when released, in oral hygiene products and tooth whitening products.

The 2011 Directive implements this opinion and adapts the earlier 1976 Directive, while ensuring the protection of public health. It established a new legal framework for tooth whitening products: those products between 0.1% and 6% of hydrogen peroxide present in tooth whitening or bleaching products, or released, can now be sold to dental practitioners and must have their first use within the dental office ie by dental practitioners (or under their direct supervision, if an equivalent level of safety is ensured). The rest of the cycle of use can be performed by consumers themselves as long as the access to the product is provided by dental practitioners, or by other qualified dental professionals who are under the dental practitioner's direct supervision and responsibility, as explained below. These concentrations cannot be used on a person under 18 years of age.

Dental Practitioners

The meaning of the term "dental practitioners" is defined under the PQD Directive 2005/36/EC, or under their direct supervision if an equivalent level of safety is ensured. Dental practitioners should then provide access to those products for the rest of the cycle of use. The PQD describes the professional activities of dental practitioners and the conditions under which a dental practitioner can pursue his/her activities. For the purposes of this Directive, the professional activities of dental practitioners are the activities defined in paragraph 3 and pursued under the professional qualifications listing.

The profession of dental practitioner is based on dental training referred to in Article 34 and is a specific profession which is distinct from other general or specialised medical professions. The activities of a dental practitioner require the possession of evidence of formal qualifications referred to in Annex V of the PQD.

Under the PQD, Member States must ensure that dental practitioners are generally able to gain access to and pursue the activities of prevention, diagnosis and treatment of anomalies and diseases affecting the teeth, mouth, jaws and adjoining tissue, having due regard to the regulatory provisions and rules of professional ethics.

As a result, by limiting the first use within a cycle of use to "dental practitioners", the new Directive is intended to ensure that only dental practitioners, and no other professionals, have direct access to tooth whitening and bleaching products containing more than 0.1% and up to 6% of hydrogen peroxide

44 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2009:342:0059:0209:en:PDF

45 The Committee was later replaced by the new Scientific Committee on Consumer Safety (SCCS).

present or released. Those products cannot be directly available to the consumer or other professionals.

Nevertheless, other qualified dental professionals can perform tooth whitening and bleaching under the supervision of dental practitioners where an equivalent level of safety is ensured. Who can perform tooth whitening and bleaching under the circumstances and how the equivalent level of safety is ensured needs to be further developed by Member States when transposing the Directive.

Indeed, in order to ensure consistency of what one should understand by "an equivalent level of safety", Member States must specify the minimum conditions under which the equivalent level of safety is ensured. For example, Member States should specify the minimum professional qualifications required (i.e., in the area of dentistry and by qualified dental care professionals) and/or, if appropriate, the need to be registered in a professional organisation or to be authorised by a competent authority.

Furthermore, the purpose of the new Directive is to enhance patient safety and to ensure that patients can only access appropriate products via trained and qualified dental professionals. The Directive explains the conditions under which these products can be safely used. It mentions that an appropriate clinical examination needs to be carried out in order to ensure that there are no risk factors or any other oral pathology of concern, and that the exposure to these products is limited so as to ensure that the products are used only as intended in terms of frequency and duration of application.

A clinical examination implies, therefore, an examination by a clinician (the dental practitioner) in a clinical setting. Moreover, the clinical examination must be carried out before the first use of tooth whitening products, and the ongoing exposure to these products (the rest of the cycle of use), which shall be limited in terms of frequency and duration of application, must be monitored by the dental practitioner.

The substances regulated

The Directive regulates the use of hydrogen peroxide and other compounds or mixtures that release hydrogen peroxide, including carbamide peroxide and zinc peroxide. Note that the active ingredient of carbamide peroxide is hydrogen peroxide where 16.62% of carbamide peroxide corresponds to 6% of hydrogen peroxide. Sodium perborate and perboric acid are also regulated as they are considered to be hydrogen peroxide releasing substances, pursuant to the opinion of the SCCS.

The SCCS was of the opinion that sodium perborate and perboric acid can be considered as "hydrogen peroxide" releasing substances and thus are covered by the 1976 Directive. Further, they considered that the general restrictions applicable to hydrogen peroxide releasing substances should apply to sodium perborate and perboric acid.

Annex 9 – 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.

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. Practise 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 10 – Code of Ethics for Dentists in the EU for Electronic Commerce

This code was adopted in Helsinki in May 2002, and amended in Brussels in November 2007, against the background of Directive 2000/31/EC on electronic commerce. The 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 11 – Patient Safety, Prevention of Risk and Environmental Concerns

Safe dental care is necessary for ensuring good general health and the dental profession is committed to minimising risks and establishing an open culture of patient safety, in which practitioners can learn from their own and others' experiences.

The types of patient safety risk and most appropriate ways of minimising them may vary according to healthcare setting. It is thus 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. In May 2008 the CED published a resolution on patient safety.[46]

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. Preventive action to reduce adverse events is in turn a facet of high quality healthcare. Quality cannot be promoted through force. New measures ostensibly to improve patient safety can often add to the bureaucratic burden in the dental practice. It must be ensured that they 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.

Prevention of Healthcare Infections

Council Recommendation on patient safety, including the prevention and control of healthcare associated infections 2009/C 151/01

Council Recommendation of 9th June 2009 on patient safety, including the prevention and control of healthcare associated infections (2009/C 151/01)[47] included a detailed first pillar, addressing healthcare-associated infections (HCAI).

The primary objectives of the Commission's general patient safety proposal were set out at the Member State and EU levels.

At the Member State level:

- prioritise the establishment and development of national policies and programmes on patient safety;
- empower and inform citizens and patients by involving patient organisations and representatives in policy development and disseminating relevant information on patient safety (policies in place, risk and safety measures, complaints procedures);
- support the establishment of, or strengthen existing reporting and learning systems on adverse events;
- promote, at the appropriate level, education and training of healthcare workers on patient safety.

At the EU level:

- classify and measure patient safety at the Community level, by working with each other and with the Commission (develop common definitions and terminology, reliable and comparable indicators of effectiveness, gather and share comparable data on patient safety outcomes);
- share knowledge, experience and best practice by working with each other and with the Commission and relevant European and international bodies;
- develop research on patient safety.

Additional recommendations on prevention and control of healthcare associated infections:

- adopt and implement a strategy at the appropriate level for the prevention and control of healthcare associated infections.

Report on implementation of the Council Recommendations[48]

In April 2011 all Member States were asked to provide a report on the extent of their implementation of the recommendations.

The Recommendation was noted to complement other EU Directives, particularly Directive 2011/24/EU, of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare in ensuring parity of quality of care across Member States.

46 http://ec.europa.eu/health/archive/ph_systems/docs/ev_20080617_rd04_en.pdf

47 http://ec.europa.eu/health/patient_safety/docs/council_2009_en.pdf

48 http://www.europarl.europa.eu/oeil/popups/summary.do?id=1247596&t=e&l=en

Most Member States had:

- embedded patient safety as a priority in public health policies, with competent authorities identified as responsible;
- encouraged training on patient safety in healthcare settings;
- shown some improvement in reporting and learning systems;
- adopted the Commission's 12-step Action Plan against the rising threats from Antimicrobial Resistance in both human and veterinarian medicine (COM(2011) 748 final)[49].

Suggested improvements to the Recommendations included:

- more active involvement of patients in patient safety;
- formally embed patient safety in training and education programmes for health professionals;
- make reporting adverse events non-punitive and more accessible for patients;
- extend safety strategies from hospital to primary care;
- at EU level, collaborate more effectively on introducing patient safety standards beyond the recommendation, progress common terminology and exchange of best practice, and develop research on patient safety.

Prevention and control of healthcare associated infections recommendations included:

- ensure adequately trained specialist healthcare staff have time set aside for this task within hospitals;
- reinforce the use of prevention and control protocols in nursing homes;
- monitor the timely detection and reporting of spread of organisms and strengthen the response to the spread (including across borders);
- at EU level, continue to progress with guidance on the control and prevention of healthcare associated infections and develop research into the prevention and control of healthcare associated infections.

The finding showed that in many Member States and at the EU level the recommendations had only recently been implemented or were still to be put into action. On 22nd October 2013, the European Parliament adopted the report's recommendations and stated that they should be given a high priority in the political agenda, particularly those concerning the prevention and control of HCAIs (2013/2022(INI)).[50] Another review will be carried out in June 2014.

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) and European Union Network on Patient Safety and the Quality of Care (PaSQ).

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 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.

Prevention of Sharps Injuries (Council Directive 2010/32/EU)

Prevention from sharp injuries in the hospital and healthcare sector

Background

The Commission drew up a proposal for this Directive following the signing of a framework agreement on 17th July 2009 by the European Social Partners, the European Hospital and Healthcare Employers' Association (HOSPEEM) and the European Federation of Public Service Unions (EPSU). The Directive was introduced on 10th May 2010 to provide a safe working environment for hospital and other healthcare workers by minimising incidences of needlestick (or "sharps") injuries in the workplace.

49 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2011:0748:FIN:en:PDF

50 http://www.europarl.europa.eu/oeil/popups/summary.do?id=1320325&t=d&l=en

Needlestick injuries are one of the most common healthcare workplace injuries in Europe and put workers at risk of a range of infectious diseases such as Hepatitis B and C and HIV. Injured workers also face the emotional impact of waiting for post-exposure test results to determine whether they have contracted one of the more than 30 serious conditions to which they have been potentially exposed.

Directive 2010/32/EU[51]

The Directive recognises that the health and safety of workers is an important issue and is linked with the health of patients. Health and safety is a hospital and healthcare sector-wide issue, and a responsibility for all members of the work force.

The framework agreement applies to all workers in the hospital and healthcare sector with the aim of providing the safest working environment possible, minimising needlestick injuries through integrated risk assessment practices.

The CED has recommended to Member States that they should take into account the specificities of dentistry when implementing measures arising from the Directive to avoid negative impact on safety and quality of oral care.

Risk assessment

All risk assessment procedures have to be conducted in compliance with Articles 3 and 6 of Directive 2000/54/EC (Biological agents at work) and Articles 6 and 9 of Directive 89/391/EEC (Safety and health of workers at work).

The assessment should cover all situations where there is potential exposure to blood or other potentially infectious material. The assessment should also take into consideration the level of resources and organisation of the work force, whether the work force is adequately trained, workplace psycho-social factors and any technology used. The outcome should be the identification of ways to eliminate exposure and consideration of possible alternative processes.

Elimination, prevention and protection

When a risk of exposure has been identified, the organisation must implement a hierarchy of controls:

- Elimination: eliminating the unnecessary use of sharps by implementing changes in practice based on the risk assessment.
- Safe Procedures: specifying and implementing safe procedures for using and disposing of sharp medical instruments and contaminated waste. The practice of recapping shall be banned with immediate effect. These procedures shall be regularly reassessed and shall form an integral part of the measures for the information and training of workers.
- Engineering Controls: providing medical devices incorporating safety-engineered protection mechanisms.
- PPE: the use of Personal Protective Equipment (gloves, masks, gowns, etc).[11]

If exposure to pathogens for which effective vaccinations exist is identified during the assessment, workers should be offered the vaccination free-of-charge and given information on the benefits and drawbacks of vaccination and non-vaccination.

Information and awareness-raising

All workers and their managers should receive information regarding best-practice on handling sharps and the risks of mishandling, information on legislation and local policies, highlight the importance of reporting any needlestick injuries, raise awareness through activities and promotional material produced in conjunction with representative trade unions or workers' representatives and provide information on support groups available.

Training

Training should be given during induction for all new staff and refreshers given at regular intervals. The training should address the risks involved in handling sharps and the potential dangers in blood and bodily fluid exposures, preventative measures that should be taken (procedures for safe use and disposal, immunisation options, etc), the correct use of medical equipment and the importance of, and the procedures for, reporting injuries or exposure.

Reporting

A "no blame" culture should be fostered where workers should immediately report any exposure to their employers and the organisation's health and safety representative. Reporting procedures should be drawn up locally in conjunction with health and safety and/or workers' representatives.

Response and follow-up

Policies and procedures for needlestick incidents should be drawn up, in line with European, national/regional legislation and collective agreements. These procedures should be made clear to all workers.

Following an incident, employers must:

- Take immediate action to ensure the care of the worker, providing necessary medical care (prophylaxis, tests, follow-ups, etc.).
- Investigate the cause and circumstances around the injury, the worker should provide the relevant information as soon as it is appropriate. The employer should then take appropriate action to minimise or eliminate the risk within the workplace.
- Guarantee provision of relevant medical treatment (including counselling where appropriate), rehabilitation, continued employment and access to compensation in accordance with national and/or sectoral agreements or legislation.

Confidentiality regarding the worker's injury, diagnosis and treatment should be respected.

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51 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2010:134:0066:0072:EN:PDF

Regulation on European Standardisation

Regulation (EU) No. 1025/2012 of the European Parliament and of the Council of 25th October 2012 on European standardisation[52]

European harmonised standards are a series of voluntary definitions and specifications on products, processes or services with which businesses or providers may comply. The specifications are elaborated on the basis of a request from the European Commission must be adopted by one of the European Standards Organisations: European Committee for Standardisation (CEN), European Committee for Electrotechnical Standardization (CENELEC), European Telecommunications Standards Institute (ETSI) and be publicly available, usually via the Official Journal of the European Union.

Medical Devices

Directive 90/385/EEC, Directive 93/42/EEC and Directive 98/79/EC

Medical devices are regulated by three main Directives:

- Directive 90/385/EEC of 20 June 1990 regarding active implantable devices
- Directive 93/42/EEC of 14 June 1993 regarding medical devices
- Directive 98/79/EC of 27 October 1998 regarding in vitro diagnostic medical devices

These three directives relate to the safety and good performance of medical devices, promoting protection of human health in the Single Market. Medical devices are classified as any item which is manufactured with the intention that it be used on humans for the purpose of:

- diagnosis, prevention, monitoring, treatment or alleviation of disease;
- diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap;
- investigation, replacement or modification of the anatomy or of a physical process;
- control of conception.

The Directive(s) state that all medical device manufacturers are required to maintain a "technical file" on the device. They are also required to keep a record of the device's "declarations of conformity". The declarations of conformity confirm that the device operates as it has been designed to and records any potential side-effects that may arise from its use (based on clinical investigation, published/unpublished studies or reports on the device, or an equivalent device).

Notified Bodies carry out the conformity assessments. While in some Member States the role may be carried out by a national authority, they may also be carried out by a third party. Member States notify the Commission of the bodies that they are appointing to carry out the task; the bodies carrying out post-market evaluations must be distinct from those that carry pre-market ones.

Any manufacturer that does not have a registered base in the EU must designate an authorised representative who resides within one of the Member States. This contact will be indicated on all product labelling and/or instructions for use. The representative is also responsible for the storage of the technical file.

All medical devices, with the exception of "custom-made devices", are required to carry a CE mark before being placed on the market. Custom-made devices, which have been specifically designed for a practitioner for their sole use, are required to maintain appropriate documentation.

Proposed revision

In 2012 a proposal by the Commission was submitted outlining several amendments to the Directive to address changes in medical technology, standardise laws and improve access to information on devices.

In line with the proposal, Directive 90/385/EEC, Directive 93/42/EEC and Directive 98/79/EC would be replaced by a Regulation on medical devices and a Regulation on in vitro diagnostic medical devices. The proposal includes:

- Extension and clarity of EU legislation on medical devices, including implants for aesthetic purposes and tests
- More powers for assessment bodies including stronger supervisions and unannounced factory inspections
- Clarification of rights and responsibilities for manufacturers, importers and distributors
- Extension of Eudamed database and making non-confidential data publicly available
- Improved traceability of medical devices enabling effective response to safety problems (e.g. recalls)
- Enhanced requirements for evidence related to assessments of medical devices
- Updated risk categories and health & safety requirements for medical devices , including labelling rules
- Improved coordination between national surveillance authorities and the Commission
- International guidelines to be incorporated into EU law

It is expected that the proposal will be adopted in 2014.

Commission Recommendation on Unique Device Identification

Commission Recommendation of 5th IMIApril 2013 on a common framework for a unique device identification (UDI) system of medical devices in the Union (Text with EEA relevance) (2013/172/EU)[53]

The recommendation sets out guidelines to assist Member States in setting up their national UDI systems in anticipation of a legally binding EU system which will be based on the future Medical Device Regulations.

52 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2012:316:0012:0033:EN:PDF

53 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2013:099:0017:0024:EN:PDF

The recommendation was drafted to improve patient care and safety through medical device traceability. The recommendations aims are to:

- improve incident reporting via an international repository of incidents recorded for a particular device;
- facilitate efficient recalls and other field safety corrective actions (FSCA);
- facilitate efficient post-market actions by national competent authorities;
- enable queries in numerous data systems;
- reduce the likelihood of errors linked to misuse or incorrect selection of the device.

The recommendations may also help reduce the distribution of counterfeit devices and improve distribution control and reimbursement issues.

The recommendation states that manufacturers should be required to display a UDI on all medical devices. The UDI is a unique number or code relating to a medical device. The UDI enables the identification of different types of devices and allows access to relevant information which is stored in a UDI database.

The UDI should be displayed as an alphanumerical code and as a barcode or other machine-readable format on the device's label, package or on the device itself. The code should include both a device identifier and a production identifier: the device identifier contains information specific to the device (company, model, etc.) and allows access to information stored in a UDI database; the production identifier information is more dynamic and specific to the devices production (e.g. date of production, batch number, expiration date, etc.) and this information is not stored in the database.

The device information will be held by the European databank on medical devices (Eudamed)[54]. As well as monitoring the application of the recommendations, particularly regarding registration, Eudamed provide Member States with up-to-date information on:

- the registration of manufacturers, authorised representatives and devices;
- data relating to certificates issued, modified, supplemented, suspended, withdrawn or refused;
- data obtained in accordance with the vigilance procedure;
- data on clinical investigations.

Movements are in place to introduce UDIs worldwide and the EU is on the managing committee of the International Medical Device Regulators Forum (IMDRF), formerly the Global Harmonisation Task Force (GHTF), alongside Australia, Brazil, Canada, Japan and United States of America with China and Russia likely to join.

The IMDRF plans to recruit a small number of regional UDI database hubs similar to Eudamed which will contribute to a Global Medical Device Nomenclature (GMDN). The GMDN will develop an internationally-agreed definition to identify medical devices. All descriptors are stored in the GMDN database which is regularly updated to accommodate new technology and innovation.

Community Mercury Strategy and Related Ongoing Activities

Mercury and its compounds are highly toxic to humans, animals and plant life. Conversion to methylmercury is possible in the environment, a highly toxic chemical that can cross the blood-brain barrier and has neurodevelopmental effects if passed via the placenta on to an unborn child. Exposure to mercury is most common via the inhalation of mercury vapour during dental treatment while exposure to methylmercury is mainly a result of consuming contaminated fish and seafood.

Community Strategy concerning Mercury [COM (2005)][55]

The strategy aimed to reduce mercury levels within the environment and therefore reduce human exposure. The strategy outlined the following objectives:

- reducing mercury emissions;
- reducing the entry into circulation of mercury in society by cutting supply and demand;
- resolving the long-term fate of mercury surpluses and societal reservoirs (in products still in use or in storage);
- protecting against mercury exposure;
- improving understanding of the mercury problem and its solutions;
- supporting and promoting international action on mercury.

A review of the strategy in 2010 (COM (2010) 723 final) found that good progress had been made with nearly all actions being carried out. Regulation (EC) No 1102/2008 banning exports of metallic mercury and certain mercury compounds and mixtures and ensuring appropriate storage of metallic mercury entered into force on 15 March 2011.

The Industrial Emissions Directive also came into force in 2010 (2010/75/EU) to further reduce environmental contamination.

However, global measures need to be implemented. The Minamata Convention on Mercury[56] was agreed by 92 countries in October and November 2013. Under the provisions of the Convention, the signing countries agreed to ban the production, import and export of a number of mercury-containing products where non-mercury alternatives are available. Within three years countries must also draw up plans to reduce the amount of mercury used in small-scale gold mining and control the level of emissions from coal-fired power stations and other large-scale industrial plants.

54 http://ec.europa.eu/consumers/sectors/medical-devices/market-surveillance-vigilance/eudamed/

55 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52005DC0020:EN:NOT

56 http://www.mercuryconvention.org/Portals/11/documents/conventionText/Minamata%20Convention%20on%20Mercury_e.pdf

EU Waste Legislation (Directive 2008/98/EC)

Directive 2008/98/EC of the European Parliament and of the Council of 19th November 2008 on waste and repealing certain Directives[57]

The Directive outlines an approach to waste management designed to prevent negative impact on human health and the environment (including air, water, soil, plants and animals) through limiting the production of waste and increasing recycling and recovery of resources.

Alongside protecting human health and the environment, the directive states waste management must not cause disruption through noise or odours and without negatively impacting the countryside or places of special interest.

Waste prevention and management shall follow the waste priority hierarchy wherever possible:

1. prevention;
2. preparation for reuse;
3. recycling;
4. other recovery, e.g. energy recovery;
5. disposal.

The costs of waste management must be borne by the original waste producer, or by the current or previous waste holders; termed the "polluter-pays" principle.

Hazardous waste should be packaged and labelled to ensure traceability at each stage from production to final destination. Article 18 of the Directive bans the mixing of hazardous waste, either with other categories of hazardous waste or with any other waste substances or materials.

The revised Directive required all Member States implement national waste prevention programmes by 12th December 2013.

57 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2008:312:0003:0030:EN:PDF

Annex 12 – EU Charter for the Liberal Professions

On 24th October 2013, the Standing Committee of European Doctors (CPME) along with the Council of European Dentists (CED), the European Council of Engineers Chambers (ECEC) and the Federation of Veterinarians of Europe (FVE) adopted a 'Charter for Liberal Professions'

Introduction

Liberal professions are a key social and economic factor in all Member States of the European Union. Europe is developing into a knowledge-based service society in which liberal professions are becoming more and more important for the state and citizens due to the increasing complexity of society. The European Commission has acknowledged that services are one of the main drivers of the EU economy: they account for over two-thirds of EU GDP and employment and have been the source of all net job-creation in recent years. Approximately one third of this can be attributed to liberal professions.

Despite their growing importance and the fact that liberal professions often provide public services in core areas of general interest, the social significance of liberal professions is still not sufficiently acknowledged at EU level. The specific situation of liberal professions particularly is often not properly taken into account by the European authorities when developing European legislation and policies. The consequences of the financial and economic crisis have put liberal professions and their professional self-government lately in the focus of the European Union authorities. This might result in initiatives which could compromise the values and the tradition of self-government of liberal professions in many Member States of the EU.

The European Commission plays in this regard a key role by strongly pushing for more economic growth in the interest of open markets for services. Liberalisation and deregulation of the liberal professions seem to be the solution to generate more economic growth. It is the task of liberal professions to show that a short term gain in economic growth could have, on the long run, disastrous consequences for society.

The Charter for Liberal Professions, elaborated and supported by European organisations representing professionals across Europe, aims therefore to set recommendations for the European Institutions to consider possible implications for liberal professions of any new or amended legislation and policies, and to enable the provision of high quality services for every citizen in Europe. The Charter also proposes a definition of the term 'liberal professions' based on the existing case law of the Court of Justice of the EU and outlines the distinguishing characteristics of liberal professions.

Historical Background

The European Institutions have emphasised the importance of liberal professions, also for European society, in various ways over the past decade. The following documents either directly or indirectly refer to liberal professions:

- Commission Communication on the 'Report on Competition in Professional Services' (COM(2004)0083),
- Commission Communication on 'Professional Services - Scope for more Reform - Follow-up to the Report on Competition in Professional Services' (COM(2005)0405),
- Commission Communication on the European semester (COM(2011)0400),
- Commission Communication on a Growth Initiative of the Internal Market (COM (2012)0299),
- Commission Communication on country specific recommendations (COM (2012)0305),
- Resolution of the European Parliament of 5th April 2001 on scale fees and compulsory tariffs for certain liberal professions, in particular lawyers, and on the particular role and position of the liberal professions in modern society,
- Resolution of the European Parliament of 16th December 2003 on market regulations and competition rules for the liberal professions,
- Resolution of the European Parliament of 23rd March 2006 on the legal professions and the general interest in the functioning of legal systems,
- Resolution of the European Parliament of 12th October 2006 on the follow-up to the Report on Competition in Professional Services,
- Council Directive 77/249/EEC of 22nd March 1977 to facilitate the effective exercise by lawyers of freedom to provide services,
- Directive 98/5/EC of the European Parliament and of the Council of 16th February 1998 to facilitate practise of the profession of lawyer on a permanent basis in a Member State other than that in which the qualification was obtained,
- Council Directive 2002/8/EC of 27th January 2003 to improve access to justice in cross-border disputes by establishing minimum common rules relating to legal aid for such disputes,
- Directive 2005/36/EC of the European Parliament and of the Council of 7th September 2005 on the Recognition of Professional Qualifications – Recital 43,
- Case law of the European Court of Justice on competition law and freedom of services in the Community, with particular regard to national provisions on minimum fees, especially case C-267/99, Adam./.Administration de l'enregistrement et des domaines de Luxembourg.
- Report Study of the Institute for Advanced Studies (IHS) on behalf of the Commission, 'Economic Impact of Regulation in the field of Liberal Professions in Different Member States' of January 2003.

Definition of the term "Liberal Professions"

Since the term 'liberal professions' is understood differently in different Member States, a common definition of this term is crucial. In 2001, the European Court of Justice issued a judgment in the case C-267/99, Adam./.Administration de l'enregistrement et des domaines de Luxembourg, according to which liberal professions are described to be: 'of a marked intellectual character, require a high level qualification and are usually subject to clear and strict professional regulation. In the exercise of such an activity, the personal element is of special importance and such exercise always involves a large measure of independence in the accomplishment of the professional activities.'

Principles

The following principles are values shared by all liberal professions.

- Liberal professions accept responsibility and serve the common good: Liberal professions are responsible for important public services in areas such as health, justice, security, language and art. By offering their services in these areas, liberal professions fulfil an important role in society and create value for society as a whole.
- Liberal professions protect trust: For the liberal professions, the protection of their relationship of trust with their clients/patients has the highest priority. This includes absolute confidentiality by maintaining professional secrecy, acting in the interest of the client/patient and avoiding any possible conflict of interest.
- Liberal professions provide high quality services: Liberal professions provide a high standard of knowledge-based services. Quality is assured through demanding requirements concerning training, continuing professional development and a system of self-regulation by colleagues.
- Liberal professionals are independent: Liberal professions are independent in their area of expertise and from the interests of third parties, and practise their professions autonomously. They are independent in arriving at their judgment and in performing their individualized service and bear full professional responsibility for their actions. Professional responsibility is not only relevant in terms of self-regulation, but also in terms of accountability to clients/patients. This balance of autonomy and responsibility is a reflection of a free, democratic society.
- Liberal professions perform their services personally: Liberal professions always provide their services to their clients/patients personally. They are only able to delegate a small part of these services to other persons but even then bear the full responsibility for these services.
- Liberal professions are reliable partners: Liberal professions have a professional ethos. It includes moral standards for the best quality delivery of liberal professionals' services. In carrying out their services the liberal professionals are not primarily motivated by commercial considerations; instead they are guided by their professional ethos. This distinguishes them considerably from purely commercial service providers.
- Liberal professions support transparent self-regulation: Liberal professions and self-regulation as a principle of liberal professional organisation belong together. Self-regulation should be protected and optimised in the interest of clients. It should be efficient and transparent and aimed at benefitting the society.
- Liberal professions invest in training: Liberal professions fulfil an important responsibility towards society in that they offer young people training opportunities in professions with above-average prospects in the labour market. In this way they contribute to skill enhancement and job creation in Europe.
- Liberal professions support an innovative Europe: Liberal professions form a key sector of the European economy. As a driving force behind innovation they make an important contribution to the realisation of the Europe 2020 goals. The medium-sized structure of the liberal professions enables them to ensure the future of high quality services in Europe. Due to their direct interaction with their clients/patients, liberal professions can react flexibly to changing needs.

This is a model that should be reinforced rather than weakened.

Recommendations

Taking into account all the above, we urge the European Union authorities to:

- Strengthen the role of liberal professions and support these professions within their competences.
- Respect the added value of the liberal professions to European society and make sure that the liberal professions are not assessed solely on the basis of market-economy criteria.
- Respect the self-governing structures of liberal professions as they exist in many Member States.
- Following the fundamental principle of subsidiarity, Member States shall have the freedom to choose their way of organising the professional structures of liberal professions.
- Acknowledge that a decision to deregulate liberal professions, without considering all possible consequences, could lead to a decline in quality and in the full coverage of supply, as for example with health services.
- Guarantee that specific impact assessment on the consequences of legislative proposals on liberal professions is carried out before and after European legislation is adopted. In this regard the European legislator shall especially take into account the negative effects of bureaucratic burden on liberal professions.
- Guarantee that services provided by liberal professions, which are individual solutions on a highly creative basis, shall not be subject of standardisation on European level.
- Guarantee that the special trust relationship between members of the liberal professions and their clients / customers / patients is fully protected.

The Charter for Liberal Professions was elaborated and is supported by the following organisations of liberal professions

Council of European Dentists (CED):
Standing Committee of European Doctors (CPME)
European Council of Engineers Chambers (ECEC)
Federation of Veterinarians of Europe (FVE)

The charter was also elaborated and is supported by the Pharmaceutical Group of the European Union (PGEU), pending approval by PGEU General Assembly.