A practical resource to help in the support of non-UK, EEA qualified dental practitioners practising in the UK

January 2011
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The first edition of this resource was produced in 2010 by Professor Kenneth Eaton, Dr Angela Garcia, Dr Renna Patel and Dr Victoria Rincon for the National Clinical Advisory Service (NCAS), where it was edited by Louise Adams and Dr Janine Brooks.

It has been updated in March and April 2012 for the Oxford and Wessex Dental Deanery by Professor Kenneth Eaton, who acknowledges and sincerely thanks the following colleagues from the 19 EEA Member States for their help in updating the resource:

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Introduction

The resource gives details about regulatory mechanisms, education and training, support systems, dental team and skill mix, the delivery of oral healthcare, quality assurance mechanisms and culture within 19 European Economic Area (EEA) member states. Its aim is to provide information which may help when working with a referring body or a self referral of a non-UK EEA qualified dental practitioner.

Background

The current situation

On 31 December 2011, of the 39,306 dentists who were registered with the General Dental Council (GDC), some 11,214 had qualified outside the United Kingdom (UK). Of these 11,214, 6,722 were nationals of the 31 member states of the EEA (the 27 EU member states plus Iceland, Liechtenstein, Norway and Switzerland) who had obtained their primary dental qualification from an EEA dental school.

There are over 170 dental schools in the EEA and, in spite of efforts to harmonise undergraduate dental education throughout this area by the DentEd project and the elaboration of Competencies of a European Dentist (Association for Dental Education in Europe (ADEE)), a number of studies have demonstrated the variability of the undergraduate dental curriculum in the different dental schools of the EEA and in the level of clinical experience achieved during dental undergraduate education, (1,2,3).

The Directive on the Recognition of Professional Qualifications for Dentists (PQD) 2005/36 EC (4) gives EEA nationals who graduated from EEA dental schools the right to establish practice anywhere in the EEA, without the need to undertake further education or training. Therefore although all UK graduates, are required to undertake a year's foundation training before they can practise independently in the General Dental Services (GDS) of the NHS, and non-EEA nationals have to show equivalent experience, this requirement is not placed upon EEA graduates who work in the UK.

The purpose of the resource

Against this background, this resource has been developed. It has been designed to provide background information on the education of dentists in EEA member states and of the systems for the provision of oral health care in these member states. It does not seek to provide great detail, rather to give an overview of each EEA member state to improve knowledge and understanding of the professional background of dentists who obtained their primary dental qualification from a non-UK, EEA member state. It is important to remember that each dentist is an individual and the support they require needs to be tailored to them, the information contained within the resource should be used only as a guide and no assumptions should be made regarding an individual dental practitioner’s
experience or skills. The resource should not be used as legal guidance and all relevant UK and European Union legislation continue to apply.

**A general overview of the resource**

This second edition of the resource does not give information on all EEA member states. As in the first edition, it concentrates on the 19 member states in each of which more than 50 dentists were registered with the GDC in December 2009, plus Malta, nearly 20 per cent of whose dentists are registered with the GDC, (Table 1). These dentists represent 97 per cent of all current EEA registrants. It is hoped to extend the resource to cover the remaining member states in future editions.
Table 1. Non-UK EEA qualified dentists by country and year of first GDC registration, 31 December 2007 - 2011 (Source: General Dental Council)

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Some background on the variations in the systems for administering and delivering oral healthcare in the EEA

There are wide variations between EEA member states. Examples include the nature of the organisations that register dentists and are responsible for their professional standards. In Malta, Ireland and the UK they are known as dental councils and are largely independent of both the Government and the dental profession. In the Nordic countries registration is the responsibility of Government departments and a number of organisations (the dental associations, the universities and the Government) are responsible for professional standards. In many other member states both registration and professional standards are the responsibility of the dental association/order/chamber and there is often very little, if any, Government or lay involvement. In these countries dentistry and other healthcare professions are frequently referred to as “liberal” (self-regulating) professions. Dentists who come to the UK from EEA member states with “liberal” professions may not be aware of the powers of the GDC and find them surprising.

The use of team dentistry provides another example where there are surprising variations. In the Netherlands this concept is very well developed with all dentists working with full-time chair-side nursing assistance and numbers of dental hygienists and clinical dental technicians working in independent practice. Whereas in Belgium, a few kilometres away, the concept of team dentistry is poorly developed, there are no dental hygienists, nor clinical dental technicians and only a minority of dentists work with a chair-side assistant.

There are also variations between the systems for the provision of oral healthcare between the former Eastern Bloc countries, many of whom have changed from a purely public dental service to a purely private system and from a stomatological training, in which dentists first completed medical training before clinical dental training, to the typical North-Western European odontological training. These changes have caused significant tensions and have lead to a situation in which the background and experience of young graduates from these member states is very different to those who have been qualified for more that 15 years. Annex 2 summarises many of the differences in a table.

There are undoubtedly cultural issues that some dentists from EEA member states are likely to encounter when they work in the UK. For example, although it is usual in the UK to discuss treatment plans with patients and to encourage them to arrive at a final decision in partnership with the clinician concerned, this is not the case in a number of EEA member states. Communication is frequently a cause for patient complaints. Language can play a key role and although an EEA dentist may speak adequate English under normal conversational circumstances, he or she may have considerable difficulty understanding a regional accent or in explaining dental terms in language that a patient can understand. Such issues are not dealt with directly in this resource and can equally apply to some UK graduates.

There are considerable differences between member states in most aspects of the provision of oral healthcare and in the education of all members of the dental team. These differences can lead to difficulties for dentists and other dental team members who come to work in the UK. In many EEA member states the concept of clinical governance is defined differently to that in the UK and it may be unusual for a patient to challenge a dentist’s treatment planning recommendations.
Country: Belgium
Population: 10,951,266 (2011)
Number of registered dentists: 8,350 (2009)
Number of active dentists: 7,800 (2009)
Qualified overseas: 118 (2007)

Number of dentists registered in the UK in:
- 2007: 53
- 2008: 51
- 2009: 51
- 2010: 49
- 2011: 46

Background

Three languages are spoken in Belgium: Dutch (just under 60 per cent), French (just under 40 per cent of the population) and German. In the main, those who live in the North of the country (Flanders) have Dutch as their first language and those in the South (Wallonia) French. There is a small German speaking community in the East of the country. Belgium is a federal state. The fees and refunds for dental treatment fall under the authority of the federal state, whereas education (including the training of dentists) and prevention campaigns fall under the authority of the communities.

There are five dental schools: two in Flanders (KU Leuven and Ghent University), two in Brussels (Universite Libre de Bruxells and Universite Catholique de Louvain la Neuve) and one in Wallonia (Universite de Liege).

The level of dental caries appears to be fairly low in Belgium, but some groups experience a high level of disease. People in these high risk groups often have limited access to oral health care. The oral health workforce is limited mainly to dentists working in private practice. There is a reduced emphasis on prevention which auxiliaries might bring if team care was practiced. A public health approach is limited at present. Nevertheless, efforts are being made to improve the system and eliminate some of its variations (6).

In 2009, the total number of registered dentists was 8,350, and 48 per cent were female (4). The national government limited the number of dentists admitted into the profession every year during the period 2002 – 2010. The number is still fixed at 140 per year (84 from the Flemish part of the country and 56 from the Wallonian part). There is an additional mechanism in Flanders to reduce the numbers of new entrants to dental schools. It takes the form of a compulsory entrance examination which has reduced the yearly intake of dental students to about 100 for the whole country (6).

Dental services, both preventive and restorative, are almost exclusively delivered within private dental practices, by private practitioners, and only to a small extent (< 5 per cent) in public clinics, which are usually hospital based. Most dentists in general practice are self-employed and earn their living through charging patient fees (5).

Since 2002, amalgam separators have been mandatory. There are specific regulations defining radiation protection. A dentist is the competent person for radiological safety in each practice.

A dentist is required to register with the Federal Ministry of Health in order to practice dentistry in Belgium. In 2008, the cost of registration was 550 Euros (5).
**Summary of relevant points**

1. **Regulatory Mechanisms**
   - A dentist is required to register with the Federal Ministry of Health in order to practice dentistry.
   - Dentists are required to work under one of two different, but congruent ethical codes, dependant upon which dental association (Dutch or French speaking) they belong to.
   - Vaccination against hepatitis B is compulsory during dental training, and is administered by the Ministry of Health.
   - Dental indemnity insurance is compulsory for dentists, and covers dentists working abroad.
   - There is an initial payment for the registration of radiation equipment, of about 275 Euros. There is an additional annual maintenance subscription of 160 Euros.
   - 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.
   - There are no limitations to the number of associate dentists, or other staff in a dental practice. Premises may be rented or owned, and can be opened anywhere. No state assistance is provided to establish a new practice, thus dentists must negotiate commercial loans. A practice must be registered at a specific address. Some health insurance systems fund their own polyclinics.
   - There are no specific contractual requirements between practitioners working in the same practice. However a dentist’s employees are protected by the National and European laws on equal employment opportunities, maternity benefits, occupational health, minimum holiday entitlement and health and safety.

2. **Education and Training**
   - There are two titles awarded for clinical dentists graduating from Belgian dental schools:
     - Flemish Tandarts
     - French Licencie en sciences dentaires
   - Since 2002, vocational training has become mandatory. A federal law has limited the number of places for vocational training to 155. No Foundation Training programme exists.
   - There are three registered dental specialties; general dental practitioner, periodontology and orthodontics. Patients may go directly to a specialist, without referral.

3. **Support Systems**
   - Dentists may belong to one of three dental associations, depending upon their language:
     - Chambres Syndicales Dentaires (CSD) for French-speaking dentists
     - Société de Médecine Dentaire (SMD) also for French-speaking dentists
     - Verbond der Vlaamse Tandartsen (VVT) for Dutch speaking dentists
   - Membership is not compulsory, and in 2007, membership was approximately 67 per cent of the dental workforce.

4. **The Dental Team**
   - Recently the number of dental assistants has gradually increased since their training has been organized. However, many learn their skills “on the job” and the majority of dentists still do not employ a dental nurse.
**Dental technicians** have a protected title, as defined by the Ministry of Economic Affairs, and complete training in specialised schools (for three years), or in the dental laboratories. They are registered with the Ministry of Health.

### 5. Dental care delivery

- Dental services, both preventive and restorative, are almost exclusively delivered within private dental practices, by private practitioners, and only to a small extent (< 5 per cent) in public clinics, which are usually hospital based.
- The system is based on a compulsory social insurance system covering all aspects of healthcare, including dental care. Working adults, both salaried and self-employed, make compulsory payments through deductions from their wages or income, which contribute to the health and social services provided by the National Health Insurance scheme. Employers also contribute additional sums for their employees (6).
- There is an agreed scale of fees for dental treatments (known as the convention), which is jointly agreed by the dental associations and health insurance organisations. Dentists generally charge patients for each item of treatment, and then patients can obtain reimbursement for part of the costs.
- Within the framework of the National Health Insurance System, reimbursement of 75 – 79% of the nationally agreed fee is provided to all inhabitants for preventive and restorative care, removable dentures and minor oral surgery. For budgetary reasons, age limitations have been installed for the reimbursement of certain treatments (e.g. removable dentures are reimbursed from the age of 50 years); these limitations have changed over time. For individuals with disabilities, reimbursement of oral care is increased up to 90%. “Free” oral health care (i.e. full reimbursement) was begun for all children up to 12 years in September 2005, extended to 15 years in July 2008 and finally up to 18 years in May 2009. It covers the majority of preventive and restorative care; but reimbursement of orthodontic treatment remains limited.
- Approximately a third of the population attend a dentist regularly, one third when necessary and the remainder almost never, or only in an emergency.

### 6. Quality assurance mechanisms

- Since June 2002, continuing dental education has been mandatory in general medicine, radiology, prevention, practice management, conservative dentistry, orthodontics, prosthodontics and radiation protection. The requirement is 60 hours over six years. Dentists must also undertake at least one and a half hours of radiation protection training every five years (5).
- There are several ways in which standards of dental care are monitored. The Institute of Health has an administrative body which regulates the non-clinical administrative forms used in dentistry. It also has an independent control department staffed by medical doctors (not dentists) which checks that the treatment codes recorded agree with the actual treatment undertaken. The convention also defines quality standards.
Patients may complain to the Provincial Medical Council. Within the Dental Associations there is an ethical commission which also manages complaints. However this mostly handles disagreements between dentists, and aims to mediate in these cases.

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### Key Points to Consider When Inducting or Supporting a Dentist Qualified in Belgium

**Dentists qualified in Belgium:**

- Have limited experience of a publicly funded health service;
- Have limited experience of UK requirements for clinical governance (e.g. clinical audit);
- If they qualified before 2002, will probably not have undertaken vocational or foundation training in Belgium;
- May have limited experience of working with a dental nurse (chair-side assistant);
- Will have no experience of working with a clinical dental technician, a dental hygienist, a dental therapist, or an orthodontic therapist;
- May have no knowledge of formal training for dental nurses or dental technicians;
- May have no knowledge of registration for dental care professionals other than dentists.
Country: Bulgaria

Number of registered dentists: 8,240 (2011)
Number of active dentists: 8,240 (2011)
Qualified overseas: 38 (2011)

Number of dentists registered in the UK:
- in 2007: 45
- in 2008: 116
- in 2009: 167
- in 2010: 243
- in 2011: 300

Background

Some 73 per cent of the population is described as urban and the other 27 per cent live in rural areas. The country is divided into 28 districts; each has administrative offices for the Health Information Centre and local insurance fund (5). Between 2001 and 2011 the population of Bulgaria decreased by 564,331, two thirds of this decrease was due to deaths and one third to emigration.

Healthcare in Bulgaria is based on mandatory health insurance which is designed as a state monopoly and is known as the National Health Insurance Fund (NHIF). About 98 per cent of dentists in Bulgaria work in general practice, although some also work in hospitals and dental faculties. Dental services are delivered either within the NHIF or privately. Among all Bulgarian dentists, over 5,500 have contracts with the NHIF. There is a significant difference between the big cities (with an excess of dental practitioners) and the rural areas (where there is a shortage of dental practitioners). The average age of dentists in Bulgaria has risen from 39.7 years in 1997 to 41.7 years in 2008 (4). 64 per cent of dentists in Bulgaria are female, this has declined from 1998 when it was 74 per cent. At present, there appears to be no risk of overproduction of new dentists. There is no reported information about unemployment among Bulgarian dentists (5).

The dental procedures in the NHIF are on a co-payment and fee-for-service base. The scope and the extent of co-payments are different for children and adolescents on one hand, and adults on the other. Insured patients are entitled to a specific package and volume of dental procedures, covered by the Fund. The additional dental services are fully paid for by the patients (5).

The NHIF monitors the quality of dental care in the system of mandatory insurance, according to criteria negotiated with the Bulgarian Dental Association (BgDA) and included in the National Framework Contract. The quality of dental care in private practice is not actively monitored. Some control is carried out by BgDA on the basis of the Ethical Code and the Rules of Good Medical Practice in Dental Medicine. Like most European countries, professional liability insurance is mandatory according to the Law of Health, and the Regional Colleges of BgDA cover the insurance of their members which is not covered for Bulgarian dentists working overseas.

Dental graduates in Bulgaria are entitled to registration immediately upon graduation. Continuing professional education is mandatory.

In summary, about (90 per cent) of dentists in Bulgaria work in individual general dental practices. There is little publicly funded dentistry; most payments for oral health care are made privately by patients themselves. Dentists generally do not work with dental nurses. There are no dental hygienists. For historical reasons, dentists are called dental physicians in Bulgaria.
### Glossary of Terms

| Allergology | The branch of medical science that studies the causes and treatment of allergies |

### Summary of relevant points

#### 1. Regulatory Mechanisms
- The principal regulatory body in Bulgaria is The Bulgarian Dental Association (BgDA). It administers the registration of dentists through its Regional Colleges. The registration of dental practices as medical institutions is administered by the Ministry of Health through its regional bodies - the Regional Centers of Healthcare.
- There are no mandatory vaccinations against Hepatitis B or other diseases.
- Professional Liability insurance is mandatory according to the *Law of Health*, and the Regional Colleges of BgDA cover the insurance of their members.
- The law assumes that the primary dental qualification allows dentists to work with ionising radiation and take radiographs.
- Individual and group dental practices may be owned and managed only by dentists.
- The disposal of hazardous waste is regulated by the *Law of Waste Management*, plus secondary legislation. Amalgam separators are only advised and they are not yet mandatory.

#### 2. Education and Training
- There are three dental schools; the school in Varna opened in 2005.
- The undergraduate course lasts for five and a half years and was fully “EU compliant” on Bulgarian accession to the EU in 2007.
- There is no postgraduate vocational training. There is a six month mandatory pre-graduate practical training in the dental schools.
- There are numerous dental specialties in Bulgaria each with a training period of three years, post registration.

#### 3. Support Systems
- 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), which, after the accession of Bulgaria in the EU, regained the title *Bulgarian Dental Association* (BgDA).

#### 4. The Dental Team
- Dental care is delivered by dentists. There are no dental hygienists.
- Dental technicians in Bulgaria graduate after three year’s training. The dental laboratories are 100 per cent private and must register with Ministry of Health. Their activities cover dental and orthodontic appliances. Dental technicians are not entitled to undertake any form of clinical work.
- Since 1989, no specific training has been available for dental chair-side assistants (dental nurses). In 1989 there were about 6,000 dental chair-side assistants, but there were very many fewer by 2008 (3000) – the
number in dental clinics is small and most dentists now work without a chair-side assistant. Those who originally trained as general care nurses are registered as such. However, there is no register for dental nurses.
- There are no clinical dental technicians (denturists), dental hygienists, or dental therapists in Bulgaria (5, 2).

5. Dental care delivery
- Voluntary health and oral health insurance is at a rudimentary, initial stage. Most of the dentists in Bulgaria work in general practice and deliver oral health care either through the NHIF or privately.
- The Bulgarian Dental Association has drafted a national programme for prevention of oral diseases in children 0-18 years.
- The entire working population of Bulgaria is required to have health insurance with the NHIF. Theoretically, the NHIF covers dentistry. However, oral health care for adults funded by NHIF is limited.
- Virtually all Bulgarian dentists work in the private sector on a self-employment base, i.e. in general practice. Most work single-handed in one chair practices.

6. Quality assurance mechanisms
- Continuing education is mandatory. A credit system has been introduced and administered by BgDA.
- The NHIF monitors the quality of dental care in the system of mandatory insurance. The quality of dental care in private practice is not actively monitored. Some control is achieved by BgDA on the basis of the Ethical Code and the Rules of Good Medical Practice in Dentistry.
- Patient complaints are generally managed by the Ministry of Health, and the regional and national Ethical Committees of BgDA.
- The penalties for infringement of the Ethical Code vary in severity, from censure, financial penalty to erasure from the register (for a term of from three months to two years).
Key Points to Consider When Inducting or supporting a Dentist Qualified in Bulgaria

Dentists qualified in Bulgaria:

- Have limited experience of a publicly funded health service if they qualified after 1990;
- Have limited experience of UK monitoring procedures (e.g. NHS dental services) or UK requirements for clinical governance (e.g. clinical audit);
- Are unlikely to have experience of working with a dental nurse;
- Will have no experience of working with a dental hygienist, a dental therapist, an orthodontic therapist or a clinical dental technician;
- May have no knowledge of formal training for dental nurses;
- May have little experience of working in a multi practitioner environment;
- May not realize that dental care professionals within the UK who undertake invasive procedures must be vaccinated against Hepatitis B;
- May not appreciate that amalgam separators are mandatory in the UK;
- Unless qualified before 2003, will not have undertaken vocational or foundation training in Bulgaria, just a 6 month mandatory pre-graduate practical training in the dental schools;
- May have no knowledge of registration for dental care professionals other than dentists.
Country: Czech Republic

Population: 10,532,800 (2011)
Number of registered dentists: 9,158 (2011)
Number of active dentists: 7,007 (2011)
Qualified overseas: 317 (2011)


Background

The country is administered as 13 regions and Prague has regional status (5).

In the Czech Republic, about 90 per cent of the dental care is delivered by private dentists and the remaining 10 per cent is provided by university dental clinics, municipal health centres, the armed forced and hospitals. According to the Czech Dental Chamber (CSK), the active dental workforce started to decrease after 2008. About 63 per cent of active dentists are older than 50 years. It is presumed that in the next few years the number of dentists, leaving their dental practices due to reaching retirement age, will be higher than the number of newly graduated dentists. There is no significant movement of dentists from the Czech Republic to neighbouring countries. The number of emigrating dentists is similar to that for immigrating dentists (5).

Dentists must register with the Ministry of Health, the CSK and their Regional Authority. The CSK maintains a register containing the dentists’ details, including qualifications and professional performance information. There is a statutory requirement for all dentists to undertake continuing professional education in order to maintain their registration (5).

Oral healthcare is co-ordinated by the CSK. It is compulsory for all Czech citizens to be a member of the health insurance system. Up to 80 per cent of dental care is paid for by the health insurance system and the balance is covered by the patients. The health insurance scheme (HIS) cover the costs of “standard” dental care for children up to 18 years of age in full, with the exception of some prosthodontics and fixed orthodontics for which special rules apply. The HIS also covers the basic dental care of adults. The costs of tooth-coloured fillings and more complex prosthodontic treatments are covered partly by the HIS (up about 30 per cent of the costs) and the remainder by patients themselves. Dental care of children and adolescents is provided predominantly by private dental practitioners (5).

The undergraduate dental course lasts five years. Prior to 2009, there was a 36 months programme of vocational training for all new Czech dental graduates. It stopped in 2009, after changes to the clinical content of the undergraduate dental course, which is now comparable to that in other EEA countries. Czech dentists, who qualified prior to 2009 were not allowed to work in other EU countries immediately upon qualification. After completing courses it is possible to obtain certificates of proficiency in periodontology, oral surgery, paediatric dentistry and general dentistry comparable in the UK to dentists with special interest (5).

There is no obligatory registration for dental hygienists, dental technicians and dental assistants in Czech Republic. Education of dental hygienists started in 1999. The number of hygienists was 307 in 2010.
## Summary of relevant points

### 1. Regulatory Mechanisms
- To work in the Czech Republic, a dentist must be registered with the Czech Dental Chamber (CSK) which defines requirements on operating a dental practice and confirms compliance with the dentists’ professional performance needs. It also maintains a register containing the dentists’ details, including qualifications and professional performance data and administrates the ethical code.
- To establish a new practice dentists have to register with the local state health authorities and fulfill all the necessary conditions (qualification, lack of disciplinary convictions, and equipment of the practice). There is a one-off registration fee payable to the Regional Authority and in 2008 it was 1,000 CZK (40 Euros) (5)
- There are no regulations to control the location or size of dental practices. The law does not allow the selling of lists of patients. The state doesn’t offer assistance for establishing a new dental practice.
- The dental workforce has to be vaccinated against Hepatitis B and has to be checked regularly for sero-conversion. The employer usually pays for vaccination of the dental staff.
- Professional liability insurance is compulsory for all dentists. For work abroad it is necessary to make a special supplement to the insurance contract.
- Training in ionising radiation is mandatory for undergraduate students as part of the curriculum. Dentists have to pass an examination on ionising radiation every ten years.
- Ionising radiation equipment is registered by the State Office for Nuclear Security it must be checked annually by an accredited company.
- Amalgam separators are obligatory. The disposal of clinical hazardous waste and amalgam must be carried out by an accredited company.
- Anyone can own a dental practice but they need a dentist present on the premises at all times.

### 2. Education and Training
- There are five dental schools in the Czech Republic. To enter to a dental school, students must pass an entrance examination.
- Since 2004, dental studies have taken place under a new a curriculum, according to the standards of the EU. The dental course lasts for five years.
- For dentists graduating before 2009, there was a programme of vocational postgraduate training for 36 months, under supervision. It was certificated by the Dental Department of the State Institute of Postgraduate Education in Medicine.
- Since 2009, dental graduates no longer undertake vocational training and are able to be fully licensed immediately upon qualification. However, in practice if a new graduate wishes to open a new practice and to contract with the health insurance scheme, they are expected to have worked under supervision for a period of time after they have graduated. Non-EEA graduates who wish to work in the Czech Republic must work for one year under supervision before they can practice independently.
- Czech vocational training is not compulsory for graduates of other EEA countries’ dental schools.
- There is specialist training in three specialties: orthodontics, clinical dental medicine and oral-maxillo-facial.
surgery
- To enter specialist training a dentist must have completed 36 months in general dental practice (for oral-maxillo-facial surgery, medical practice is an acceptable alternative). Specialist training in orthodontics takes three years, for clinical oral medicine it takes four years and oral maxillo-facial surgery takes six years

### 3. Support Systems
- The CSK protects the interests of dentists and patients and maintains professional standards and ethics of dentists
- To obtain registration, a dentist coming from another EEA state must have a recognised qualification, permission for permanent residence in the Czech Republic, a work permit, and pass an examination in spoken Czech. Dentists from non-EEA countries must pass the full recognition process as required by Directive 2005/36/EEC

### 4. The Dental Team
- There is no obligatory registration for dental hygienists, dental technicians and dental assistants
- Dental hygienists are permitted to work after completion of three years training in a special higher school specifically for dental hygienists. Dental hygienists can only work under the supervision of a dentist and their duties include scaling, cleaning and polishing, removal of excess filling material, local application of fluoride agents, the application of preventive sealants and oral health education
- Dental technicians can train in a variety of ways. Four years in a high school for dental technicians, after which they can only work as assistant dental technicians is the usual pattern. Some will study for a further three years and can then work independently and employ other technicians. They normally work in private laboratories, only a few are employed by dentists or dental practices
- Dental nurses must undertaken three years at the school for dental nurses or can be general nurses trained by dentists. They are permitted to undertake oral health education

### 5. Dental care Delivery
- Oral healthcare is coordinated by the CSK.
- Most children (97 per cent) and adolescent up to 18 years age, pensioners and 67 per cent of adults are covered by an obligatory tax-financed public health insurance run by the nine state-approved health insurance companies. The rest of the population is insured by health insurance schemes and employees by sick funds.
- The insurance fund is part of the compulsory public health insurance system. Up to 75 per cent of dental care is paid from the health insurance system. The Sick Funds are self-regulating under the national legislation.
- The dental service is delivered through a system of university clinics, or by private dentists. In 2007, about 90 per cent of dental care was delivered by private dentists.
- The insurance system provides cover for all standard conservative treatment such as amalgam fillings, basic endodontic treatment, surgical and periodontal items and for a few basic prosthodontic items.
- Cosmetic fillings and non-basic endodontic treatment, 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.
For dentists working within the health insurance system, it is mandatory that they complete a price list of items partially covered by the insurance system, or items which are fully covered by the patient. Control of the price-lists is maintained by the financial authority and is checked routinely, by audit of bills and documentation or as a result of a complaint by a patient.

The contracted dentist sends a monthly invoice with the list of patients and the treatment provided to the health insurance company. The payment from the insurance company follows in 30 days.

The dental services provided in hospitals by dentists usually cover all aspects of oral health care and in-patient oral surgery. Hospital dentists also assist in the education and training of dental undergraduates. About half of the dentists working in hospitals are specialists, the others are in training. They can be either fully or partially employed and they can also work in private practice.

Less than 1 per cent of dentists (mainly in Prague and in other larger cities) work completely outside the system of health insurance. Their fees are totally unregulated.

<table>
<thead>
<tr>
<th>6. Quality assurance mechanisms</th>
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<tbody>
<tr>
<td>Participation in continuing education has been obligatory since 2004</td>
</tr>
<tr>
<td>The outcome of the CSK continuing postgraduate education cycle is a Certificate of Proficiency in general dentistry, periodontology, oral surgery, paediatric dentistry and orthodontics.</td>
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<tr>
<td>The attendance of dentists at recommended practice-oriented courses or theoretical lectures is evaluated by credits</td>
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<tr>
<td>The Certificate is valid usually for three to five years, it can be repeated after that period of time</td>
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<tr>
<td>The CSK resolves complaints and, when necessary, disciplines its members</td>
</tr>
<tr>
<td>A complaint may be made to the health insurance company concerned or to the CSK</td>
</tr>
<tr>
<td>Final complaints are processed by the Regional Dental Chambers’ Auditing Boards</td>
</tr>
<tr>
<td>Any serious breach of the law can be referred to court and even result in imprisonment. An appeal to the CSK is possible.</td>
</tr>
</tbody>
</table>
Key Points to Consider When Inducting or Supporting a Dentist Qualified in Czech Republic

Dentists qualified in Czech Republic:

- May have limited experience of a publicly funded health service;
- Have limited experience of UK monitoring procedures (e.g. NHS dental services) or UK requirements for clinical governance (e.g. clinical audit);
- If they qualified after 2009, will not have undertaken vocational or foundation training in Czech Republic;
- May have little experience of working within the wider team of dental care professionals;
- Will have no experience of working with a dental therapist, an orthodontic therapist, or a clinical dental technician in Czech Republic;
- May have little experience of working with a dental hygienist;
- May not be aware that dental nurses, dental technicians and dental hygienist have to be registered in the UK;
- Since 1990, have mainly worked in private practice and have contracts with the public insurance scheme.
Country: Denmark

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<tr>
<td>Number of active dentists: 5,000 (estimate 2012)</td>
<td>Qualified overseas: No data</td>
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**Background**

The number of registered dentists in Denmark has remained stable over the last decade. However, a forecast by the Danish Health and Medicines Authority (DHMA), 2010 predicted that the number of dentists will decrease continuously by around 70 dentists a year until 2025 mainly because of retirement of a large number of older dentists. There are no data on dentists qualified overseas but there is little movement of dentists in and out of Denmark. The percentage of female dentists is 60 per cent. About 68 per cent of the dentists in Denmark work in private practice (5).

Denmark has a highly decentralised National Health Service, largely funded by general taxation. Oral healthcare (including orthodontics) is free for children from 0 to 18 years of age and subsidised for adults. Approximately 1,000 dentists work within the municipal dental care sector (public dental service) treating children, adolescents and people with special care dental needs. Dental care is usually delivered in municipal school dental clinics, by salaried public dentists. It is estimated that 99 per cent of children and adolescents utilise the service each year. Most adults obtain oral healthcare from the private sector. A proportion of the cost of this care is refunded by the public health insurance scheme financed by the government. In response to improving oral health in the population and changing patterns of treatment needs, the DHMA estimates an increased need for dental hygienists in the future.

There is a well-developed system employing dental auxiliaries in which dental hygienists, clinical dental technicians and dental nurses provide clinical support for dentists (5).

**Summary of relevant points**

1. **Regulatory mechanisms**
   - The DHMA administers initial registration and maintains a national register of dentists. ([http://www.sst.dk/DS/OpslagAutReg.aspx](http://www.sst.dk/DS/OpslagAutReg.aspx))
   - In order to be a principal in private practice and receive government payments, dentists must also register with the regional branch of the Danish Dental Association (DDA) and with the DHMA who certify that he/she has worked as an employed dentist for 1440 hours.
   - Dentists who work in the public dental service are not required to register with the DDA. Directors of
public clinics must be authorised by the DHMA.

- All dentists qualified outside the EEA are required to take additional dental courses prior to registration in Denmark.
- Dental practices can be rented or owned and there is no state assistance for establishing a dental practice.
- Hepatitis B vaccination is not compulsory in Denmark.
- Professional liability insurance is provided by the DDA and is compulsory for private dental practitioners. This only covers dentists in Denmark.
- It is mandatory for undergraduate dental students to take training in ionising radiation protection. Continuing education in ionising radiation is not mandatory. All new X-ray equipment must be registered by the DHMA.
- Only approved companies are allowed to collect amalgam. The dentist must have written documentation for its disposal.

### 2. Education and training

- There are two dental schools in Denmark. Dental education is state-funded and lasts for five years.
- After graduation students obtain an authorization as a dentist issued by the DHMA which allows them to work as employed dentists, but if one wishes to own a practice, he/she needs to have a permission from the DHMA to practise independently. This can be obtained if the dentist has worked for at least 1,440 hours after qualifying. The dentist must have treated adult patients and children for at least 360 hours. There is no registration fee, but to practise independently the dentist must pay approximately 147 Euros to the DHMA (2010).
- To undertake specialist training a graduate must have had at least two years’ post qualification work experience. Trainees are paid by the hospital or dental school.
- There is formal training in two specialties: orthodontics and oral surgery.
- The training for specialists in oral surgery lasts for five years and three years for orthodontics.

### 3. Support systems

- There are two federations or trade unions for dentists in Denmark, DDA and the Public Dentists Group.
- The main goals of the two trade unions are: to look after the interests of all dentists in all aspects of the profession, to promote oral health within the Danish society and to develop all aspects of dental care for the Danish population.

### 4. The dental team

- Dental hygienists undertake three years training at The School for Dental Nurses and Dental Hygienists.
After graduation dental hygiene students obtain an authorization as a dental hygienist issued by the DHMA which allows them to work independently or as an employed dental hygienist.

Dental hygienists undertake basic diagnostic examinations with the main focus on dental caries and periodontal diseases, oral health promotion and disease prevention, tooth cleaning, basic periodontal treatment (not surgery) and administer local anaesthetic.

Training for dental technicians is two years in a school for dental technicians. They work mostly in laboratories, hospitals or dental faculties and are salaried. Some are employed by dentists in private dental practice.

Dental nurses’ training is carried out at a School for Dental Nurses and Dental Hygienists and or in technical schools which exist in several municipalities.

Clinical dental technicians/denturists undertake a four-year training course at a dental technician school. They need a licence from the DHMA to practise independently. They provide full dentures without the patient being seen first by a dentist. For partial dentures, a treatment plan from a dentist is required. A patient with pathological changes must be referred to a dentist.

**5. Dental care delivery**

Dental services for children aged 0 to 18 years are organised by the municipalities and are free of charge. This includes orthodontic treatment. Since January 2004, children can choose to receive dental care from a private practitioner instead of the public service but they have to pay 35 per cent of the costs. At the age of 16 years, children may change to a private dentist with the full cost of treatment still being met by municipalities until they are 18 years old.

The dental service for adults is operated by an agreement between the regions and the DDA. Patients pay 30 to 65 per cent of the cost of their fees depending on the patient’s age and the treatment. The cost is refunded by the public health insurance scheme, financed by the government out of general taxation.

The subsidy is higher for preventive care and essential treatments. Subsidies for 18 to 25-year-olds are also higher. The treatment subsidies include examination and diagnosis, restorations, oral surgery, periodontology, and endodontics. For adults, orthodontics, crowns and bridges and removable prosthodontics have to be paid for in full by the patient.

People with social security or unemployment benefits, such as the homeless or victims of drug and alcohol abuse, usually receive free dental care after prior approval from the municipality where they live.

The Danish counties offer highly specialised care and treatment for patients with rare diseases or special needs for whom the underlying condition leads to special oral problems.

The provision of dental care for the elderly living in nursing homes and for those with special needs
living in their own homes but who are not able to use the normal dental care system, is now one of the roles of the municipal dental care service.

- It is mandatory to make public the price list of the treatments not covered by the state scheme. Dental fees are defined in a departmental order, with suggestions from the Danish Regional authorities and the DDA to the government.
- Dentists who work in hospitals are mostly oral surgeons.
- Dentists working in university dental faculties not only have teaching responsibilities but also have to treat patients in university clinics, undertake research, or have a mixture of management, research and student supervisory responsibilities. Dental teachers usually work part-time and spend their remaining time in practice.

### 6. Quality Assurance mechanisms

- Continuing education is not mandatory for dentists. However, in 2009 the DDA started a voluntary scheme which requires its members to complete 25 hours of registered CPD per year. This does not apply to dentists who work in the public dental service (5). The County Dental Society of the region monitors standards of oral health service through auditing the treatment figures which every dentist has to submit in order to claim public subsidy. Any dentist who carries out particular treatments by approximately more than 40 per cent of the regional average has to provide an explanation.
- Monitoring the standards of private dental practice is the responsibility of the Society of the five regional bodies and the DDA. Monitoring consists of statistical checks and official procedures for dealing with patient complaints.
- There are two systems for dealing with complaints. One relates to complaints against dentists working with 'the agreement of adult dental care' and the National Agency for Patients’ Rights and Complaints deals with complaints about other dentists and auxiliaries.
- A complaint system is managed in the regions by regional politicians and members of the DDA. The sanctions can vary from a reprimand to a recommendation to the DHMA to take away the authorisation to practise. The decisions can be appealed to a national committee.
## Key Points to Consider When Inducting or Supporting a Dentist Qualified in Denmark

**Dentists qualified in Denmark:**

- Probably have considerable experience of a publicly funded health service;
- May not appreciate that professional indemnity is not provided by the Dental Association in the UK;
- May not appreciate that hepatitis B vaccination is compulsory in the UK;
- May not appreciate that continuing professional education is a requirement for continuing dental registration in the UK and to work in public dental practice;
- If they have graduated in the last ten years, will not have undertaken vocational or foundation training in Denmark;
- May not appreciate that clinical dental technicians are able to see patients for complete dentures without a referral by a dentist;
- Are likely to have experience of working with a dental hygienist, who may be able to work independently and to provide basic diagnostic tests and administer local anaesthetic;
- Will have experience of working with qualified dental nurses, dental technicians and clinical dental technicians;
- May have little experience of working in 100 per cent private dental practices.
Country: France
Population: 65,075,300 (2011)
Number of registered dentists: 44,537 (2008)
Number of dentists in active practice: 40,968 (2008)
Number qualified overseas: 660 (2008)

Number of dentists registered in the UK in 2007: 82 in 2008: 82 in 2009: 78 in 2010: 82

Background

In 2008, there were 44,537 registered dentists and 40,968 in active practice and 37 per cent of dentists were female (5). Oral health care is predominantly private in France (91 per cent of provision). A mandatory insurance system called "Sécurité Sociale" (Social Security) covers the entire population. The "Sécurité Sociale" was set up in 1945/1946 with two main objectives (10):
- To compensate patients for loss of income due to illness;
- To allow entitled persons to cover the medical or paramedical expenses resulting from their own illness or from the illness of any members of their dependent family.

Most oral healthcare is provided by independent practitioners in accordance with an agreement known as the Convention, and almost all dentists (99 per cent) in France practice within this system. Where a dentist does not work within the Convention, then the patient cannot reclaim the fees paid for treatment. All legal French residents are entitled to treatment under the Convention (5). Patients pay full fees to the dentist. There are many private dental insurance schemes and approximately 90 per cent of the population utilise complementary insurance schemes, either by voluntary membership or through the Convention to cover all, or part of their treatment (5).

Professional liability insurance has been compulsory for all dentists since March 2002.

The Ordre National des Chirurgiens-Dentistes manages the registration of dentists in France. It stipulates an Ethical Code which defines the contract with the patient, consent and confidentiality, continuing education, relationships and behaviour between dental surgeons and advertising (10).

Glossary of Terms

Stomatologist Stomatologists are medical doctors who have specialised in stomatological sciences. The professional title is: "Médecin spécialiste qualifié en stomatologie". This is considered a medical specialty. They can undertake the same treatment as qualified dentists, as well as maxillofacial procedures. The duration of their training is six years (medical training) followed by four years of specialist internship. They then obtain a diploma of "Doctor in Medicine" as well as a diploma of qualification (DES Diploma of Specialised Studies).
## Summary of relevant points

**1. Regulatory Mechanisms**

- The Ordre National des Chirurgiens-Dentistes manages the registration of dentists in France. The register of dentists is held primarily by Departmental (Regional) Dental Councils, but a national register also exists. The cost of registration in 2008 was 354 Euros and practitioners are required to pay an annual charge in order to remain on the register.
- The Ordre National des Chirurgiens-Dentistes is applicable to all dental practitioners in France (departments and overseas territories included). The Ethical Code covers the contract with the patient, consent and confidentiality, continuing education, relationships and behaviour between dental surgeons and advertising.
- Vaccination against hepatitis B, diphtheria, tetanus, and poliomyelitis is a mandatory requirement, as stipulated by a Health General Regulation.
- Liability insurance has been compulsory for all health professions since March 2002. For Confédération Nationale des Syndicats Dentaires (CNSD) members, it is included as a part of the association membership fee. Insurance companies can also provide professional civil liability cover for a dentist’s patients during their working life. This insurance does not cover dentists for working abroad, except for a maximum duration of two months in EU countries (including Andorra and Switzerland for temporary practice, or for dentists migrating and acquiring new insurance).
- Dentists may run practices as corporates, either 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 an incorporated practice), where a legal successor of a dead dentist can inherit the practice for five years.
- Training in radiation protection is now part of the undergraduate curriculum. Equipment must be registered with the Institut de Radioprotection et de Sûreté Nucléaire, and the registration is valid for five years. New rules governing Radiation Protection Supervisors have recently been implemented.
- The use of amalgam separators is mandatory.
- There are no rules limiting the size of a dental practice in terms of the number of associate dentists or other staff. Dentists can work on their own, and in association, or with, an assistant-dentist. But a dentist may only employ one assistant-dentist. Premises may be rented or owned. Generally recent dental graduates buy the practice of a retiring dentist.

**2. Education and Training**

- The dental degree is six years in duration.
- Degrees included in the register are (5):  
  - Diplome d'état de chirurgien dentiste (Dentist) – before 1972
  - Diplome d'état de docteur en chirurgie dentaire (Doctor in Dental Surgery)
- There is no post qualification vocational training, nor Foundation Training Programme in existence in France.
- Orthodontics is the only recognised dental specialty in France.
- There is no referral system in France for access to specialists – patients self-refer to a specialist directly.
- The Ordre, University and other professional organisations (including CNSD) have agreed to introduce the specialty of Oral Surgery as soon as legislation permits this.
- Oral Maxillo-facial surgery is considered a medical specialty.

### 3. Support Systems
- The main professional union for dental surgeons is the Confédération Nationale des Syndicats Dentaires (CNSD), encapsulating 100 departmental unions, and representing approximately 50 per cent of the practicing dentists in France. The Union works alongside the government in planning national oral healthcare services, and also partners the Social Security Caisses (Health insurance funds), and is recognised as the representative union by the public authorities.
- The French Dental Association (ADF), founded in 1970, represents the entire dental profession in France (general dental practitioners, surgeons, specialists, academics, hospital, individual members of professional unions, scientific societies etc).

### 4. The Dental Team
- In France no auxiliaries are permitted to work in the mouth. The only recognised auxiliary personnel are dental chair-side assistants, receptionists and dental technicians.
- Many dentists work without full-time chair side support from a dental assistant (5,10).

### 5. Dental care delivery
- A mandatory insurance system known as "Sécurité Sociale" (Social Security) covers the entire population. Patients pay full fees to the dentist and the "Sécurité Sociale" reimburses about 70 per cent of these fees on a fee-per-item basis. This includes treatments such as extractions, restorative dentistry, prosthetics and orthodontics (if the treatment begins before the age of 16 years). Scaling, sealing and fluoride tablet administration are also reimbursed in the same way as preventive treatments (10). Children and teenagers aged 6, 9, 12, 15 and 18 are entitled to an annual examination which is fully covered by health insurance.
- The cost of the examination is directly paid to the dentist. Restorative treatment, as well as preventive measures such as fissure sealants, are also free. For other treatments e.g. orthodontics and prosthetics, dentists may set their own fees, after informing the patient of the estimated cost. Most prosthetic treatment is paid for entirely by patients, who may take out additional private insurance to cover part, or all, of such costs. 76 per cent of the population does this. A proportion of these fees are usually covered by the social security system on the basis of a fee scale, subject to prior approval. The patient pays the full fee to the dentist and is then issued with a form which is used to reclaim the relevant amount. There is no restriction on how often treatment can be undertaken.
- A Universal Sickness Insurance (CMU) was created on 1st January 2000 to enhance access to care for the more vulnerable members of the population. Practitioners are directly paid by Social Security and complementary insurance. The fees for restorative and surgical care are defined in the Convention (annual contract between the dentists and the health fund). About five per cent of the population belonging either to low income groups or to groups without any income, benefit from this free care.
- For prosthetic dentistry there is an alternative scale of fees which have not been reviewed since their creation on 1st January 2000.
- Domiciliary care can be provided on request, by a limited number of patients, such as those ill or disabled. Once requested, a dentist must provide this care.
- Most oral healthcare is provided by general dental practitioners in accordance with an agreement known as the Convention and almost all dentists (98 per cent) practise within the Convention.
- Oral health care is predominantly private in France. There are many private dental insurance schemes and approximately 90 per cent of the population utilize complementary insurance schemes, either by voluntary membership or through the CMU to cover all, or part of their treatment.

### 6. Quality assurance mechanisms
- If a patient is not satisfied with the quality of care they receive, they are able to request that the dentist is assessed to determine their capacity and competence in undertaking such treatment. Complaints can be sent either to the Social Security Caisses, or to the departmental Council of the Ordre National.
- In a conventional conflict, the dentist’s case is studied by a committee composed of dentists and, representatives of professional organisations, which have contracted to the convention. There is no lay (non-dental) representation on the committee. Sanctions range from financial penalties to temporary suspension or erasure from the register.
- Continuing education has been mandatory since 2004. This is managed by a body, composed of the colleges (Ordre, Unions, Universities) which stipulates the required subjects and topics, as well as the content of the proposed training sessions. It also defines the number of required credits – points: 800 every five years with at least 150 per year. Since 2004, training in patient radiation protection has been mandatory. By 19 June 2009, every dentist was required to have undertaken this qualification. The qualification must be renewed every ten years.
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<tr>
<th>Key Points to Consider When Inducting or Supporting a Dentist Qualified in France</th>
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<td>Dentists qualified in France:</td>
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<tr>
<td>• Have limited experience of a publicly funded health service;</td>
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<td>• Have limited experience of UK monitoring procedures (e.g. NHS dental services) or UK requirements for clinical governance (e.g. clinical audit);</td>
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<tr>
<td>• Will not have undertaken vocational or foundation training in France;</td>
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<tr>
<td>• May have little experience of working within the wider team of dental care professionals;</td>
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<tr>
<td>• May have little or no experience of working with a dental nurse;</td>
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<tr>
<td>• Will have no experience of working with a dental hygienist, dental therapist, a clinical dental technician, nor an orthodontic therapist in France;</td>
</tr>
<tr>
<td>• May have no knowledge of formal training processes for dental nurses or dental technicians.</td>
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</tbody>
</table>
Country: Germany
Population: 81,751,600 (2011)
Number of registered dentists: 86,428 (2010)
Number of active dentists: 67,808 (2010)
Qualified overseas: 2,838 (2008)


Background

Germany has the highest number of dentists of all EEA countries. Between 1500 and 1600 new dentists graduate each year and the number of dentists is increasing. However, this growth has slowed in the early years of this century. The German Dental Association believes that there are too many dentists and some minor unemployment of dentists in Germany has been reported. (5). Most dentists (98 per cent) have a contract with the statutory health insurance system (the Krankenkassen) and work independently in private dental practices. A limited number of dentists are employed in the Public Dental Service (PDS) (11).

There is a statutory health insurance system in which health care depends on mandatory membership of a state-approved “sick fund”. Employers contribute 52 per cent and employees 48 per cent and together pay a sum equal to about 14 per cent of an individual’s total pay for health insurance. The majority of the German population (around 88.5 per cent) belongs to a sick fund which provides a legally prescribed standard package of oral health care that is managed jointly by the sick funds and the Associations of Statutory Health Insurance Dentists (KZV). In principle, membership of a statutory sick fund entitles all adults and children to receive oral care within the statutory health insurance system. In 2012, about 10 per cent of the working population, who had an income of more than 4,237 Euros per month were members of a private insurance scheme. However, the premium for private insurance is lower and private insurance schemes offer more flexible packages of care, it covers only one person and not spouses or children (11).

The range of auxiliaries is complex and includes dental chair-side assistants, dental prophylaxis assistants, specialized dental assistants, dental administrative assistants and dental hygienists (11). In Germany, auxiliary personnel can only work under the supervision of a dentist, who is always responsible for the treatment of the patient (5).

Summary of relevant points

1. Regulatory Mechanisms
   - The delivery of oral health care is organised nationally by the Federal dental authority (KZBV) and locally by the regional dental authorities (KZV). There are 17 KZVs in Germany and they represent all the dentists who can treat patients covered by sick funds.
   - The standards of dental care are monitored by a federal committee on guidelines for dental care.
   - The sick funds and the KZBV establish within the legal framework the range of treatments (and the value of them) which are necessary and can be legally provided as a part of the sick fund system.
   - Routine monitoring is carried out by the KZV and consists of checking invoices and the amount of work provided by each dentist.
   - The contract with the patient is usually verbal, but for complex treatments or those requiring prior approval
from the sick funds, written consent and terms of payment must be recorded. All treatment carried out must be recorded by the dentist and must demonstrate informed consent.

- Infection control is regulated by law and has to be followed by the dentist and his/her team.
- Training in radiographic protection is mandatory for undergraduate dentists. Radiation equipment must be registered.
- Amalgam separators have been obligatory since 1990.

2. Education and Training

- To enter dental school a student has to have passed the general qualification for university entrance and obtain a successful result in a Medical Courses Qualifying Test.
- All but one of the 31 dental schools are publicly funded and the undergraduate programme lasts five years.
- The state examination certificate is part of the degree and is compulsory to obtain registration as a dentist.
- In order to register as a dentist and provide care within the sick fund system, a German dentist with a German diploma must complete two years of approved supervised experience in a dental practice.
- Four dental specialties are recognised, although not in all seventeen states. They are: oral surgery, orthodontics, periodontology, dental public health.
- Training for all specialties lasts four years and takes place in University clinics or recognised training practices, except for dental public health.
- The trainee has the status of an employee and gets a salary from his or her employer.
- After completion of specialised training the trainee has to pass an examination organized by the dental chamber.
- In recent years, postgraduate Masters programmes have been established by the universities, mostly part-time, for example in implantology, functional therapy, periodontics, endodontics, orthodontics, surgery, aesthetics, and lasers in dentistry.

3. Support Systems

- The Dental Chambers (associations) are the bodies which represent the interests of dentists working in all of the oral health systems.
- The membership is compulsory for dentists.
- The German Dental Association is the professional representative organisation for all German dentists, at a federal level.

4. The Dental Team

- The number of dental hygienists was 350 in 2007. Their duties include advice and motivation of patients in prevention, therapeutic measures for prophylaxis and scaling of teeth.
- A feature of German dentistry is the high number of Dental Technicians (65,000). A dentist may employ a dental technician but most use independent laboratories. They produce prosthodontic appliances according to a written prescription from a dentist.
- Dental nurses are able to obtain a qualification after three years work in dental practice, attendance at a vocational school and passing an examination set by the Dental Chamber.
- There are three grades of dental chair-side assistant (nurse):
Zahnmedizinische Fachassistentin (ZMF): who have completed 700 hours training. Their duties include support in prevention and therapy, organisation and administration, and training of dental assistants.

Zahnmedizinische Prophylaxeassistentin (ZMP): who have completed a minimum of 400 hours training. Their duties include support in prevention/prophylaxis, motivation of patients and oral health information.

Zahnmedizinische Verwaltungsassistentin (ZMV): who have completed a minimum of 350 hours training. Their duties include support in organisation, filing and training of dental assistants.

5. Dental care

- There is a long-established statutory health insurance system in which health care depends on membership of a “sick fund”.
- Sick funds are state-approved health insurance organisations, and there are currently 146 in the country and 85.7 per cent of the population belong to them.
- General dental practitioners in private practice provide almost all oral health care in Germany.
- The Sick funds entitle all adults and children to receive care from the statutory health insurance system. For radiographic investigation, examinations, diagnoses, fillings, inlays, oral surgery, preventive treatments, periodontology and endodontics, the sick funds pay 100 per cent of the cost of the care. The cost of advanced treatment such as crowns and bridges and implants, are reimbursed via a system of fixed grants up to 50 per cent of the cost and orthodontics for children 80 per cent.
- Children and spouses are covered without making any contributory payments. The unemployed make only a small contribution.
- Before seeking general care from the state oral health system a patient must have an ehealth-card from a sick fund. This voucher is both a certificate to demonstrate entitlement to care, and to access a doctor or dentist's practice.
- Since January 2004, for each dental visit per quarter, adult patients must pay a 10 Euros “practice fee”, which the dentist has to transfer to the legal sick funds.
- Fees are not standardised nationally. Negotiations between the national association for dental care (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.
- 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.
- Preventive programmes for groups of children started in 1989 and have become nationwide within the Social Security Code. At the same time, private dentists started their own programme in which they developed a preventive programme for local kindergartens and schools.
- Less than 2 per cent of all dentists in private practice treat only patients with private insurance, they have no contract with the statutory sickness funds.
### Quality assurance mechanisms

- In Germany there is an ethical obligation to participate in continuing education (CE). The costs for participation in CE courses are tax deductible as a practice expense.
- Since January 2004, compulsory CE and regular monitoring in the form of recertification has to be completed every five years.
- A dentist must undergo regular five-yearly mandatory continuing training in ionising radiation protection.
- If a patient complains about treatment, both the Dental Chamber and the KZV have grievance committees.
- If they judge that the original care was unsatisfactory then the work must be repeated at no extra charge to the patient. Under both grievance procedures a dentist has a right of appeal to the grievance committee.
- For serious complaints about malpractice the dental chambers have boards of arbitration. There are also the civil courts. The sanctions from a civil court may be: an oral or written rebuke or admonition, administrative fine (up to 50,000 Euros), or temporary or permanent withdrawal of the license to practice.

### Key Points to Consider When Inducting or Supporting a Dentist Qualified in Germany

**Dentists qualified in Germany:**

- May have limited experience of working in a publicly funded health service;
- May have considerable experience of working in a multi practitioner environment;
- May not appreciate that Hepatitis B vaccination is compulsory in the UK;
- Are very unlikely to have experience of working with a dental hygienist but may have considerable experience of working with a wide range of dental care professionals;
- Will have no experience of working with a dental therapist, or a clinical dental technician in Germany.
Country: Greece
Population: 11,329,600 (2011)
Number of registered dentists: 13,919 (2011)
Number of active dentists: 12,574 (2012)
Qualified overseas: 2,051 (2008)

Number of dentists registered in the UK in 2007: 419
in 2008: 449
in 2009: 466
in 2010: 509
in 2011: 579

Background

There are thirteen regions but no regional governments, and many services were provided locally through fifty four prefectures, each managed by a public health department (5). In January 2011, the prefectures were abolished and reformed into 76 peripheral units (27).

In 2012, 48 per cent of Greek dentists were aged over 50 years and only 1 per cent were under the age of 30 years. 47 per cent of dentists were female. The workforce grew until 2008, when there were 14,260 dentists but has declined slightly to 13,919 in December 2011 (27) and to 12,574 in March 2012, approximately 6 per cent of dentists were unemployed (5).

Oral healthcare in Greece is almost entirely delivered by private practitioners, with patients paying the full cost of treatment themselves. 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 Social Security Organisation which manage outpatient departments in many urban areas, providing dental care to insured people of all ages (5).

National Health Service (NHS) health centres mainly provide annual consultations, preventive and other simple restorative treatment to children under the age of 18. The Social Security pays 75 per cent of the dental care for children up to 16 years of age – the parents are required to pay the balance (5).

The Government is responsible for the payment of fees, the quantity and quality of work and, in association with the Hellenic Dental Association, (HDA) ethical behaviour. The quality of work carried out within the Social Security Schemes, is monitored by dentists employed part-time by the Schemes (5).

Professional liability insurance is not compulsory for dentists. Apart from requiring the standard “CE” tag, radiological equipment does not require any other specific notification (5).

For dentists practicing within the National Health Service, continuing education is mandatory. However, since there is no structured continuing education programme available, there are no sanctions connected with non-compliance (5). The HAD proposed a compulsory CPE scheme for all dentists. This was implemented in February 2012. All dentists (both those working in the public and the private sectors now have to provide evidence of 150 hours CPE in a five year cycle to renew their practicing licence.

There are two dental schools, both publicly funded and part of the main University. There is no regulated post-qualification vocational
training, nor a foundation training programme in Greece.

All regional Societies are automatically members of the Hellenic Dental Association (HDA). Dentists pay an annual fee, in order to be registered with the competent Regional Societies (5).

### Summary of relevant points

<table>
<thead>
<tr>
<th>1. Regulatory Mechanisms</th>
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<tbody>
<tr>
<td>• Until March 2012, in order to practice in Greece, a dentist required a recognised diploma, and a licence to practice from the Competent Authority (the Prefecture). Since April 2012, the licence is issued by the Regional Dental Society and dentists must be registered with one of the 52 competent Regional Dental Societies.</td>
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<tr>
<td>• Dentists in Greece must work within an ethical code which defines the relationships and behaviour between dentists, and also advertising. The ethical code is implemented by the Regional Dental Associations and the HDA.</td>
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<tr>
<td>• Vaccination against hepatitis B is not compulsory for dental workers. However, since 1995, all faculty members and all undergraduate level students at the University of Athens, School of Dentistry have been vaccinated against hepatitis B.</td>
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<tr>
<td>• Liability insurance is not compulsory for dentists. However, professional indemnity insurance is available from private general insurance companies.</td>
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<tr>
<td>• Both the EU and the National Radiological Protection Board Guideline Notes for Dental Practitioners have been adopted.</td>
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<td>• Amalgam separators are a mandatory requirement.</td>
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<td>• Dentists are allowed to form corporate bodies (companies) under a Presidential Decree of 2001.</td>
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<th>2. Education and Training</th>
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<tr>
<td>• There are two dental schools, both publicly funded and part of the two main Universities.</td>
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<tr>
<td>• In 2011 - 2012, their intake was 236 students.</td>
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<td>• For those graduates who apply for enrolment in a postgraduate programme, in a clinical dental specialty, a two year period of clinical experience after graduation is required for acceptance into the programme. There is no Foundation Training programme.</td>
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<tr>
<td>• There are two recognised specialties (orthodontics and oral and maxillo facial surgery).</td>
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<tr>
<td>• In addition to the recognised specialists, there are a considerable number of specialists who are working in private practice, or at a University in the common specialisations in dentistry (5).</td>
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<th>3. Support Systems</th>
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<tr>
<td>• There is a single national association, the HDA, to which all dentists must belong through their registration with the Regional Dental Society.</td>
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<th>4. The Dental Team</th>
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<td>• The only dental care professionals are dental technicians and a limited number of chair-side assistants</td>
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</table>
| • Training as a dental technician involves a three year programme in a Technical Professional Institute or
| 5. Dental care delivery | The NHS provides free healthcare to all. NHS health centres mainly deliver preventive and other simple restorative treatment to children under the age of 18. The Social Security funds 75 per cent of the dental care for children up to 16 years of age – the parents are required to pay the balance. Oral healthcare in Greece is almost entirely delivered by private practitioners, with patients paying the full cost of treatment themselves. 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 Social Security Organisation (IKA), which has its own outpatient departments in many urban areas, providing dental care to insured people of all ages. NHS dentists are not allowed to practice privately, whilst IKA-employed dentists may do so. Approximately 80 per cent of dentists work in private practice (4). Dentists in private practice are self-employed, and earn their living through charging fees per item of service. Approximately 10 per cent of dentists in private practice are also part-time salaried employees of the IKA, of other social security funds or are part-time academics or military dentists. 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. Treatment is free at the point of delivery (5). Within NHS hospitals, dentists provide preventive care and emergency or full treatment, as required, to all hospitalised patients, free of charge. Adults over the age of 67 also receive social security subsidies if they are on low incomes, as well as those who have been handicapped due to accidents or birth defects (5). The social security organisation delivers primary dental care via its Dental Clinics, or its dentists working within the System directly to insured or retired adult patients, plus full and/or partial dentures. Crowns, bridges and inlays are not available (5). |
| 6. Quality assurance mechanisms | Continuing education is a mandatory requirement, but in reality is not actively monitored. NHS staff members are self-regulated for CPD and attend various seminars either at their hospital or from other seminar providers. CPD activities are organised by the HAD, universities, hospitals and dental societies in various fields and specialties. Since February 2012, there has been a requirement for 100 hours of CPD in a four year cycle in order to... |
retain a licence to practice.

- However, since there is no structured continuing education programme available, there are no sanctions connected with non-compliance.
- The National Government has ultimate responsibility for the payment of fees, the quantity and quality of work and, in association with 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.
- Serious complaints by patients are referred to the Central Disciplinary Council of the Ministry of Health and Welfare. Within the NHS there are also disciplinary councils in hospitals, and in local health centres. In addition, the disciplinary boards of each local dental association will also deal with complaints. Where complaints are not due to misunderstandings, a patient may be examined by a specialist dentist from the University.
- The ultimate sanction for either a private practitioner or an 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. Within this process, dentists have a right of appeal, to the disciplinary board of the HDA. Ultimately patients also have the right to appeal to Greek civil and criminal law (5).
Key Points to Consider When Inducting or Supporting a Dentist Qualified in Greece

Dentists qualified in Greece:

- Have limited experience of a publicly funded health service;
- Have limited experience of UK clinical governance requirements (e.g. clinical audit);
- Will not have undertaken vocational or foundation training in Greece;
- May have little experience of working within the wider team of dental care professionals;
- Are unlikely to have experience of working with a dental nurse;
- Will have no experience of working with a dental hygienist, dental therapist, an orthodontic therapist, or a clinical dental technician in Greece;
- May have no knowledge of formal training for dental nurses or dental technicians;
- May not appreciate professional indemnity is compulsory in the UK;
- May not appreciate that continuing professional education is a requirement for continuing dental registration in the UK, and is actively monitored;
- May not be vaccinated against hepatitis B;
- If recently qualified, may have experienced difficulty in finding a job in Greece.
Country : Hungary  
Population: 9,986,000 (2011)  
Number of registered dentists: 5,673 (2010)  
Number of active dentists: 4,963 (2010)  
Number qualified overseas: 664 (2010)  

Number of dentists registered in the UK in 2007: 146  
in 2008: 187  
in 2009: 202  
in 2010: 249  
in 2011: 264  

Background

The Dental Division of the Hungarian Medical Chamber reports that the workforce is decreasing in number as fewer Hungarian dentists are being trained than those retiring, or otherwise leaving full-time work as a dentist. 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 up to 2013, more than the number of Hungarian nationals who will graduate from the four Hungarian dental schools (5). In 2011, male dentists accounted for 43 per cent of the total and females 57 per cent (5).

It has been concluded that there was relatively little movement of dentists into and out of Hungary during the period between 1970 and 2005 (13). Migration of dentists into Hungary appears to have occurred for political, economic and cultural/linguistic reasons (12). However, before 2005, relatively few dentists had been motivated to leave Hungary. It appears that in spite of major political changes, no more than 85 dentists emigrated from Hungary between 1989 and 2005 (12). More recently, a number of Hungarian dentists have come to the UK (28).

The number of dentists registered in 2010 was 5,673, and the number in active practice was 4,963.

There are specific regulations defining radiation protection. Radiographic equipment must be registered by the Department of Public Health Service, and is checked regularly (5).

No vocational, nor foundation training programmes currently exists. Prior to 2010, the government provided financial support for a limited number of dentists who were undergoing specialist training. This has now ceased and specialist trainees have to pay their own tuition fees during their specialist training which lasts for three years for all specialties other than oral and maxillo-facial surgery. Although maxilla-facial trainees start with a medical degree, they are required to attend special dental theoretical, pre-clinical and clinical courses, which form a significant part of their postgraduate training.

Summary of relevant points

1. Regulatory Mechanisms
   - Hungarian dentists are required to register with the Ministry of Health in order to practice dentistry. The annual registration fee is 5000Ft (19 Euros).
   - The ethical code in Hungary is enforced by both local and national ethical committees. This is a joint system with the medical profession, but the ethical committee always includes two dental members.
Dentists, and those who work for them, must be vaccinated against hepatitis B. The employer usually pays for vaccination of the dental staff.

Indemnity insurance is compulsory for all dentists in Hungary and there are many insurance companies which offer this service.

Dentists are allowed to form corporate bodies (companies). A non-clinician can 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.

There are specific regulations defining radiation protection. Radiation equipment must be registered by the Department of Public Health Service, and is checked regularly by them.

Amalgam separators are not mandatory in older dental units, but are a legal requirement in all new units. By 2008, approximately 50 per cent of practices were appropriately equipped with amalgam separators.

2. Education and Training

There are four dental schools, all state funded. The largest of the four dental schools is at the Semmelweis University in Budapest. The other three schools are at Szeged, Debrecen and Pecs. The Ministry of Health determines the number of publicly funded places annually. There are a number of dental students from other countries. There are over 650 dental students at the Budapest school with about a third from EU and non-EU countries – Greece, Cyprus, Israel, USA, Sweden, Canada, Ireland, China and countries in the Middle East. Most are taught predominantly in English, but there is one course taught in German.

Since 2004, the Hungarian Doctor of Dental Medicine (DDM) degree has provided full competence and the right to practice dentistry independently on qualification. Previously, after qualification, there was a two year mandatory vocational training programme as well as a licensing examination. However, Vocational or Foundation Training programmes do not currently exist.

The recognised dental specialties which involve three years of training are: orthodontics; periodontology; paediatric dentistry; endodontics and conservative dentistry; prosthetic dentistry; oral and maxillofacial surgery (available for medical doctors only) and dento-alveolar surgery which is a new speciality, for dentists only (5).

Since 2004, a new specialty "conservative dentistry and prosthodontics" has replaced the previous "general dentistry and oral diseases" vocational training examination.

3. Support Systems

The Hungarian Medical Chamber is the national professional association with a dedicated dental division. However, membership to this body has not been mandatory since January 2007. In 2008, about 90 per cent of all Hungarian dentists were voluntarily registered.

The Hungarian Dental Association is a scientific organisation and incorporates 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.
4. The Dental Team

- There are three kinds of dental care professionals: dental hygienists, technicians and nurses.
- In 2010, there were 2,077 dental hygienists. Most dental assistants have a dental hygienist qualification, however only 600 are actively practicing as a hygienist. To become a qualified dental hygienist, it is necessary to undertake training in a school specifically delivering a dental hygienist training programme for one year, following two years of training as a dental assistant. They are required to work under the supervision of a dentist and their duties include scaling and polishing, the placement of preventive sealants and delivering oral health education. Currently, registration is not a requirement, but this is planned for the future.
- The training for dental technicians is three years in duration; theoretical training is undertaken at school, and practical training at appointed laboratories. They are responsible for constructing prostheses according to a dentist’s treatment plan.
- In 2010, there were 4,307 dental nurses (28). 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 fewer centres.
- It is compulsory for a dentist to work with a dental nurse (chairside assistant).
- It is presumed that there are illegal denturists in Hungary because of the complaints received from patients (5).

5. Dental care delivery

- In 1993 a National Health Insurance Fund (NHIF) was introduced which is based on compulsory payroll contributions from employers (75 per cent), and employees (25 per cent). Almost all Hungarians are members of a public healthcare scheme. Dental services are provided through the NHIF, or by private dentists (5).
- Almost all Hungarians have insurance and are members of a public healthcare scheme (9). The National Health Insurance Company provides oral health care for most of the population. All employees and employers are obliged to pay into this insurance company. The NHIF is financed by compulsory contributors. Employers contribute 75 per cent, while the employee contributes the remaining 25 per cent. Complementary schemes and voluntary funds also exist and 70 per cent of their total expenditure is spent on dental treatment.
- Dental treatment is free for children and young adults between 0-18 years, and those over 60, but these patients must pay full laboratory costs (5). Expectant mothers, nursing mothers (168 days following the birth of a child), military personnel, pensioners and people with work related illnesses also receive free care (9).
- For dentists with a contract with the NHIF, the prices are regulated; the Insurance Fund establishes the minimum cost of each treatment intervention. For procedures not financed by the Fund, e.g.: crown and bridge work, the dentists’ fees are matter of a negotiation between patient and dentist. There is no centralised control on dental and laboratory fees.
- A dentist would typically have up to 2,100 regular patients on his/her “list”.
- In a few towns there are dental clinics which are owned by the local government. Dentists may work in these clinics and participate in the NHI system on the same terms as private dentists, although they are salaried employees of the clinic. Patients may receive fillings, surgery and endodontics within the NHI, but will have to make co-payments for prosthetic appliances.
- Prevention programmes are generally poorly developed (5).
- There are only 160,000 people who have private health insurance in Hungary (2008), with one of the 42 private insurance companies (just 9 private insurance companies have more than 5,000 members) – so they have little significance in the dental health care system.
- About 40 per cent of dentists work wholly privately, outside the state system (2008). Patients pay their dentist directly, under an item of treatment system. There is no regulation of private fees. Of the 70 per cent 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.
- Domiciliary care is not formally provided in Hungary, although some private dentists may provide it (5).

### 6. Quality assurance mechanisms

- Continuing professional education is mandatory in Hungary. The system is managed principally by the Dental Division of the Hungarian Medical Chamber. There is a scoring system, with accredited continuing education courses. A dentist must achieve 250 points in five years. This represents 250 hours, and a limited amount of reading can be included. The ultimate sanction for non compliance is suspension from practice. Radiation protection training is mandatory for both undergraduate dentists and for practicing dentists possessing X-Ray equipment. The licensing course must be retaken in each five year period.
- There is a compulsory internal quality assurance system for those dental care providers who are contracted with the National Health Insurance Company.
- Quality Assurance in public clinics is undertaken by the heads of the respective clinics, (5).
- 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 civil courts. Ethical complaints are judged by the Ethics Committee of the Medical Chamber.
- Only the Hungarian Ethical Court may withdraw the license to practice for a practitioner.
- There are authorised regional legal representatives for patients, who help with obtaining remedial actions on their behalf. 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.
### Key Points to Consider When Inducting or Supporting a Dentist Qualified in Hungary

**Dentists qualified in Hungary:**

- Have limited experience of a publicly funded health service, unless they qualified before 1990;
- Have limited experience of UK monitoring procedures (e.g. NHS dental services) or UK requirements for clinical governance (e.g. clinical audit);
- Will not have undertaken vocational or foundation training in Hungary, unless they qualified before 2003;
- May have little experience of working within the wider team of dental care professionals;
- May have limited experience in working with a dental hygienist;
- Will have no experience of working with a dental therapist, a clinical dental technician nor an orthodontic therapist in Hungary.
Country: Ireland

Population: 4,480,200 (2011)
Number of registered dentists: 2,646 (2011)
Number of active dentists: 1,990 (2008)
Qualified overseas: 683 (2011)

Number of dentists registered in the UK in 2007: 661
in 2008: 652
in 2009: 625
in 2010: 684
in 2011: 721

Background

The total number of dentists registered in 2011 was 2,646, and 41 per cent were female (5).

General healthcare is administered largely by the Health Service Executive (HSE). Health sector reform plans envisage the replacement of the HSE over the next two years by smaller regional or functional units with the Department of Health taking a more direct role in the planning of service. A significant proportion of healthcare is privately funded, and the private sector is subsidised through tax allowances for health insurance premiums. Dental health care for almost all adults is provided mainly by general dental practitioners. There is also a public dental service for children up to the age of sixteen; patients who cannot afford private dentistry; patients with special needs and/or patients with restricted access to dental services (5). The public dental service is organized at local level in 17 administrative areas of the HSE, each of which is managed by a Principal Dental Surgeon (PDS). In 2012, a national dental office was established under the direction of a dentist (National Clinical Oral Health Lead), who will advise the Department of Health and will effectively take over the role of a Chief Dental Officer for Ireland.

For treatments funded by the State, the standard of dental care is mainly monitored by the funding body. A Dental Inspectorate has been established in 2012 as part of the dental services reform and will be largely responsible for quality assurance of all publicly funded dental schemes. The quality of dentistry in the public dental service is assured through dentists working under the direction of the PDS, working with the Inspectorate. Complaints regarding publicly funded schemes are currently made via the HSE complaints officers or the local PDS. Complaints regarding private dentists can be made to the Irish Dental Council.

Vaccination against hepatitis B is highly recommended for general dental practitioners and is required for those who work in a hospital (5).

All dentists must acquire a license from the RPII (Radiological Protection Institute of Ireland) in order to take radiographs on their premises (5).

Continuing education specifically related to ionising radiation is not a compulsory requirement (5).

There is no mandatory post-qualification vocational training scheme in Ireland. However, a voluntary scheme has been in operation for some years. No Foundation Training Programme currently exists (5).
The principal regulating body is the Irish Dental Council (IDC). Ultimately, the IDC also has a statutory responsibility to promote high standards of professional education and to ensure high standards of professional conduct and ethics amongst dentists (5).

There are registers for dentists, dental hygienists, clinical dental technicians and a voluntary list for dental nurses. There is no register for dental technicians.

### Summary of relevant points

#### 1. Regulatory Mechanisms
- The principal regulating body is the Irish Dental Council, and the following must register:
  - Graduates in dentistry from a university in Ireland
  - Nationals of EEA Member States graduated within the EEA with a dental degree/diploma.
  - Nationals of EEA Member States who qualify for registration under the provisions of the Directive 2001/19/EC
- Ultimately, the IDC has a statutory responsibility to promote high standards of professional education and to ensure high standards of professional conduct and ethics amongst dentists.
- All dentists in Ireland are required to work under a code of professional behaviour and dental ethics, as stipulated by the Dental Council of Ireland. The code defines relationships and behaviour between dentists, contracts with patients, consent and confidentiality, continuing professional development, advertising and the quality of treatment delivered. This includes a duty to provide emergency care for patients outside of normal surgery hours
- Vaccination against hepatitis B is strongly recommended for general dental practitioners and hospital dentists, but is not a legal requirement (5).
- Liability insurance is provided for HSE public dental surgeons and is compulsory for general dental practitioners participating in either the Department of Social and Family Affairs or the Department of Health and Children Schemes. It is not compulsory for other dentists, but strongly recommended.
- Corporate Bodies are precluded by law from engaging in the practice of dentistry.
- The use of amalgam separators is not mandatory.

#### 2. Education and Training
- There are two public Dental Schools in Ireland.
- There is no mandatory post-qualification vocational training but a 12 month voluntary scheme has been in operation for some years. No system for foundation training exists.
- There are two dental specialties in Ireland: oral surgery and orthodontics (5). Other dental specialties such as paediatric dentistry, periodontology and endodontics, are not formally recognised. However, where practitioners have undertaken further training in these specialties, they can limit their practices to these specialities.

#### 3. Support Systems
- Professional representation is via the Irish Dental Union and the IMPACT trade union for public employees.
4. The Dental Team

- There is no register for dental technicians. Training is consists of a four year apprenticeship programme, or a three year course at the Dublin Dental Hospital/Trinity College, leading to a Diploma in Dental Technology. All work must be undertaken under the prescription of a dentist.
- Dental Hygienists may only practice under the prescription of a dentist, where the dentist will have prescribed the treatment plan and will be responsible for treatment. There are two hygienist education programmes, each of two year’s duration, which both lead to a Diploma. A BA degree programme adapted to European Credit Transfer System (ECTS) is pending.
- Dental nurses undergo formal training in one of the dental schools after leaving secondary school with a Leaving Certificate. They obtain a recognised qualification. Others are trained ‘on the job’, and may or may obtain a formal qualification through night school.
- Qualified dental nurses and hygienists can train to provide radiography services but there is no validation of this training. Dental nurses who have registered with the Dental Council can take radiographs as long as they have attended a course which has been approved by the Dental Council.
- Clinical Dental Technicians have been legal in Ireland since 2009.
- Dental therapists and orthodontic therapists are not yet recognized.

5. Dental care delivery

- Dental health care for almost all adults is provided mainly by general dental practitioners, who are mostly self-employed and earn their living partly through fees from patients, and partly from government subsidised treatment schemes.
- For general dental practitioners, care is mostly charged on a fee per item basis, but there are two ways in which patients are eligible for state subsidised treatment and the total cost of treatment is calculated differently under each. These are (5):
  - **Department of Social and Family Affairs Dental Treatment Benefit Scheme (DTBS)**
    Insured employees and their spouses may receive wholly or partly subsidised dental care for a limited range of treatments.
  - **Department of Health and Children Dental Treatment Services Scheme (DTSS)**
    The service is for those over 16 yrs of age who have “low income”, including those over 70 years of age. Patients are referred to as Medical Card Holders (MCH). It is essentially a basic oral health care system which covers examination, scaling, fillings, extractions and root treatments, periodontal and removable prosthetic treatment. The service is provided free of charge.
- The public dental service is operated by the HSE, and is known as the Health Board Dental Service (HBDS) (14). Public dental surgeons (HSE employees) are responsible for providing treatment to children under 16 years of age (pre-school and primary school children, but also to others who are institutionalised, medically compromised or otherwise limited in their ability to access a general dental practitioner), adult medical card holders and patients with special needs (5).
- There are very few private insurance schemes to cover dental care costs. A limited number of dental procedures are covered by private health insurance, related mostly to in-patient oral surgery.
6. Quality assurance mechanisms

- CPD is not mandatory
- There is an extensive system for the delivery of continuing education, through courses provided by the Postgraduate Medical and Dental Board, the Dental Schools, the Royal College of Surgeons, the Irish Dental Association, and various societies.
- Following graduation, no further training or continuing education in ionising radiation is legally required for dentists.
- Any person can apply to the Dental Council for an inquiry into the fitness of a registered dentist to practice dentistry on the grounds of:
  - Alleged professional misconduct
  - Alleged unfitness to practice because of physical or mental disability
- For treatments where some or all of the cost is shared with the state, the standard of dental care is mainly monitored by the funding body.
- The quality of dentistry in the public dental service is assured through dentists working within teams which are led by experienced senior dentists. The complaints procedures are the same as those for dentists working in other situations. In addition, Health Boards have their own complaints handling procedures (4). For Private dentistry, not covered under either of the State Schemes, the only other control on the quality of care is through patient complaints. In the first instances complaints are normally addressed to the dentist directly. A complaint may be made to the Irish Dental Council. If the complaint or misunderstanding cannot be resolve, it might become necessary to instigate civil litigation.
### Key Points to Consider When Inducting or Supporting a Dentist Qualified in Ireland

**Dentists qualified in Ireland:**

- May have limited experience of UK clinical governance requirements (e.g. clinical audit);
- May not have undertaken vocational training in Ireland;
- Will not have undertaken foundation training in Ireland;
- May have little experience of working within the wider team of dental care professionals;
- Will have no experience of working with a dental therapist, or an orthodontic therapist, in Ireland;
- May not appreciate that professional indemnity is compulsory in the UK;
- May not appreciate that amalgam separators are mandatory in the UK;
- May not be vaccinated against hepatitis B.
Country: Italy

<table>
<thead>
<tr>
<th></th>
<th>Country: Italy</th>
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<tbody>
<tr>
<td>Population: 60,626,400 (2011)</td>
<td></td>
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<tr>
<td>Number of registered dentists: 58,065 (2011)</td>
<td></td>
</tr>
<tr>
<td>Number of dentists in active practice: 48,000 (2007)</td>
<td></td>
</tr>
<tr>
<td>Number qualified overseas: 1,172 (2011)</td>
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</tbody>
</table>

**Background**

The number of dentists registered in 2011 was 58,065 and 27 per cent were female. There is reported unemployment amongst dentists in Italy, especially in Southern Italy due to a supply-demand imbalance (5).

In principal, until 2009, a comprehensive oral healthcare system existed within the National Health Service (NHS). Implants are the only treatment interventions that are not formally included within the NHS. However, in reality, the dental services provided will vary according to local health priorities, and there are thus significant differences within and between regions. In many areas, only emergency dental treatment is provided. Thus, in reality, publicly provided dental treatment comprises principally of extractions and, sometimes, restorations. It is due to this under-provision of treatment that dentistry is considered a private sector service. However, in the last few years, there has been evidence of an increase in the provision of public dental services, in the form of new models for delivery, and of joint public/private financing especially in Lombardia, Piemonte, Veneto, Emilia and Romagna (5). The government is also looking to prioritise vulnerable groups, including the socio-economically disadvantaged members of the population, the elderly with systemic diseases and high-risk children. Regional insurance schemes are also being planned. These will cover any additional dental care not delivered by the public dental services (16).

There is no formalised direct monitoring of the quality of care in either the public or private sector, other than by patient complaints. However, both public and private practices are “regulated” by District Health Service Inspectors. Vaccination against hepatitis B is not mandatory, but it is expected. Radiation protection is regulated by law. The competent person is always the dentist (5).

In 2002, continuing dental education (CPE became a mandatory requirement. Continuing education and training in radiation protection must be undertaken every 5 years (5).

Since September 2009, the dental degree has increased in length to six years, and ends with the award of a Masters degree.

**Glossary of Terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Stomatology</td>
<td>A medical specialty that relates to the mouth and its diseases, originally practiced by medical doctors. Historically it was a medical specialty.</td>
</tr>
</tbody>
</table>
## Summary of relevant points

### 1. Regulatory Mechanisms
- In order to register as a dentist in Italy, an applicant requires a degree or a diploma in dentistry recognised by the Ministry of Health (Foreign Affairs) and must be a citizen from an EU or other appropriate country.
- The registration list is held by the Federazione Ordini dei Medici Chirurghi e degli Odontoiatri - the competent authority for dentistry (5). Registration is annual, and the fee varies as it is dictated by each provincial branch medical/dental board.
- This national body manages the registration and ethics of all dental practitioners (5).
- Professional liability insurance is not compulsory for dentists, but insurance is generally provided by private general insurance companies, or the dentists themselves.
- Dentists can legally incorporate and form companies where the only partners are dentists. Non-dentists can be members of these professional companies, but clinical matters must be the responsibility of a Dental Director.
- Clinical waste is stored for a month at the practice before being disposed of by a sanitary waste company. Spent X-ray chemicals and amalgam are generally disposed of once a year. Amalgam separators are not compulsory by law.

### 2. Education and Training
- In 2008, there were 34 dental schools, with an annual intake of 800 students.
- The primary degrees included in the register are:
  - University degree in dentistry and dental prosthesis with a degree to practice dentistry and dental prosthesis.
  - or (until January 1984) University degree in medicine and surgery accompanied by specialisation in the dental sector with a degree to practice medicine and surgery.
- From January 2003, only a university degree in dentistry is required to register as a dentist.
- There is no post qualification vocational training in Italy, nor a foundation training programme.
- In Italy two specialties, orthodontics and oral surgery, are formally recognised currently. In the future, paediatric dentistry and general dentistry may also be added to this list (5).

### 3. Support Systems
- There are two main national dental associations, the Associazione Nazionale Dentisti Italiani (ANDI) and the Associazione Italiana Odontoiatri (AIO). Both associations represent the full range of dental professionals: private practitioners, state-employed dentists, university teachers and dental specialists.

### 4. The Dental Team
- Chair-side assistants are generally trained by their employer. However, a training and education programme exists, and in some regions a certificate of completion is issued (5).
- A formalised education pathway exists for dental hygienists and technicians.
- Since 2003, there has been an increase in opportunities for dental hygienists to practice, without direct supervision by a dentist. Their duty of responsibility (defined by Decree in 1999) includes oral hygiene instruction, scaling and dietary advice, but not the administration of local anaesthesia. Dental hygienists
can work autonomously, but must work to the prescription of a dentist

| 5. Dental care delivery | • In 2008, the range of dental services delivered within the National Health Service was redefined to include (5):
  ➢ Dental health care programmes specifically for those between the age of 0-14 years
  ➢ Dental and prosthetic care to specific “vulnerable patients.”
  • For the general population, including those who are not defined as protected groups, the following treatment is guaranteed (5):
  ➢ Dental examinations following diagnosis of neoplastic pathologies of the oral cavity.
  ➢ Immediate treatment of dental emergencies - treatment of severe infection, bleeding, pain, and pulpotomy
  • Access to private dentistry is not a problem but access to the public dental sector is limited, with under-provision of services (even when the treatment is guaranteed) or waiting lists.
  • The Public Dental Service exists in most regions as the only alternative to private practice. It thus provides the only government funded primary care service. In theory, all members of society are eligible to attend the service, but in reality it is largely the lower and middle class, who cannot afford private care, who will use this service. The Public Dental Services are organised and delivered by local health authorities and vary greatly throughout the country. Publicly provided dental treatment comprises mainly of extractions and, on occasion, restorations. Emergency treatment of oro-facial trauma is also delivered. In most regions, orthodontic or prosthetic treatment is not normally covered by the public system. It is due to this under provision of service that dentistry is considered a private sector service
  • There are a few private healthcare insurance plans available, but they generally exclude routine dental care. Most, however, include hospital-based oral surgery on an “item of care basis”. There are no private dental care plans.

| 6. Quality assurance mechanisms | • There is no formalised direct monitoring in either the public or private sector, other than by patient complaints. However, both public and private practices are “regulated” by District Health Service (ASL) Inspectors.
  • In private practice complaints are directed to the appropriate ethical committee, but in the Public Service they are first investigated by a clinical officer who theoretically has the power to suspend or dismiss the dentist concerned.
  • Each ethical body exercises disciplinary powers and patients are able to complain directly to them about the care that they have received. Both the patient and the dentist can be legally represented during any hearings. This system is applicable in both the private and public sector.
  • Continuing professional development for dentists has been mandatory since 2002. The Italian Ministry of Health stipulates that dentists must undertake 150 units of CPE within a three-year period (2008-10), including a minimum of 30, and a maximum of 70 units each year. Continuing education and training in radiation protection must be undertaken every five years (5).
### Key Points to Consider When Inducting or Supporting a Dentist Qualified in Italy

**Dentists qualified in Italy:**

- Have limited experience of a publicly funded health service;
- Have limited experience of UK monitoring procedures (e.g. NHS dental services) or UK requirements for clinical governance (e.g. clinical audit);
- Will not have undertaken vocational or foundation training in Italy;
- May have little experience of working within the wider team of dental care professionals;
- Will have no experience of working with a dental therapist, an orthodontic therapist, or a clinical dental technician in Italy;
- May not appreciate professional indemnity is compulsory in the UK;
- May not be vaccinated against hepatitis B;
- May not appreciate that amalgam separators are mandatory in the UK.
- In some dental schools may have treated very few patients in person before qualifying.
In 2012, there were 3,773 registered dentists, some 83 per cent of whom were female. About 20 per cent of the dentists work in the public service and about 80 per cent in private practices, (17). The active dental workforce is stable but increasing slowly. There is no reported unemployment among dentists. Approximately 200 dentists asked for a “Certificate of Good Standing” to work abroad through the years from 2004 to the end of 2006, but there is no a reliable source of information of how many of them have left Lithuania (5).

The system of the State Social Insurance in Lithuania covers nearly all residents. It is based on the principle of solidarity. Some patients (children, the elderly and the disabled) may receive some or their entire oral healthcare free. Adults must pay for part or for all of the costs of their treatment, (5).

Oral health care expenses may be reimbursed from state or municipal and mandatory health insurance funds, supplemented by health insurance funds and contributions from patients. Only essential oral health care services are provided free of charge. The Ministry of Health sets the fees for the services provided by state, district and municipal institutions. Private fees are set by dentists themselves. Adult dental care in public dental service is partly funded by reimbursement from public insurance and partly paid for by the patient. Private oral health care must be covered in full by the patient (17). The Mandatory Health Insurance fund covers a fixed amount of money for prostheses for the retired and disabled.

The membership to the Chamber (Dental Association) is mandatory for all dental care professionals.

There is a well developed use of specialists for advanced dental care. Continuing education for dentists and dental auxiliaries is mandatory. Dental auxiliaries (dental care professionals) are considered vital in the dental practice.

**Summary of relevant points**

<table>
<thead>
<tr>
<th>1. Regulatory Mechanisms</th>
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<tbody>
<tr>
<td>• Dentistry in Lithuania has special laws: “Law on Dental Practice” and the “Law on the Dental Chamber”. Dental care is also regulated by laws approved by the Minister of Health and the Lithuanian Dental Chamber.</td>
</tr>
<tr>
<td>• The Licensing Committee at the Lithuanian Dental Chamber is the official unit, responsible for organising and giving licences to all dentists and dental specialists.</td>
</tr>
<tr>
<td>• To establish a new private dental practice, dentists have to gain approval from the local state authorities</td>
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</table>
and a licence from the health authorities. It has to be insured by a health insurance company.

- All dental workers must undergo a medical examination annually. The dental workforce is recommended to be vaccinated against Hepatitis B and to be checked regularly for sero-conversion.
- Infection control is regulated by law. Non-compliance leads to sanctions.
- Liability insurance is compulsory for dentists and dental hygienists. The insurance does not cover dentists working outside Lithuania.
- There is a requirement to have a licence to use radiation equipment and it is mandatory that every five years dentists attend eight hours of courses on ionising radiation.
- Amalgam separators are not mandatory. The use of amalgam is not popular with patients or dentists.
- Anyone can own a dental practice but the person responsible for the organisation of the clinical treatment must be a dentist.

<table>
<thead>
<tr>
<th>2. Education and Training</th>
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<tr>
<td>- There are no entrance examinations to the dental school, students are selected according to the grades of the secondary education final examinations, and annual marks averages</td>
</tr>
<tr>
<td>- The undergraduate training programme lasts for five years. Teaching languages are English and Lithuanian.</td>
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<tr>
<td>- Vocational training for dentists is now included in the five year undergraduate curriculum</td>
</tr>
<tr>
<td>- After vocational training, dentists are granted a licence to practice independently.</td>
</tr>
<tr>
<td>- There are six recognised specialties: endodontics, orthodontics, paediatric dentistry, periodontics, prosthodontics, oral surgery. Training for all of them lasts for three years with the exception of oral maxillofacial surgery which lasts for five years after six years of general medicine.</td>
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<th>3. Support Systems</th>
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<tr>
<td>- The Dental Chamber (association) is in charge of the implementation of self government of dentists. It coordinates their activities, pursues the strategic tasks of dental care within the healthcare system, manages the development of dental activities such as education of patients, professional training of dentists and medical culture, and organises drafts of legal acts relating to the activities of dentists, dentists specialists and dental care professionals to be presented to the Ministry of Health.</td>
</tr>
<tr>
<td>- Membership of the Lithuanian Dental Chamber is compulsory.</td>
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<tr>
<th>4. The Dental Team</th>
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<tbody>
<tr>
<td>- Dental nurses, dental technicians and dental hygienists are known as oral health care specialists. They must be registered with the Lithuanian Dental Chamber and have licences to practice and also need to undertake continuing education.</td>
</tr>
<tr>
<td>- Dental hygienists are trained in two colleges for three years and in Kaunas University of Medicine for four years. Graduates of Kaunas University of Medicine receive a bachelor degree and the qualification of dental hygienist.</td>
</tr>
<tr>
<td>- Dental hygienists can practice as employee, employer or freelancer. They may accept payments from patients. They have competence to diagnose and to plan treatment for patients (under prescription of a dentist) and their duties include scaling, cleaning and polishing, whitening, removal of excess filling</td>
</tr>
</tbody>
</table>
material, local application of fluoride agents, application of preventive sealants and oral health education. They may give local anaesthetics.

- Dental technicians train for three years. Technicians normally work in commercial laboratories, only a few are employees of dentists or dental practices. They have legal responsibility for their work but do not accept payments from patients.
- Dental nurses train for three years in a College specifically for dental assistants. Courses on infection control and emergency care are obligatory. In addition to assisting dentists, they are permitted to undertake oral health education.

5. Dental care Delivery
- The national health insurance system scheme offers reimbursement of the cost of some dental treatment. Only essential dental care services are provided free of charge.
- About 13 per cent of dentists work part-time in public and part-time in private practice.
- Public oral health care is free of charge, for children and teenagers under the age of 18 years. Prosthodontic care for pensioners and the disabled is reimbursed with a fixed sum of money. For adults between 18 and 65, dental care in the public dental service is partly financed by the fund and partially (to cover dental materials) by copayments from patients.
- The Ministry of Health establishes the cost of dental care services provided by state, district and municipal institutions.
- Dentists who work in hospitals are salaried employees. Hospitals usually are publicly owned, and the dental services provided are oral and maxillofacial surgery. These dentists will also assist in the dental education and training.
- Dentists can work as full-time or part-time employees of universities. Their salary range is 700 to 1200 Euros per month.
- Combinations of part-time teaching and private practice is permitted by Universities.
- Private fees are set by dentist.

6. Quality assurance mechanisms
- The Lithuanian Dental Chamber coordinates the continuing education of dentists and oral care specialists.
- In order to remain registered a dentist needs to attend the courses and obtain a certain number of professional training hours: 120 hours in five years for dentists, 60 hours for dental hygienists and dental technicians and 50 hours for dental nurses (chair-side assistants).
- The quality of dental care is monitored by the Lithuanian Dental Chamber in different ways and emphasis is placed on quality improvement and assurance. Quality improvement is achieved through continuing education and the development of standards and certification.
- The State Health Care Accreditation Agency under the Ministry of Health is the institution for health care services. Its main functions are to represent and defend patients’ rights to effective, accessible and safe health care.
- The Chamber is involved with patient complaints about the quality of care.
A complaint may be made by a patient to: the health insurance company, the Dental Chamber, the State Health Care Accreditation Agency, complaints have to be initially investigated at the dental practice.

Where there is a violation of professional ethics in the dental practice, or patient safety compromised, there is a range of penalties which are normally administered by the Regional Ethical Committee of the Dental Chamber. The Dental Chamber is usually involved in the investigation of complaints.

The penalties may include a reprimand, a penalty or even the loss of the licence to practice (the dentist cannot be suspended immediately). Any serious breach of the law can be referred to court and may even result in imprisonment.

Key Points to Consider When Inducting or Supporting a Dentist Qualified in Lithuania

Dentists qualified in Lithuania:

- May have experience of working in public dental care services;
- Have limited experience of UK monitoring procedures (e.g. NHS dental services) or UK requirements for clinical governance (e.g. clinical audit);
- May have little experience of working in a multi practitioner environment;
- Will have no experience of working with a dental therapist, an orthodontic therapist, or a clinical dental technician in Lithuania;
- May not have used amalgam for fillings.
|-----------------|-------------------------------|-------------------------------------|-----------------------------------------------|-------------------------------------|

**Background**

In March 2012, the number of registered dentists in Malta was 190, with 142 in active practice. Thirty four percent of dentists were female (5).

Referrals to public clinics are made according to established guidelines. Additionally, dentistry is delivered to all school children within school dental clinics. Private medical insurance only covers specific dental procedures, such as surgical interventions (5). A specific dental insurance was launched in 2011, however, to date very few patients have taken out this insurance.

In the public sector, the quality of dental care is assured through dentists working under the direction of experienced specialists. An annual check by health inspectors ensures that all dental clinics are set up and function according to requisite regulations (5).

The EU Hazardous Waste Directive is incorporated into law and actively enforced. The use of amalgam separators is a compulsory requirement. There are specific regulations regarding radiation protection, as defined by the Public Health Act, Health and Safety regulations, the Radiation Protection body and the enabling act from the Prime Minister. Employers are required to ensure that they have undertaken adequate training, and that their staff are also provided with training (5).

There is a non-compulsory form of vocational training in existence in Malta. Upon qualification, students are strongly encouraged to join the scheme. No system for Foundation Training exists (18).

The Medical Council provides the dentist with a license to work.

**Summary of relevant points**

1. **Regulatory Mechanisms**
   - Dentists are automatically registered with the Medical Council of Malta following graduation, and the cost of registration is currently 35 Euros annually (2012). The President of Malta provides a dentist with a licence to work.
   - Dentists are subject to the same ethical code as their medical colleagues.
   - Hepatitis B vaccinations are mandatory in Malta and are provided free by the Health Department.
Professional indemnity insurance is not mandatory.
- The concept of “corporate dentistry” does not exist in Malta.
- Specific regulations exist defining radiation protection protocols, as defined by the Public Health Act, and the enabling Act of the Prime Minister, Health and safety regulations and the Radiation protection board. Continuing education and training in radiation protection is not a mandatory requirement (5).

2. Education and Training
- The primary degree, listed on the register of the Medical Council, is the Bachelor of Dental Surgery (BChD).
- There is a non-compulsory form of foundation training in existence. Thus if FT is not undertaken, a graduate dentist still has a licence to practice after completing the five-year degree.
- There are two dental specialities in Malta which are officially recognised by the member states of the European Union. Specialist training started in orthodontics in January 2010 and in Oral Surgery in 2011.

3. Support Systems
- The principal national association is the Dental Association of Malta (DAM), and approximately 80 per cent of active dentists are members.

4. The Dental Team
- The Board of Professions Supplementary to Medicine maintains the register of dental hygienists. Dental hygienists work under the prescription of a dentist, in a clinic or private practice. Their duty of care includes basic periodontal treatment and delivering oral hygiene instruction.
- A formalised four-year training pathway exists for dental technicians. Their register is managed by the Board for Professions Supplementary to Medicine.
- A two-year course for Dental Assistants was implemented in October 2007, with a total of 15 trainees. In 2012, it was estimated that 85 per cent of dentists working in private practice worked with a dental chair-side assistant (18).

5. Dental care delivery
- Dental services are provided in both the public and private sectors. The Public Primary Healthcare Service provides free and basic dental care to children and adults. The general population is entitled to examinations and preventive care, periodontal treatment, and oral surgery (with or without hospitalisation) within the public dental service, provided free of charge. In addition, the Public Healthcare Service offers emergency care on Sundays and National holidays. Children (0 - 15 years) and specific patient groups, including institutionalised patients, the Police, and Armed Forces of Malta, are eligible for free restorative care. Free orthodontic treatment is also provided to all children up to the age of 16. Other types of treatment are only offered to adults under special circumstances.
- The majority of dentistry in primary care is delivered by private practitioners. Most dentists in private practice are self-employed, and work on a fee-per-item basis. Approximately 60 per cent of private practitioners work in single-chair practices. No official fee scale exists, and pricing is unregulated in Malta.
- Although approximately 35 per cent of the population has private health insurance, it only covers a very limited range of dental treatment such as surgical interventions. To date very few patients have registered with the new dental insurance scheme (Denplan).
- The normal frequency for routine oral examinations is every six months.
6. Quality assurance mechanisms

- Continuing dental education is not mandatory in Malta, but the Dental Association of Malta, together with the Faculty of Dental Surgery, organise regular accredited lectures and courses which award continuing dental education points to participants. The Department of Primary Care organises an Annual Dental Conference. Proposals for legislation to make continuing dental education compulsory for the renewal of a licence to work as a dentist are awaited, (5). Continuing education and training in radiation protection, is not a mandatory requirement (5).

- A patient is entitled to lodge a complaint and demand compensation, before either a medical court or a common court. Maltese dentists are governed by the Health Care Professions Act which came into being on the 21st November 2003. A complaint can be lodged by anybody, including lay people with an interest in the case. In the private sector, it is the Medical Council of Malta which manages such issues.

- In the public sector, the quality of dental care is assured through dentists working under the direction of experienced specialists. The complaints procedures are the same for dentists working in other clinical settings. An annual check by health inspectors ensures that all dental clinics are set up and functioning according to requisite regulations.

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Key Points to Consider When Inducting or Supporting a Dentist Qualified in Malta

**Dentists qualified in Malta:**

- Have limited experience of UK clinical governance requirements (e.g. clinical audit);

- On graduation will have had limited experience of working in a public dental service;

- Will probably not have undertaken a formalised foundation training programme in Malta;

- May have little experience of working within the wider team of dental care professionals;

- May not appreciate professional indemnity is compulsory in the UK;

- Will have no experience of working with a dental therapist, an orthodontic therapist, or a clinical dental technician in Malta;

- May not appreciate that continuing professional education is a requirement for continued dental registration in the UK.
The Netherlands

<table>
<thead>
<tr>
<th>Population: 16,655,000 (2011)</th>
<th>Number of registered dentists: 12,654 (2011)</th>
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<tbody>
<tr>
<td>Number of active dentists: 8,827 (2011)</td>
<td>Qualified overseas: 799 (2011)</td>
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</tbody>
</table>

**Background**

The Dutch Dental Association (NMT) has reported that the active dental workforce is decreasing but in 2008 there was a balance between supply and demand. About 45 per cent of the dentists in active practice are over 50 years of age and about 6 per cent of the dental workforce qualified outside the Netherlands. There is no major movement of Dutch dentists out of the Netherlands. (5)

Health care is provided by a government-regulated system of health insurance. Patients must belong to public schemes (sick funds), or private health insurance. The public scheme is compulsory and covers all citizens. (5)

On the basis of the Public Health Care Act, those under 22 years of age have access to preventive oral health care and basic treatment (excluding crowns and bridges and orthodontic treatment) completely free of charge.

Patient complaints may be handled in various ways through an internal procedure at professional organisations, or the Dutch legal system of client complaints and the medical code. Sanctions in the latter may be a warning, a reprimand, a fine or suspension/ removal from the register.

Whilst the use of specialists is limited to orthodontics and oral maxillo-facial surgery, it is possible for dentists to undertake three year training programmes in periodontology, endodontics and paediatric dentistry and then limit their practice to the specialty.

There is a broad use of dental auxiliaries such as dental technicians, dental nurses, dental hygienist and denturists. Continuing education became mandatory in January 2012.

**Summary of relevant points**

1. **Regulatory Mechanisms**
   - The Institute for a Quality Register for Dentists is the organisation in charge of the transparency of dentists’ quality of care, and thereby contributes to patient safety. In order to be registered, dentists must meet five registration standards: unconditional registration in the BIG (the Individual Health Care Professions Act) register, observing the code of conduct and guidelines, studying professional literature (240 hours every five years), following extra training and refresher courses and consulting with colleagues and having a complaints procedure in place.
   - If a patient visits a dentist with a problem such as pain, then under Dutch law the dentist is obliged to see...
them. However, the dentist is not required to accept the patient on a regular basis. It also states that when established patients (those who receive regular care from that dentist) face financial difficulties a dentist must continue to treat them.

- Hepatitis B vaccination is mandatory for dental workers.
- Indemnity insurance is not compulsory for dentists and is provided by general insurance companies. General insurance covers damage to persons, property, capital liability and employer liability. It also covers dentists working in other European countries but only if their main activity as a dentist takes place in the Netherlands (5).
- A practice needs a permit to use radiation equipment. Intraoral radiographs can only be taken by dentists or by trained dental staff on the order of a dentist. Panoramic x-rays may be taken by hygienists who have been trained for the purpose.
- Amalgam separators have been required in practices by law since 1997.

### 2. Education and Training

- There are three dental schools in the Netherlands. The training lasts for six years.
- Dental students receive the title “Bachelor of Science” after three years, and after six years they qualify with the title “Master of Science of Dentistry (MSc).
- No post-qualification vocational training is necessary for entering into full, unsupervised practice.
- Two dental specialties are recognised: oral and maxillo facial surgery and orthodontics. However, it is possible for Dutch dentists to undertake three year training programmes in professional “differentiations” such as periodontics and then limit their practice to the area concerned. Specialists must be registered by the Specialist Registration Board ‘Specialisten-Registratiecommissie (SRC).

### 3. Support Systems

- The main national associations are the Nederlandse Maatschappij tot bevordering der Tandheelkunde (NMT) or Dutch Dental Association and the Association Netherlandse Tandarlandse (ANT). A dentist is free to become a member or not. Three quarters of dentists and dental specialists are members of the NMT.

### 4. The Dental Team

- Dental hygienists are paramedics with independent status. They form an official profession with a legally protected title are required to be qualified and have a diploma. They train in special dental hygienist schools for four years full time. Two thirds are employees in dental practices, some work in hospitals and centres for paediatric dentistry or independently from a dentist. Patients have free access to hygienists without being referred by a registered dental practitioner.
- Besides the preventive competencies dental hygienists are taught how to provide routine dental treatment e.g. take radiographics, administer local anaesthetic and place simple fillings to the prescription of a dentist.
- Dental technicians train in special schools, for two years full time or for four years part time. On completion of training they receive a diploma, but are not required to register. Most dental technicians work in dental laboratories.
- There is ‘certified training’ available for dental chair-side assistants (nurses); although there are approximately 30 training schools and a postal course, most assistants are trained by individual dentists in their dental practices.
- Because of a shortage of dental hygienists, some assistants also carry out scaling but not root planning.
- Clinical dental technicians are trained for three years part-time, after completion of training as a dental technician. They are only allowed to provide removable prosthetic appliances and may work in independent practice.

5. Dental care Delivery

- Almost all dentistry is provided by dentists working in general dental practice. About 90 per cent of the dentists working privately have a contract with a public insurance schemes.
- Dental treatment is provided under the public and private systems. From January 2012, fees are no longer legally regulated. For a trial period of the next three years, dental care providers are permitted to set their own fees. This trial is being monitored by a Government appointed body. Those under 18 years of age have access to preventive oral health care and treatment (excluding crowns, bridges and orthodontic treatment) completely free of charge. Coverage for oral health for adults over 18 years is restricted to patients with special medical conditions and patients who need full dentures. The rest of the population is encouraged to take out private health insurance to cover their oral health needs. In most cases these insurances refund up to a fixed (limited) maximum of total costs (19).
- Patients normally attend for their re-examinations about every 9 months. There is no formal system for domiciliary care.
- Apart from the extension of coverage of the public insurance scheme, to provide dental care for young people and those with special needs, there is no separate public dental service in the Netherlands.

6. Quality assurance mechanisms

- Continuing postgraduate education became compulsory for dentists in January 2012 and is now required for re-licensing.
- Quality improvement is achieved through continuing education, peer review and the development of standards and certification. The purpose of the BIG Act 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.
- A Dutch Health Inspectorate makes occasional visits to practices. Their checklist for screening dental practices covers: clinical practice, infection control, waste disposal and radiation practice.
- Patients’ complaints may be handled in various ways. Under the law patients’ complaints, regarding care provision are considered by one of five regional medical disciplinary boards. Sanctions may be a warning, a reprimand, a fine or suspension/removal from the register (5). Any appeal will be heard by a board of three lawyers (including the chairman) and two dentists. Complaints regarding financial or other consumer matters are considered by other institutions.
- 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.

### Key Points to Consider When Inducting or Supporting a Dentist Qualified in the Netherlands

Dentists qualified in the Netherlands:

- Mainly work in private practice and have a contract with the public insurance scheme;
- Will not have undertaken foundation training in the Netherlands;
- Are likely to have experience of working with a dental hygienist, who may be able to work independently and to provide routine dental treatment e.g. fillings, extractions for children or can take panoramic x-rays, this may result in confusion between the role of the dental hygienist and the dental therapist in the UK;
- Will have experience of working with a dental technician or a clinical dental technician in the Netherlands;
- May have little experience of working in a multi practitioner environment;
Country: Poland

Population: 38,200,037 (2011)
Number of registered dentists: 29,947 (2008)
Number of active dentists: 21,750 (2008)
Qualified overseas: 600 (2008)


Background

In 2008, the total number of registered dentists was 29,947 and 78 per cent were female.

In general dental practice, only the dentist or a radiographer can act as the competent person for the use of ionising radiation. Others trained in radiography can only act under the prescription of a dentist. In 2008, there were ten dental schools, and the intake was 855 students. The number of graduates was 809, and 80 per cent were female (5). In 2002, the undergraduate training curriculum was changed to bring it in line with the requirements of the EU. More clinical training was added, prior to that the curriculum contained more general medical training. After graduation each dental graduate is required to apply for a limited licence (limited right to practice the profession). In order to be awarded the (full) “right to practice the profession” a graduate must complete a post-graduate internship of 12 months (vocational training) and pass a State Dental Examination. There are seven principal dental specialties in Poland (5):

- oral surgery
- oral and maxillo-facial surgery
- orthodontics
- paediatric dentistry
- prosthodontics
- periodontology (in Poland the speciality of periodontology includes oral pathology but the official title for this specialty is periodontology)
- conservative dentistry with endodontics

In addition dentists can also specialise in:

- public health
- epidemiology

The principal regulatory body in Poland is the Polish Chamber of Physicians and Dentists, consisting of a Supreme Chamber and 24 Regional Chambers, and membership is mandatory.

Glossary of Terms

Stomatologist: The title awarded upon qualification from Dental School between 1996 and 2004, treated as equivalent with the current title.
### Summary of relevant points

1. **Regulatory Mechanisms**
   - The principal regulatory body in Poland is The Polish Chamber of Physicians and Dentists, and membership is mandatory. All dental graduates who wish to practice the profession are required to register, according to their place of residence, with the Regional Chamber of Physicians and Dentists (5). The Chamber is the competent authority, as determined by the state, and maintains the registers of dentists and of dental specialists. It also awards the right to practice dentistry (5).
   - Dentists are bound by the ethical code, which was adopted in 1993 and later amended. The sanctions against a dentist found guilty of breaching the ethical code by a Medical Court are laid down in the law on chambers of physicians and include admonishment, reprimand, fine, suspension of the licence (for up to five years) or full removal of the licence. Any appeal is made to the Supreme Medical Court (5), thereafter one may appeal to the Polish Supreme Court.
   - Vaccination against hepatitis B is not mandatory, but “recommended”. Students are vaccinated against hepatitis B at Dental School (5).
   - Dental indemnity insurance is mandatory (5).
   - In general dental practice, only a dentist can act as the competent person to utilise ionising radiation. Others trained in radiography can only act under the prescription of a dentist (5).
   - Amalgam separators are not a legal requirement (5), but they are commonly used.
   - The regulations for entry onto the dental practice list are specified by an Act, as well as by the Minister of Health. There are specific regulations governing the practice site, local epidemiological surveys, ionising radiation, sterilisation, storage and disposal of waste materials. The practice must also be registered with the Regional Chamber of Physicians and Dentists (5).

2. **Education and Training**
   - Training in ionising radiation is now part of the new undergraduate course. Previously radiography was restricted to qualified radiographers only. Courses are currently organised in the medical faculties for those who did not receive training as part of the previous undergraduate course (5).
   - The titles awarded upon qualification have been or are (5):
     - Dental doctor - until 1996
     - Stomatologist - 1996 to 2004
     - Dental doctor - since 2004

In order to be awarded the “right to practice the profession” a graduate must complete a post-graduate internship of 12 months (vocational training). Each dental graduate is required to apply for a provisional licence - “limited right to practice the profession”. This licence is awarded in order to undergo vocational training. Since October 2004, there has been an additional requirement to pass the State Dental Examination which can be undertaken during, or after the internship (5).
3. Support Systems

- The main professional organization of dentists is the Polish Chamber of Physicians and Dentists – which provides professional self-government associating the two professions – physicians and dentists. The self-government consists of the Supreme Chamber and 24 Regional Chambers. Membership is mandatory – every dental practitioner holding the right to practice the profession in Poland is by virtue of the law a member of one of the regional chambers. The main tasks of the chambers are: regulation of the profession (awarding the right to practice, supervision over professional conduct, setting the principles of professional ethics, carrying out disciplinary actions, accrediting and supervising continuing professional development and the representation and protection of the profession.
- Besides the chambers there are other professional dental organisations - scientific societies that are established for specialized dentists (eg. the Polish Orthodontic Society). The Polish Dental Society is the main scientific dental association. Membership of scientific associations is not mandatory for all dentists.
- Other registered scientific and dental specialist societies are: the Polish Society of Oral Cavity and Maxillo-Facial Surgery, and the Polish Society of Stomatological Implantology. All dental specialists, but not general dentists, must belong to an appropriate scientific specialist society (5).

4. The Dental Team

- There are three groups of auxiliary dental care professionals in Poland: dental nurses, dental hygienists and dental technicians (5).
- There are two dental hygienist training programmes, each of three years in duration (5).
- Dental hygienists’ duties include delivering preventative dental care, and oral health promotion. They are not permitted to formulate a diagnosis, nor deliver local anaesthetic, and cannot work without the physical presence of a dentist on site. They cannot accept fees from patients, except on behalf of a dentist (5).
- The training for dental technicians takes place in schools at medical schools and universities, and is two and a half or three years in duration (5).
- There are three groups of dental care professional in Poland: dental nurses, dental hygienists and dental technicians.
- Dental nurses used to be trained by the supervising dentist, nowadays there is a formalised training programme available – regulated by the Ministry of Science (a new law that has been drafted will fully regulate the auxiliary dental professions). Besides assisting the dentist at the chair side, they are not permitted to undertake other treatment (5).

5. Dental care delivery

- Dental care in Poland is delivered as part of the public health insurance system, within the National Health Fund (NHF), and also within the private sector. The delivery of NHF dental services is limited due to the Fund’s limited financial resources (20). Thus only a third of practitioners work within the state system, and the remainder work outside the NHF, within the private sector (5).
- A compulsory health insurance system exists, in which salaried employees are required to contribute 9 per cent of their salary to one of the sixteen regional funds. This contribution also ensures health care cover for family members of the insured individual. Health insurance contributions are paid by the Social Insurance
Institution for retired individuals. The unemployed and the homeless are also covered within the public health insurance system (20,9).

- Basic dental services are provided for employees and their children, as specified by the Ministry of Health. These include examinations; preventive care (oral hygiene instruction, topical fluoride application, fissure sealing); diagnostic procedures (radiographs-limited to two per patient per year, and biopsies); restorative treatment (restorations, endodontic treatment of single-rooted teeth in adults, endodontic treatment of all teeth in those aged 18 years and under); extractions; basic periodontal treatment; basic emergency treatment of dental trauma; orthodontic treatment with removable appliances; and treatment of oral mucosal lesions. Children and young people are entitled to an additional periodical examination and a broader range of services. Pregnant women, or nursing mothers (up to 42 days after childbirth) are also entitled to additional services (20, 9).

- There is currently no private, nor state additional insurance, although these may be introduced in the future (20, 9).

- For adults, any interventions not delivered within the NHF can be undertaken on a private basis, via a co-payment, subject to availability at the practice concerned (20, 9). Private fees are negotiated between a dentist, and their patient according to market value. Patients pay the full cost of treatment for specialist dental interventions (5).

6. Quality assurance mechanisms

- Continuing dental education is a mandatory requirement, and a credit-point system operates, where 200 credit points must be accrued in a four year period (5)
- Radiation protection training is followed by a test, which is repeated every five years for certification (5)
- Quality assurance of those practitioners working in single chair practices, and dentists working in multi-chair private practices is undertaken by dentists from the regional chamber, (offices of the dental association). The quality of service delivered within the NHF is monitored through NHF consultant dentists. Regular inspections are carried out in this sector, as well as those undertaken specifically following a complaint. All private practitioners are monitored by the Chamber of Physicians and Dentists (5).
- A patient is entitled to lodge a complaint, and demand compensation before a medical court or a common court (5).
- Fitness to practice and the management of disciplinary matters is governed by the Act for the Profession for Physicians and Dental Practitioners. The Medical, and Supreme Medical Courts comprise both dentists (dental doctors/stomatologists) and physicians. However, cases of poor dental practitioner performance are managed solely by dentists. Other more general problems involving a breach of 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, monitor compliance with the ethical code (5).
- Patient complaints are managed by a screener. Proceedings may be abandoned, or a case may be brought to a regional medical court. An appeal can also be made to the Supreme Screener. In addition, a complaint may be brought to the common courts by a complainant, and if an error is suspected, the case may be
Key Points to Consider When Inducting or Supporting a Dentist Qualified in Poland

Dentists who qualified in Poland:

- Prior to 1989, oral health care was almost exclusively provided with a state (public) system;
- Since 1989 an independent, private system for the delivery of oral care has developed very rapidly;
- May have limited experience of a publicly funded health service, if they qualified after 1992;
- May have little experience of working in a multi practitioner environment;
- Have limited experience of UK clinical governance requirements (e.g. clinical audit);
- Will probably have undertaken foundation training in Poland;
- May have experience of working with a dental hygienist;
- Will have no experience of working with a dental therapist, an orthodontic therapist, or a clinical dental technician in Poland;
- May have no knowledge of formal training for dental nurses or dental technicians;
- May have little experience of working within the wider team of dental care professionals;
- May not be vaccinated against hepatitis B;
- May not appreciate that amalgam separators are mandatory in the UK;
- May require training in dental radiography, if they qualified prior to 2008.
Country: Portugal

Population: 10,561,614 (2011)

Number of registered dentists, stomatologists and odontologists: 8,026 (2010)
Number of dentists: 6,972 (2010)
Number of Stomatologists: 680 (2009)
Number of Odontologists: 374 (2010)
Number qualified overseas: 695 (2009)

Number of dentists registered in the UK in 2007: 216
in 2008: 272
in 2009: 338
in 2010: 407
in 2011: 447

Background

Dental care is delivered by dentists, stomatologists and odontologists, (see glossary for definitions) (5). In 2007, 10.5 per cent of all dentists registered in Portugal, qualified outside Portugal and 72 per cent of these overseas dentists were Brazilians (21). In general, Portuguese dentists are younger than those in most other European Member States, with a mean age of 36.9 years. 55 per cent of dentists in Portugal are female. Most dentists work in single-handed practice but occasionally multiple practices are established, with a dentist, a stomatologist or even an odontologist.

Dental care is excluded from the Public Health System and as a result most oral healthcare is provided in private practices. Although a few hospitals and Health Centres from the National Health Service employ stomatologists and some dentists. Due to the overproduction of dentists, and increasing numbers of new graduates, there is a high risk of under or unemployment for the profession (21). This may lead to more Portuguese dentists seeking employment outside Portugal. In 2008, the Portuguese Dental Association (Ordem dos Médicos Dentistas (OMD)) reported that there was a significant cross border movement by Portuguese dentists (5). The publicly funded health care system is complex and financed by taxes. Dentists may contract with one or more private or public insurance schemes. Each scheme has its own list of eligible treatments and scale of fees and most include emergency care. However, few provide cover for crowns, bridges and dentures (5). Since 2008, the Government has tried to give more emphasis to prevention and treatment for deprived groups so that some of the most vulnerable citizens, especially children, pregnant women and seniors on low income, have better access to oral healthcare (22). There are no formal controls on the quality and quantity of care provided in private practice, other than those described in the ethical code, as defined by the OMD. There is no mandatory requirement for dentists to take part in continuing professional education.

Since 2005, the undergraduate dental course has been five years in length. Previously, it was six years. After graduation, dentists must be registered by the OMD, which apart from being the representative body for dentists is also the body in charge of the regulation and supervision of their performance (15).

There is no compulsory formal training for dental nurses. It is mandatory for dentists to work with a dental nurse. There are relatively few dental hygienists (380 in 2009) and they are not allowed to work independently and without supervision. (5)
In summary, dentistry in Portugal is largely provided under private contracts. There is little publicly funded dentistry. Dentists are required to work with dental nurses. There are a few dental hygienists.

**Glossary of Terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomatologist</td>
<td>Medical practitioners with additional dental training of three years after obtaining the medical degree. They can work in hospitals, in private practice and work in other countries of the EEA under “acquired rights” legislation.</td>
</tr>
<tr>
<td>Odontologist</td>
<td>A professional category introduced by the Portuguese government many years ago to meet the problem of illegal dental practice of some people working in dentistry before 1974 (dictatorial regime). They perform as dentists but haven't received any academic training. The Commission deemed that the profession of &quot;odontologista&quot; would therefore seem to be alternative to and to compete with that of dentist. All odontologists are now over 55 years of age.</td>
</tr>
</tbody>
</table>

**Summary of relevant points**

1. **Regulatory Mechanisms**
   - The principal regulatory body in Portugal is the Portuguese Dental Association (Ordem dos Médicos Dentistas (OMD)). It regulates and supervises the performance of dentists; additionally it is the support organisation that provides relevant information on topics such as international and national legislation.
   - There is no specific body to register odontologists, although they do need to register with the Ministry of Health. Stomatologists are members of a college of the Portuguese Medical Association and odontologists have their own association. There is also a disciplinary body which regulates the practice of odontologists. Odontologists are not permitted to work in countries other than Portugal.
   - Vaccination against hepatitis B is not compulsory for the dental workforce, but it is encouraged.
   - Professional liability insurance is not compulsory for dentists, however, it is provided by private general insurance companies.
   - The law assumes that the primary dental qualification allows dentists to work with ionising radiation and take radiographs. There is no mandatory continuing professional education requirement specific to dental radiography.
   - Dentists may form companies which must have a clinical director, who must be a dentist.
   - There is a regulation that recommends the use of the amalgam separators, but this is not legally mandatory.

2. **Education and Training**
   - There are seven dental schools; three are state run, four are private.
   - Since 2005 undergraduate dental education takes five years, previously it was for six years.
   - The number of registered dentists has risen from 4,203 in 2005 to 7,180 in 2009 (6,972 active dentists in 2010).
   - There is no mandatory post-qualification foundation training.
   - There are two recognised specialties in Portugal: orthodontics and oral surgery, each with a training period...
of three years, post registration.

<table>
<thead>
<tr>
<th>3. Support Systems</th>
<th>The OMD is the national association. It provides relevant information such as international and national legislation. Stomatologists are members of a college of the Portuguese Medical Association and odontologists have their own association.</th>
</tr>
</thead>
</table>
| 4. The Dental Team | Dental care is delivered by dentists, stomatologists, odontologists and dental hygienists.  
In 2009, the number of registered dental hygienists was 380. They have to work under the supervision of a dentist and they are not permitted to give local anaesthetic.  
Training for dental technicians is at dental schools and Health Institutes and lasts three years. Legally, they can only prepare prostheses and not treat patients directly. 
There is no compulsory formal training for dental nurses but dentists must work with a dental nurse. 
The majority of “practicing” dental nurses and dental technicians has no specific training and have learned from the dentists they work for or from others. |
| 5. Dental care delivery | Dental care is virtually excluded from the Public Health System, for this reason oral healthcare is provided in private practices although a few hospitals and Health Centres from the National Health Service employ dentists. Only Stomatologists are allowed to work in the approximately 80 Public hospitals in Portugal, and there are very few posts for them.  
There is a National Programme for Oral Health Promotion (PNPSO). Since 2008, a part of the public budget has been allocated to specific target groups in the population: it covers children and teenagers from 3 – 16 years, pregnant women, and elderly people with lower incomes.  
Dentists may contract with one or more private sick fund schemes. Each scheme has its own list of eligible treatments and scale of fees and most include emergency care.  
Most dentists work in single-chair practices but occasionally dental practices are established, with a dentist, a stomatologist or even an odontologist (the premises may be shops, special buildings, or converted houses). |
| 6. Quality assurance mechanisms | There are no formal controls on the quality and quantity of care provided in private practice, other than those described in the ethical code as defined by the OMD.  
Complaints from patients are dealt with in two different ways. If the issue involved is solely one of contract then it is considered by a legal assessor. If the quality of care is challenged then the patient is examined by the Clinical Director in a sick fund and/or by an independent dentist, followed by the ethical council of the OMD. All the procedures are very slow and could take from two to three years.  
The Ethical Council of the OMD has the power to reprimand, suspend for up to five years or remove from the register. |
Key Points to Consider When Inducting or Supporting a Dentist Qualified in Portugal

Dentists qualified in Portugal:

- Have limited experience of a publicly funded health service;
- Have limited experience of UK monitoring procedures for clinical practice or UK requirements for clinical governance;
- May have little experience of working in a multi practitioner environment;
- Will not have undertaken foundation training in Portugal;
- Are unlikely to have experience of working with a dental hygienist;
- Will have no experience of working with a dental therapist, an orthodontic therapist, or a clinical dental technician in Portugal;
- May have no knowledge of formal training for dental nurses or dental technicians;
- May have little experience of working within the wider team of dental care professionals;
- May not appreciate that professional indemnity is compulsory in the UK;
- May not appreciate that amalgam separators are mandatory in the UK;
- May not appreciate that continuing professional education is a requirement for ongoing dental registration in the UK;
- May have experienced difficulty finding employment as a dentist in Portugal.
Country: Romania

Population: 21,413,800 (2011)
Number of registered dentists: 16,456 (2010)
Number of active dentists: 15,395 (2010)
Qualified overseas: 485 (2010)


Background

In Romania the number of dentists is increasing rapidly, in November 2009 there were 13 dental schools and the number of dentists graduating per year was 1,500. If this level of graduation is maintained, there will potentially be many under or unemployed dentists in Romania (5). In September 2009, 2,000 students of which 35 per cent were not EU citizens entered Romanian dental schools. Almost 90 per cent of dentists work in private practice and 60 per cent of dentists are owners of their dental practices. Private fees are set and negotiated by dentists. A full-time dentist working either in the National Statutory Health Insurance Scheme (NSHIH) or privately would have about 2,500 patients on his/her list.

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 Houses (NSHIH) at national level and County Social Health Insurance Houses (CSHIH) at county and capital level administer 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. It includes 100 per cent of the preventive care for children and adolescents, dental treatments of children and adolescents (up to 18 years), preventive consultation; pain relief and emergency surgical treatments. In theory the statutory health insurance scheme covers dentistry. However, in practice as each dentist receives a maximum of 200 Euros per month from the CSHIH, most dental care is provided under private arrangements. In rural areas only 15 per cent of the population access dental treatment; in urban areas, 85 per cent of the population has access. Continuing education is compulsory for all dentists. There are relatively few dental auxiliaries in Romania. At present, with the large numbers of dentists graduating each year, there is little enthusiasm to train or employ dental hygienists.

Summary of relevant points

1. Regulatory Mechanisms

- The practice of the profession is organised by the Medical Chamber for Medicine and Dentistry with mandatory membership. It is regulatory, advisory, scientific and a trade union.
- The Romanian Collegiums of Dental Physicians (RCDP) registers all dentists and dental specialists. Since 2004, it has been a legally based, non-governmental organisation and serves the whole country at national level.
- Dentists work under the ethical code for general physicians, which cover relationships and behaviour between physicians, dentists, contracts with patients, consent, and confidentiality, continuing education and advertising. It is administered by the regional body of the RCDP in each of the 40 counties and in Bucharest.
- The main functions of the National Social Health Insurance Houses (NSHIH) at national level and County
Social Health Insurance Houses (C SHIH) are to pay the providers of medical and dental services and to control the quantity and quality of the services.

- The quality of dentistry in the public dental service is assured by each County Health Board, who monitor aspects such as infection control.
- All dental team members must be vaccinated against hepatitis B and this has to be monitored by the County Health Board. However, it is known that a number of dentists refuse to be vaccinated against hepatitis B.
- Indemnity insurance is compulsory for all dentists. Dentists are free to choose the level of indemnity insurance cover starting from a minimum level established by NSHIH.
- Since 1998, dental practices can be limited companies and no more than one third of members can be non-dentists (5).
- Training in radiation protection is given during undergraduate studies and the dentist is the only competent person in the dental practice to undertake radiography. There is no ongoing continuing education requirement for this.
- There is compulsory verifiable collection and incineration of bio-hazard contaminated medical and dental waste. Amalgam separators are not required by law.
- The CSHIH controls the number of new dental practices able to work within the National Health System. However, the local RCDP councils often allow dentists to establish their own general dental practices. There are no rules regarding the type of a dental practice in terms of type of building. There is no state assistance for establishing a new practice, so some dentists take out commercial loans from a bank. When starting new practice, private dentists have to inform the local health authorities, and to obtain all the necessary permissions.

2. Education and Training

- Until 2003, dental schools were known as Faculties of Stomatology, as a part of a University of Medicine and Pharmacy. Now they are called Faculties of Dental Medicine.
- In 2011, the number of dental schools was 13 and the student intake was 2,000 (35 per cent of whom are neither Romanian nor EU nationals); and the number of graduates was 1,500. Three of the dental schools are privately funded.
- To enter dental school a student needs to be a high school graduate and pass an entry examination.
- Since 2003 dental training lasts five years.
- To obtain the right to work as a dentist, a dental graduate has to undertake a written test with 200 questions, a practical test and to defend his or her diploma project.
- There is no need for foundation training prior to entering independent practice.
- Specialist training is undertaken in the Dental Faculties and the Boards of the Faculties monitor and are responsible for the quality assurance of the training.
- There were three recognised specialties in Romania: orthodontics: three years training; oral-maxillofacial
surgery: five years training; dento-alveolar surgery: three years training. A further three: endodontics, periodontology and prosthodontics were recognised in October 2009.
  - Any dentist can undertake specialist training, but the Ministry of Health limits the number of specialist training places. The trainees are paid during their course by a fixed salary supported by the Ministry of Health. In this period they cannot work in private dental practice.
  - In the past, dentists followed a stomatological training in which they completed a primary medical degree followed by a period of clinical dental training leading to qualification as stomatologists (dental physicians). A number of older Romanian dentists still have this title.

### 3. Support Systems

- The Romanian Dental Association of Private Practitioners (RDAPP) used to represent and the dental profession. However, there is also another association – the National Union of Associations of Dentists (NUAD) which now represents some dentists.
- Specialists have their own professional associations.

### 4. The Dental Team

- Dental technicians are trained in dental technician colleges, within the dental schools. Their training lasts for three years, with a final examination leading to a diploma. Since 2007 dental technicians have to register with the Order of Romanian Dental Technicians.
- Dental technicians normally work in separate dental laboratories and invoice dentists (or directly to the patient) for completed prosthetic work.
- There is some illegal practice by non qualified dental technicians, but the number of cases is decreasing every year.
- Dental nurses train in secondary medical schools, for three years of study leading to a final examination and diploma. They must register with the Order of Romanian Medical Assistants.
- The duties of dental nurses are: assisting dentists, maintaining records, sterilisation, infection control, and office work. There are limited numbers of dental nurses in Romania.
- There are about 100 dental hygienists in Romania. Schools for dental hygienists have opened and closed over the last 20 years. At present, with the large numbers of dentists graduating each year, there is little enthusiasm to train or employ dental hygienists.
- The RCDP have provided data which shows that there are eight denturists in Romania, but there is no further information about these.

### 5. Dental care delivery

- Romania has a statutory health insurance system which was established in 1998 and there is compulsory membership of each insured citizen in the Social Health Insurance System.
- Patients pay dentists who work in the private sector directly and completely. Every dentist chooses whether to work only with CSHIH or in independent practice or both. There are two systems of payment, one is item of treatment fees, for NSHIH dentists and for private dentists the patient has to pay all fees themselves.
- Since the end of 2002, dental treatment fees have not been amended, as the NSHIH stated that the
contract is not mandatory but optional for dentists. The NSHIH pays dentists who accept the terms offered to them. Some work is paid for completely, whilst other work is paid at only 40-60 per cent of the cost.

- 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 per cent of the costs of the list of dental treatments. Patients directly pay the difference of 90 per cent.
- Almost 95 per cent of dentists work in private dental practice and 60 per cent of dentists are owners of their dental practice. Private health insurance companies are not yet functioning in Romania although private dental insurance companies are legally recognized.
- Dentists working in hospitals are part of maxillo-facial surgery teams. All of them are employed by the hospitals, which are owned and run by regional government. They can also work part-time in private practices. In each “county” capital there are clinics for emergency dental treatment, where the dentists are paid for by the state.
- Academic dentists are normally salaried employees of the Faculty of Stomatology (Dental Schools). Most also work in private practice. The titles of university teachers are Professor, Associate Professor, both of which involves a further degree (publication activities, a record of original researches and a PhD is also required) and Lecturer.
- In 2009 in rural areas, there were 1,597 dental practices and about 15 per cent of the population accessed dental treatment. In the same year, in urban areas there were 10,086 dental practices. Some specific groups in rural areas, (children, farmers, retired persons) are having trouble accessing dental care. However, in cities with dental schools, there are many dentists and the dentist : population ratio is often 1:400.

6. Quality assurance mechanisms

- Continuing education is compulsory for all dentists. It is provided by universities and by specialist dental societies. The RCDP records the hours completed by dentists who are required to complete 200 hours in five-year cycles.
- A mixed commission of the CSHIH and the RCDP investigates complaints from patients. However they can only judge the quality of work in the NSHIH system.
- In the private system, the quality of dental work can be judged only by the RCDP. From the quality point of view, the CSHIH has the right to control regularly the activities of dentists who have a contract with them.
- A complaint by a patient is first screened by the Local Board of RCDP and is then forwarded to a commission of the RCDP that deals with complaints. Those that are judged to be reasonable are sent to a commission of dental experts, with more than 10 years’ experience, nominated from RCDP membership. If the complaint 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 can impose “gradual sanctions”, which can lead to the suspension of the dentist. A complaint may be referred to the judicial system.
- The final sanctions are validated by the RCDP county level; judicial 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, paying for all the costs.

### Key Points to Consider When Inducting or Supporting a Dentist Qualified in Romania

**Dentists qualified in Romania:**

- Unless they qualified before 1990, have limited experience of a publicly funded health service;
- May have little experience of working in a multi practitioner environment;
- Have limited experience of UK monitoring procedures (e.g. NHS dental services) or UK requirements for clinical governance (e.g. clinical audit);
- Will not have undertaken foundation training in Romania, if they have qualified since 1990;
- May have little experience of working with dental nurses;
- Are highly unlikely to have experience of working with a dental hygienist;
- Will have no experience of working with a dental therapist, an orthodontic therapist, or a clinical dental technician in Romania;
- May have little experience of working within a wider team of dental care professionals;
- May not appreciate that amalgam separators are mandatory in the UK;
- May not appreciate the severity of the disciplinary sanctions possible in the UK;
- May not have knowledge of working with private health insurance companies;
- May have experienced difficulties in obtaining employment as a dentist in Romania.
Country: Slovakia  
Number of registered dentists: 3,248 (2011)  
Number of active dentists: 3,248 (2011)  
Qualified overseas: 0 (2007)  

Background

In 2011, the Slovak Chamber of Dentists register included 3,248 dentists of whom 1973 (62 per cent) were women and 1275 (38 per cent) were men. Of these, 2495 dentists (76 per cent) worked in their own private practice and 579 (24 per cent) worked as employees either in these private practices or in state institutions. Over 80 per cent of active dentists work in private practice.

The distribution of dentists is not balanced, there are too many dentists in big cities and there is a shortage of dentists in some rural areas (24).

Dentists working in private practice work as independent entrepreneurs and are free to decide where and how they will work (5).

There are relatively few dental hygienists. However the use of dental nurses is widespread (5). Every dentist must work with a nurse by law.

There are two public dental schools in the Slovak Republic. Training for dentists lasts for six years after which dental graduates are free to obtain a licence and are allowed to work independently. There are three dental specialties recognised in Slovakia: orthodontics, paediatric dentistry and oral maxillo-facial surgery. Continuing Professional Education is mandatory and is evaluated every five years (24).

Summary of relevant points

1. Regulatory Mechanisms

- The Slovak Chamber (Association) of dentists acts as a regulatory and support body for dentists. It creates an environment and conditions for a high-quality provision of dental services for patients following international standards.
- There are three steps towards establishing general practice: first registration with the Slovak Chamber of dentists, then a licence for the practice of dentistry issued by the Chamber and finally permission to open a dental practice is issued by the municipality office.
- It is compulsory for dentists to have indemnity insurance. Every dentist has to be insured against civil liability for the practice of his/her profession. The Chamber has a collective contract of insurance covering members.
- If there are claims from 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 Public Health Authority of the Slovak Republic is the body responsible to give permission for the running and the operation of ionising radiation equipment. The dentist must undergo a training course in dental radiography and pass an examination every five years.
- Amalgam separators are legally required.
- The steps to obtain registration as a foreign dentist are as follows: recognition of the diploma by the Ministry of Education and pass a language test of knowledge of the Slovak language controlled by the Ministry. The employer is also required to prove that the language competency of the employee is sufficient.
- Hepatitis B vaccination is compulsory.

### 2. Education and Training

- To enter dental school students have to pass the state qualification for university entrance and a successful result in the dental studies entrance examination.
- The undergraduate course lasts for six years.
- An average of 56.5 per cent of time is allotted to medical science and 40.5 per cent to dental science.
- From 2009 foundation training is not required and dentists are able to open their own practice immediately after graduating.
- Slovakia has three specialties: orthodontics, paediatric dentistry, oral maxillo-facial surgery. The training for orthodontics and paediatric dentistry lasts for three years. Oral maxillo-facial surgery lasts for four years.
- The co-ordinating role in continuing education is undertaken by the Chamber together with the educational institutions and associations of specialists. Training takes place at Dental School clinics, or at the Slovak Medical University, or in dental practice under supervision of a specialist.

### 3. Support Systems

The Slovak Chamber of dentists acts as a regulatory and support body for dentists. It creates an environment and conditions for a high-quality provision of dental services for patients following international standards.

### 4. The Dental Team

- Training for dental hygienists is conducted at state-medical schools. After high school they study for three years at the University of Prešov, which leads to a bachelor degree. They must be registered with the Association of Dental Hygienists.
- Dental hygienists must work only under the supervision of the dentist. The number of hygienists is low.
- Training for dental technicians is conducted at secondary schools. The length of the course is four years. To open their own dental laboratory, a dental technician has to pass a three years' specialised study at University. They have to register with the Slovak Chamber of Dental Technicians.
- Dental technicians can work in independent laboratories or, rarely, be employed by a dentist or a dental practice.
- Dental nurses are educated at secondary schools for four years, they work at the chair side as employees of dentists.
- Dental nurses are registered with the section for nurses working in Dentistry of the Chamber of Nurses and Midwives.

### 5. Dental care Delivery

- All citizens of Slovak Republic must be compulsorily insured with one of three health insurance companies.
- Since 2000, the government listed treatments and services that can be provided within the scheme and set co-payments for other treatments not covered by the scheme (4, 5).
- About 90 per cent of private dentists have an agreement with an insurance company.
- Dentist are paid from the health insurance according to the treatment completed and are paid fully or partly by the insurance company depending on the patient’s co-payment.
- Health insurance companies have fixed amounts of funds allocated to oral health care and once the annual allocation is reached, they stop payments to dentists (24).
- General dental practitioners calculate their own prices but net profit should be a maximum of 30 per cent. A dentist whose profit is more than that breaks the law on prices, which may lead to a fine or other sanctions.
- There are public polyclinics in the Slovak Republic with a number of health professionals. They can be public or private. They also can provide private services. Dentists employed at public establishments receive a fixed salary.
- In hospitals the treatment is limited to oral maxillofacial surgery, undertaken by specialists.
- Dentists who work in dental schools are normally full-time salaried employees of the university. They are able to combine part-time teaching and to work in private dental practice (with the permission of the university).
- Dentists working in private practice work as independent entrepreneurs. Prices in private practices are different, dependent on the place and region of the provider and also on the overheads of the provider. Before each treatment, an informed approval of the choice and way of treatment must be obtained from the patient.

### 6. Quality assurance mechanisms

- Continuing education for dentists is compulsory and it is evaluated by the Chamber over a five year period.
- The dentist needs to provide proof of 250 credits for each five year period.
- Dental practitioners may be quality controlled by another dentist who is employed by an insurance company; they control the invoices that dentists send to the insurance company from a professional (clinical) point of view.
- In most cases quality is controlled by patient’s complaints. A patient can present a complaint to a 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 the court.
- Patients who are not satisfied with provided oral care can contact the Authority with a written complaint directly. A patient is entitled to lodge a complaint and demand compensation before going to court (5).
- The sanctions against dentists who break the ethical code may lead to an admonishment. If they repeatedly fail to respect the admonishment, then the dentist will get a fine of up to SK 10,000 (300 Euros)
or up to SK 50,000 (1,470 Euros) (2012).
- The ultimate sanction is to be excluded from membership of the Slovak Chamber of dentists.

Key Points to Consider When Inducting or Supporting a Dentist Qualified in Slovakia

Dentists qualified in Slovakia:

- Since 1990, have worked mainly in private practice and have contracts with the public insurance scheme;
- May have experience of working in a multi practitioner environment;
- Have limited experience of UK monitoring procedures (e.g. NHS dental services) or UK requirements for clinical governance (e.g. clinical audit);
- If they have graduated from 2009 onwards, will not have undertaken foundation training in Slovakia;
- Are unlikely to have experience of working with a dental hygienist;
- Will have no experience of working with a dental therapist, an orthodontic therapist, or a clinical dental technician in Slovakia;
- May have little experience of working within the wider team of dental care professionals;
- May have little experience working in wholly private dental practice;
- May have a lot of experience on following guidelines, infection control measurements and administrative tasks;
- May not appreciate that the dental training in the UK is five years and not six years as in Slovakia.
Country: Spain

Population: 47,190,493 (2011)

Number of registered dentists: 27,826 (2010)
Number of active dentists: 27,826 (2010)
Qualified overseas: 5,879 (2009)


Background

Spain is divided into 17 autonomous regions and two autonomous cities. Each region/city has autonomy over its health policy, but with a coordinating body at a national level which specifies the coverage offered by the public health system. Whilst the universally accessible Spanish Health Service offers extensive medical care coverage, oral health care coverage for the adult population is limited to oral surgery and the prescription of pharmaceutical products by salaried dentists. Dental treatment is mainly provided in a private fee-for-service system which includes more than 90% of dental professionals. Recently, all Spanish children aged 6-15 years have been able to access free basic oral health care and treatment of their permanent teeth. How this is offered depends on the Region; about half run a capitation system (with public finance and public or private provision of services), with the other half running an older model in public clinics. Most of the autonomous regions/cities have developed dental public health programmes with preventive activities including oral health education and fluoride mouth rinsing.

Dental care is delivered mostly by dentists, although a few hospitals employ stomatologists (see glossary for definitions). Approximately 92 per cent of the profession work privately and are largely in single-chair practice. There is a small Public Dental Service (PDS) which operates in Primary Health Care Units managed by each regional healthcare institution. This only provides emergency care, which is a legal requirement. Regions have delegated powers to establish local systems for the provision of health care which may supplement the PDS through specific programmes. At present, these programmes are largely confined to prevention and paediatric dentistry (5).

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 an annual budget for health. However, the social security fund is often in deficit, and has to be supplemented from national taxation (5).

Some 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 PDS pay nothing for their care.

There are no formal controls on the quality and quantity of care provided in private practice, other than those described in the ethical code. Like most European countries, professional liability insurance is compulsory for dentists and is provided by private general
insurance companies. There is no mandatory requirement for dentists to take part in continuing professional education. An extended system of evaluation of the continuing education systems is being developed, after encouragement by the government (5).

Until 2001, it was possible to train as a stomatologist, in Spain; this involved a period of medical training, followed by further training as a dentist (5). No specialties are formally recognised. Some Spanish universities offer postgraduate courses in different specialist areas, some of which are full-time for three years and would lead to recognition as a specialist in other countries. Some Spanish dentists have also completed specialist training in other EU member states. However, they are not recognized in Spain. After graduation, dentists must be registered by the Consejo General which has a central register held in Madrid.

There is no formal training or qualification for dental nurses; they are trained by dental practitioners (5). Dental hygienists must hold a registerable qualification. They 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 (5). They are not allowed to give local anaesthetic (25). Dental technicians may only work in commercial laboratories (5).

In summary, dentistry in Spain is largely provided under private contracts. There is little publicly funded dentistry. Dentists generally work with dental nurses. There are dental hygienists and dental technicians and the numbers of each group are growing. At present, there appears to be both un- and under-employment of new dental graduates in Spain (25).

<table>
<thead>
<tr>
<th>Glossary of Terms</th>
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<tbody>
<tr>
<td>Stomatologist</td>
<td>Medical practitioners with additional dental training of three years after obtaining the medical degree. They can work in hospitals, in private practice and work in other countries of the EEA under “acquired rights” legislation.</td>
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<table>
<thead>
<tr>
<th>Summary of relevant points</th>
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<tbody>
<tr>
<td>1. Regulatory Mechanisms</td>
<td>The principal regulatory body in Spain 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.</td>
</tr>
<tr>
<td></td>
<td>Vaccinations such as hepatitis B are not compulsory for the workforce, although they are recommended.</td>
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<tr>
<td></td>
<td>Liability insurance is compulsory for dentists and is provided by private general insurance companies.</td>
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<td></td>
<td>There are many radiation protection regulations relating to facilities, dosage and controls. To take a radiograph formal training must have been undertaken, with a license at the end of this. However, continuing training in dental radiography is not mandatory.</td>
</tr>
<tr>
<td></td>
<td>Dentists are permitted to form companies, in which to practice. Non-dentists can own or be on the board of such companies.</td>
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<td></td>
<td>Since 1986 it has been mandatory to fit amalgam separators to all newly equipped premises or newly installed units. This requirement extends to the installation of older units in new premises. However, there may be differences in the autonomous regions towards compliance.</td>
</tr>
</tbody>
</table>
2. Education and Training
- In 2008 there were 12 publicly funded dental schools and six private dental schools.
- In all the schools the course lasts five years.
- Currently about 2,000 students enter Spanish dental schools each year.
- Until 2001, it was possible to train as a stomatologist; this involved a period of dental training by qualified medical practitioners, followed by further training as a dentist.
- There is no requirement for post-qualification foundation training in Spain.
- No specialties as defined in the 1978 EU Dental Directives are formally recognised.

3. Support Systems
- The Consejo General de Colegios Oficiales de odontólogos y estomatólogos de España which has a Council (Consejo General) is the support organisation for dentists in Spain.

4. The Dental Team
- Dental care is delivered by dentists, stomatologists and dental hygienists.
- In 2007, the number of registered dental hygienists was 3,000. They have to work under the supervision of a dentist and they are not permitted to give local anaesthetic.
- There is a qualification for Dental Technicians which is obtained after training and education at schools of Formacion Professional, over a two year period. Voluntary registers are kept by the regional associations, but there is no national mandatory requirement. However, in some regions it is compulsory and the numbers of such are growing.
- Dental assistants work at the chair side. They have no formal training or qualification; they are trained by dental practitioners, (4). Most Spanish dentists appear to work with a chair side assistant.

5. Dental care delivery
- There is a small Public Dental Service which operates in primary health care units.
- Most oral healthcare is provided in private (liberal) practices. Dentists who practice outside hospitals, universities or the public dental service are referred to as private practitioners. Approximately 92 per cent of the profession work in this way and are largely in single-chair practice.
- Regions which have delegated powers to establish local systems for the provision of health care may supplement this service through specific programmes. At present, these programmes are largely confined to prevention and paediatric dentistry.
- Only 18 per cent of the population (2007) uses these private insurance schemes to cover their dental care costs.
- Patients in Spain do not attend for dental care on a regular (periodical) basis, but tend to go when they have dental problems, only. There is no form of domiciliary (home) care. Less that 40 per cent of Spaniards attend a dentist each year.

6. Quality assurance mechanisms
- An extended system of evaluation of the continuing education systems is being developed, after encouragement by the government. It becomes compulsory in 2012.
- Complaints are investigated through a medical system. Where these are upheld a warning may be recorded on the dentists file, but they may only be prevented from practicing in the service by judicial
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.

Key Points to Consider When Inducting or Supporting a Dentist Qualified in Spain

Dentists qualified in Spain:

- Have limited experience of a publicly funded health service;
- Have limited experience of UK monitoring procedures (e.g. NHS dental services) or UK requirements for clinical governance (e.g. clinical audit);
- Will not have undertaken foundation training in Spain;
- Will have no experience of working with a dental therapist, an orthodontic therapist, or a clinical dental technician in Spain;
- May have no knowledge of formal training for dental nurses or dental technicians;
- May have some experience of working within the wider team of dental care professionals;
- May not appreciate that continuing professional education is a requirement for continuing dental registration in the UK;
- May not appreciate that amalgam separators are mandatory in the UK;
- If they have graduated in the last two years, are likely to have experienced difficult in obtaining a job in Spain.
Background

For a number of years there has been a net loss of dentists from Sweden. Most of the Swedish dentists who have emigrated have moved to the United Kingdom and Norway. However, by 2008, the trend of movement out of the country appeared to be ending. During 2004 and 2005 the net immigration of dentists was positive (5). In the mid 1990s, the Government reduced the number of undergraduate places in dental schools by 40 per cent. As a result, the number of active dentists is currently decreasing and the number retiring is increasing. Furthermore, the number of dentists emigrating is higher than the number of dentists moving to Sweden. However, the loss of retired dentists is balanced by the newly-qualified. The main reason for the reduction in the numbers of active dentists has therefore been due to emigration (5).

In 2009 there were 7,447 active dentists, 3,982 working in public dental care and 3,475 in private dental care There is no information about any unemployment amongst Swedish dentists (5).

The Public Dental Service (PDS) began in 1938. Initially, its purpose was to establish a systematic oral health care system for children and teenagers. At present, the PDS offers dental care to all children up to the age of 19 years and specialist treatment for both children and adults. Adults of all ages also have the right to use the PDS within available resources. A new financial Support System for oral health care for people aged 20 and over commenced in 2008. The support consists of a dental care voucher (a general dental care allowance), which can be used as part payment for a dental check-up at any dentist or dental hygienist, and a high-cost protection scheme. The dental care voucher is issued every other year. Not all types of dental care are reimbursable under the new Support System. Based on a diagnosis made by the dental care provider or a predefined condition, certain measures qualify for dental care support. Preventive measures and treatment of diseases are given high priority. Reimbursable dental care is required to be both cost-effective and socio-economically efficient (26). Continuing education is optional and continuing education and training in radiology is not mandatory (5). Vaccinations are not compulsory for the dental workforce, but there is a general recommendation to undergo certain vaccinations such as Hepatitis B, (5)The use of dental care professionals is well developed in Sweden and they undertake a considerable proportion of dental care (5).

Summary of relevant points

1. Regulatory Mechanisms
   - The principal regulatory body for Qualification and Education is a government department, the National Board of Health and Welfare (NBHW) which maintains the register of dentists, and awards the licence
required in order to practice as a dentist.

- Dentists do not need to re-register annually, and the cost of registration in 2008 was 64 Euros.
- The Social Insurance Office also keeps a register of practitioners who are affiliated with the national social insurance scheme, and dentists must be on this register before they can claim social insurance fees.
- The Swedish Dental Association (SDA) has formulated a number of ethical guidelines for its members.
- The Swedish Association of Private Dental Practitioners has also formulated an ethical code for their members.
- No standard contractual arrangements are prescribed for dental practitioners working in the same practice, but they are highly recommended by the professional organisations.
- Vaccinations are not compulsory for the dental workforce, but there is a general recommendation for certain vaccinations such as hepatitis B (5).
- For the most commonly used X-ray machines (up to 75 kilovolt intraoral receiver), no specific regulatory permission is required. However, to operate the equipment, a dentist must satisfy the requirements as defined by the Swedish Radiation Safety Authority.
- Dentists are able to form limited liability companies. Non dentists may fully or partly own these companies.

2. Education and Training

- All four dental schools are state owned and financed. They are part of the Faculties of Medicine of the respective universities.
- There is no post-qualification foundation training. Although this was required prior to 1993.
- There is specialist training in eight disciplines: Orthodontics, endodontics, paedodontics, periodontology, prosthodontics, oral radiography, stomatognathic physiology and oral surgery.

3. Support Systems

- The Swedish Dental Association (SDA) has four member associations: the Swedish Association of Private Dental Practitioners, the Swedish Association of Public Dental Officers, the Swedish Association of Dental Teachers, the Swedish Association of Dental Students.

4. The Dental Team

- The use of dental auxiliaries is well established in Sweden, and they undertake a considerable proportion of dental care.
- After qualification all hygienists are licensed by the NBHW, and they are able to work independently. Their duty of care includes the diagnosis of caries and periodontal disease, placing temporary fillings and giving local anaesthetic.
- After qualification, dental technicians are licensed by the NBHW, but they do not require to be registered to be able to work.
- Orthodontic operating auxiliaries can carry out specified procedures, but must work under the direction of an orthodontist.
- Since January 2008, a standardised national education programme for dental nurses has been
implemented. No registration is required.

### 5. Dental Care Delivery
- The Public Dental Service (PDS) provides free dental care and specialist treatment for children and young adults up to the age of 19 years.
- Adults and elderly people, who are not entitled to free care from the PDS, can obtain subsidised dental care from the PDS or dentists in private practice.
- A new national insurance scheme was introduced in July 2008. This new state dental care financial Support Systems is for people aged 20 and over and involves the use of a dental care voucher within a high protection scheme to provide compensation equal to 50 per cent of a patient’s dental care costs between 321 – 1,590 Euros, and 85 per cent of costs exceeding 1590 Euros. The first 320 Euros is always paid by the patient. Compensation levels are based on “reference prices” which enable patients to compare dental prices more easily. Not all kinds of dental care are reimbursable; preventive measures and disease treatment are prioritised.
- Dentists in private practice set their prices themselves.
- Patient fees, both in the public and private sectors, are not regulated by the government and the price for the patient may vary depending on their choice of dentist/dental hygienist.

### 6. Quality Assurance Mechanisms
- In 2007, The NBHW started to develop national evidence-based guidelines and these standards are monitored by the Regional Departments of the NBHW. They were planned to be finished in 2011.
- 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.
- The monitoring of dentists in the PDS is the same as that for dentists in private practice
- Continuing education is optional and continuing education and training in radiography is not mandatory (5).
- If a patient complains, and the dentist cannot resolve the matter directly, there are two bodies through which the issue may be considered:
  1. Local Boards for Private Practice (composed of dentists), and Local Boards for Public Dental Services (may consist of people from another profession than dentistry)
  2. Medical Responsibility Board (HSAN), on behalf of the National Board of Health and Welfare.
## Key Points to Consider When Inducting or Supporting a Dentist Qualified in Sweden

**Dentists qualified in Sweden:**

- Mainly work in private practice and have contracts with the public insurance scheme;
- May have considerable experience of working in a multi practitioner environment;
- Will not have undertaken foundation training in Sweden unless they qualified before 1993;
- Will have no experience of working with a dental therapist or a clinical dental technician in Sweden;
- Will have experience working with an orthodontic therapist;
- May not appreciate the need to register annually with the GDC in the UK;
- May not appreciate that continuing professional education is a requirement for maintenance of dental registration in the UK;
- May not appreciate that hepatitis B vaccination is compulsory in the UK;
- If they have graduated since 2000, may have little or no experience of placing amalgam fillings,
- May not appreciate that dental hygienists in the UK have to work under the supervision and legal responsibility of the dentist;
- May not appreciate that dental care professionals in the UK have to be registered in order to be able to work.
Annex 1: References


Useful Links and Publications

- National Clinical Assessment Service (NCAS): [www.ncas.nhs.uk](http://www.ncas.nhs.uk)
- Association of Dental Education in Europe: [www.adee.org](http://www.adee.org).
- Conference of Orders and Assimilated Bodies of Dental Practitioners in Europe (CODE), responsible for regulation, registration and supervision of dental practitioners: [www.code-europe.eu](http://www.code-europe.eu)
- Council of European Dentists: [www.eudental.eu](http://www.eudental.eu)
- General Dental Council (GDC): [www.gdc-uk.org](http://www.gdc-uk.org)
- NHS Employers: [www.nhsemployers.org](http://www.nhsemployers.org)
- Online journal on free movement of workers within the European Union: EUL14128_FMWMag_101119[1].pdf - twice yearly online journal
Annex 2: A summary of key points of variation across the non-UK EEA member states

The following table summarises key points of variation across the non-UK EEA member states. The key below explains the colour coding behind the analysis.

It is clear that significant variations exist between non-UK EEA member states. The most obvious difference seems to focus on the use of the dental team, particularly the wider dental team. In certain countries, for example, in the Netherlands, the team approach is well developed with all dentists working with full-time chair-side nursing support and large numbers of dental therapists, hygienists and some clinical dental technicians. However, just across the border, in Belgium, few dentists work with chair-side assistants (dental nurses) and there are no dental hygienists or therapists or clinical dental technicians.

There are also wide variations between the systems for the provision of oral healthcare between countries and many practitioners from non-UK EEA member states will have relatively little or no experience of working within a publicly-funded health service. This is particularly evident in former Eastern Bloc countries, many of whom have, in the last 20 years, changed from a purely public dental service to a purely private system. More recently, these countries have ceased foundation training. In many EEA member states the concept of clinical governance is defined differently to that in the UK.
Table 2: Summary of key variations across the non-UK EEA member states

| Key points to consider about the individual or their country of origin | Belgium | Bulgaria | Czech Republic | Denmark | France | Germany | Greece | Hungary | Ireland | Italy | Lithuania | Malta | Netherlands | Poland | Portugal | Romania | Slovakia | Spain | Sweden |
| Is professional dental indemnity compulsory? | Y | Y | Y | Y | N | N | Y | N | N | Y | N | Y | Y | Y | Y | Y |
| Is hepatitis B inoculation compulsory? | Y | N | Y | N | Y | N | N | N | Y | Y | N | Y | Y | N | N |
| Is continuing professional education compulsory? | Y | Y | Y | N | Y | Y | Y | Y | N | Y | Y | N | Y | Y | Y | N |
| Experience of working in a publicly funded health service | L | L² | L | H | L | L | L | M | L | M | M | L | L | L | L | M |
| Experience of clinical governance requirements | L | L | L | L | L | M | L | L | L | L | L | M | L | L | L | L | M |
| Is DF1 training programme available? | Y¹ | N | Y³ | Y⁴ | N | Y | N | Y⁵ | Y | N | Y | Y¹⁴ | N | Y⁷ | N | N⁹ | N¹⁰ | N | N¹¹ |
| Is DF2 training programme available? | N | N | N | N | N | N¹³ | N | N | N | N | N | N | N | N | N | N | N⁹ | N¹⁰ | N | N |
| Experience of working with a dental nurse | L | L | H | H | L | L | H | H | H | H | H | M | H | H | H | L | H | H | H | H |
| Experience of working with a dental hygienist | N | N | L | H | N | L | N | L | H | M | M | M | H | L | L | L | H | H | H | H |
| Experience of working with a clinical dental technician | N | N | N | H | N | N | N | N | L | N | N | H | N | N | N | N | N | N | N | N |
| Experience of working with a dental therapist | N | N | N | N | N | N | N | N | N | H | N | N | N | N | N | N | N | N | N | N |
| Experience of working with an orthodontic therapist | N | N | N | N | N | N | Y¹² | N | N | N | N | N | N | N | N | N | N | N | N | Y |

**Colour Key to table:**
- **L**: Low/Limited
- **N**: No
- **M**: Moderate
- **H**: High
- **Y**: Yes
Footnotes to table

1. If qualified after 2002
2. If qualified after 1990, before then high
3. If qualified before 2009
4. Only if the practitioner has graduated in the last 10 years
5. If qualified before 2004
6. If qualified after 1992, before then high
7. If qualified since 1993
8. Unless qualified before 1990
9. If qualified between 2001 and 2009. Some new graduates are now offered FT
10. If qualified after 2009
11. Unless qualified before 1993
12. Orthodontic nurses work in some lander (regions)
13. In Germany there is a 2 year period in which new graduates work as an assistant to an established dentist. There is no training in secondary care and the training does not equate to foundation training
14. FT is available in Malta but is not compulsory
Annex 3: Checklist

Below is a checklist of topic areas which may help as an aide memoir when supporting an organisation contracting/commissioning or employing any dentist who has not previously worked in the General Dental Services in the UK. It may be particularly helpful where the practitioner is younger or who has only previously worked in salaried services or those who qualified outside of the UK. These topics have been developed in accordance with guidance and regulations issued by the GDC and Departments of Health, (Department of Health, Social Services and Public Safety (Northern Ireland), NHS Scotland, NHS Wales).

The final column has been designed to provide an opportunity to record whether the topic has been discussed.
<table>
<thead>
<tr>
<th><strong>Checklist</strong></th>
<th></th>
<th></th>
<th><strong>Context</strong></th>
<th><strong>Discussed?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topic</strong></td>
<td><strong>Requirement</strong></td>
<td></td>
<td></td>
<td>(Y/N)</td>
</tr>
<tr>
<td>Regulation and registration</td>
<td>Registration with the GDC</td>
<td>All dentists who wish to practise dentistry in the UK are required to be registered with the GDC. An annual retention fee (ARF) must be paid each year to remain on the Dentists’ Register. The deadline for dentists to pay every year is the 31 December. Dentists who work without having paid are practising illegally.</td>
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<tr>
<td>Ethics</td>
<td>Understanding GDC guidance documents</td>
<td>Dentists must understand the requirements of the GDC guidance document ‘Standards for Dental Professionals’* and the supplementary guidance booklets.</td>
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<tr>
<td>Indemnity insurance</td>
<td>Obtaining adequate and appropriate indemnity insurance</td>
<td>All GDC registrants are required to ensure that there are adequate and appropriate arrangements in place so that patients can claim any compensation they may be entitled to. Indemnity insurance from a dentist’s country of origin may not always provide cover for working in the UK. The only appropriate arrangements recognised by the GDC are: membership of a dental indemnity organisation, i.e. Dental Protection Limited, Dental Defence Union or the Medical and Dental Defence Union of Scotland (whether your own membership or employer’s membership); arranged by yourself, or your employer; or NHS indemnity.</td>
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<tr>
<td>Health and safety at work</td>
<td>Understanding cross infection control procedures</td>
<td>A dentist is required to have knowledge of cross infection control procedures including knowledge of Control of Substances Hazardous to Health (COSHH) regulations, HTM 01-05 decontamination guidelines for dental surgeries, and other relevant health and safety policies.</td>
<td></td>
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<tr>
<td>Health and safety at work</td>
<td>Inoculation against hepatitis B</td>
<td>Dentists, and clinical dental care professionals who work for them, must be inoculated against hepatitis B, and checked for seroconversion after the primary course. Thereafter, if immunity levels are satisfactory, one booster is needed after five years.</td>
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<tr>
<td>Ionising radiation</td>
<td>Understanding radiation protection guidelines</td>
<td>Only a fully trained person is permitted to take radiographs in a dental practice. Ongoing training (continuing professional development (CPD)) in radiology and radiation protection is a mandatory GDC requirement.</td>
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<tr>
<td>Hazardous</td>
<td>Understanding</td>
<td>Clinical waste is considered ‘hazardous’ under the Hazardous Waste (England and Wales)</td>
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<table>
<thead>
<tr>
<th>Topic</th>
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<th>Context</th>
<th>Discussed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>waste</td>
<td>hazardous waste regulations</td>
<td>Regulations 2005. Similar regulations cover Scotland and Northern Ireland.</td>
<td>(Y)</td>
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<td></td>
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<td>All waste dental amalgam is now classified as hazardous waste and must not be discharged to a sewer. Amalgam separation units must be installed in all dental practices. Collected waste amalgam must be disposed of in accordance with the regulations.</td>
<td>(Y)</td>
</tr>
<tr>
<td>Clinical practice</td>
<td>Understanding drug prescribing protocols</td>
<td>Each practice is required to adhere to defined drug prescribing protocols.</td>
<td>(Y)</td>
</tr>
<tr>
<td>Clinical practice</td>
<td>Managing medical emergencies</td>
<td>Dentists are required to be able to recognise and manage medical emergencies in the dental practice. Cardio-Pulmonary Resuscitation (CPR) training is a mandatory requirement, as is an awareness of the practice emergency drug protocol.</td>
<td>(Y)</td>
</tr>
<tr>
<td>Clinical practice</td>
<td>Understanding fluoride content levels in UK drinking water</td>
<td>Approximately six 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 has a naturally occurring fluoride level of around this level. In some areas (e.g. 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. Dentists new to the area should familiarise themselves with the local situation by talking to colleagues (Consultant in Dental Public Health) or the commissioning/employing organisation.</td>
<td>(Y)</td>
</tr>
<tr>
<td>Clinical practice</td>
<td>Delivering high quality dental treatment</td>
<td>Are there any aspects of clinical practice which the dentist is proposing not to offer? Are there any areas where the dentist might need further training before starting work in the practice? Is the dentist are of local referral to colleagues protocols and procedures? It is also useful to establish if the applicant's previous experience is mainly of working in a single unit practice, or a multi-surgery practice.</td>
<td>(Y)</td>
</tr>
<tr>
<td>Clinical practice</td>
<td>Use of amalgam</td>
<td>A number of dental schools within the EEA, including some in the UK no longer train dental students in the use of amalgam as a filling material. Dentists not trained in the use of amalgam may need additional support to interpret NHS guidelines for this material.</td>
<td>(Y)</td>
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<tr>
<td>Working in the NHS</td>
<td>Understanding NHS regulations</td>
<td>An applicant can only be included on one dental performers’ list in England at any one time, although this does allow the dentist to work in other geographic areas. In order to work in Scotland, Wales and Northern Ireland, a dentist must also be included in a dental performers’ list or equivalent in that country.</td>
<td>(Y)</td>
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<tr>
<td>Topic</td>
<td>Requirement</td>
<td>Context</td>
<td>Discussed? (Y/N)</td>
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<tr>
<td><strong>Working in a dental team</strong></td>
<td><strong>Understanding the importance of team work in dentistry</strong></td>
<td>A dentist must understand the NHS regulations in providing treatment for patients, including how different contractual arrangements exist in general dental practice in Scotland and Northern Ireland, and England and Wales. Attendance at a nationally available 'Introduction to NHS Course' is recommended (e.g. organised by the British Dental Association (BDA) or deaneries), as part of the compulsory local induction plan, particularly for dentists who have qualified outside of the UK. An understanding of employment and contract law in the UK is recommended. The BDA produces useful advice sheets and the ACAS website also has helpful material.</td>
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<tr>
<td>Private practice</td>
<td>Does the dentist understand the regulations describing the interface between NHS practice and private practice? The BDA produces useful advice sheets about private practice.</td>
<td>It is important toascertain the applicant’s experience of working in a dental team and their level of understanding of the roles and responsibilities of other dental care professionals. A dentist will be required to participate in staff training and staff meetings where necessary. A dentist will be expected to work with a dental nurse when treating a patient. There are six types of dental care professionals (registrants) in the UK: 1. Dental nurses work at the chair-side to assist dentists. Education and training is through a combination of in-practice learning and formal training courses, leading to a registrable qualification. Assistants are able to undertake further training which qualifies them to provide assistance in undertaking sedation and working with special care patients, taking radiographs and oral health promotion. Expanded duties training is also available, e.g. topical fluoride application, impression taking and suture removal. 2. Dental hygienists may only work under the direction of a dentist, who must develop a treatment plan. The dentist does not need to be present on the premises during treatment. 3. Dental therapists may only work under the direction of a dentist, who must develop a treatment plan. The dentist does not need to be present on the premises during treatment. 4. Orthodontic therapists undertake specified aspects of orthodontic treatment under the prescription of a dentist. 5. Dental technicians are permitted to produce dental technical work to the prescription of the dentist, but cannot work in the mouth.</td>
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<tr>
<td>Topic</td>
<td>Requirement</td>
<td>Context</td>
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<tr>
<td>Clinical dental technicians</td>
<td>6. Clinical dental technicians are qualified dental technicians who provide dental devices to patients under the prescription of a dentist. They can also provide, without a dentist’s prescription, complete dentures and mouth guards.</td>
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<tr>
<td>Maintaining quality in dental care delivery</td>
<td>Understanding quality assurance mechanisms in the UK</td>
<td>The treatment data of providers (contract holders) and their performers who receive payment through the NHS primary care dental services is monitored and reported to the commissioning/employing organisation via regular reports which make comparisons to local and national averages. The Dental Reference Service of the Business Support Agency provides risk based clinical monitoring of NHS primary dental services contracts. Clinical Policy Advisers are available to support and advise PCO’s with regard to concerns relating to particular primary dental services contracts. From 1 April 2011, under the requirements of the Health and Social Care Act 2008, all providers of primary dental care services who provide regulated activities must be registered with the Care Quality Commission (CQC). The CQC will be responsible for ensuring that all dental providers in England comply with their requirements of registration.</td>
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| Continuing dental education | Understanding continuing dental education requirements | All registered dentists must participate in continuing professional development (CPD): 250 hours in five years, as defined by the GDC. This requirement is subdivided into 75 hours verifiable CPD and 175 hours of general (informal) CPD. Certain core (compulsory) subjects must be included in the verifiable activity, including:  
  - medical emergencies (at least ten hours in every five-year CPD cycle);  
  - disinfection and decontamination (at least five hours in every CPD cycle);  
  - radiography and radiation protection (at least five hours in every CPD cycle).  
In addition, it is recommended that training is undertaken in law and ethics, complaints and oral cancer.  
A dentist is required to keep a record of activity and certify compliance annually.  
Awareness of the importance of clinical governance requirements is useful.  
Awareness of the role of Postgraduate Dental Deans in continuing professional development and postgraduate education, including and understanding of the deanery competency frameworks is useful. |
| NHS complaints procedures | Understanding NHS complaints procedures | An understanding of practice NHS complaints procedures is required.  
Each NHS practice and clinic is required to have a complaints procedure and that any patient complaint must first be made to the dentist. |
<p>| Foundation Training (FT) | Understanding FT | Graduates of non-UK EEA dental schools are exempt from the requirement for foundation training, although they may apply for a place if they wish. Places cannot be guaranteed. |</p>
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<tr>
<th>Topic</th>
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<th>Context</th>
<th>Discussed?</th>
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<tbody>
<tr>
<td>Specialist training in the UK</td>
<td>Understanding specialist training in the UK</td>
<td>Foundation trainees are salaried at a national rate.</td>
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<td>There are 13 specialist lists held by the GDC.</td>
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<td>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.</td>
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<td>An application to the GDC is required in order to register as a specialist. The title “specialist” can only be used if a dentist is on the specialist list.</td>
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<td>There is an annual retention fee for each of the specialist lists</td>
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<tr>
<td>Support systems in the UK</td>
<td>Understanding the role of support systems in the UK</td>
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<td>The main dental organisation for dentists in the UK is the BDA. As well as acting as a professional organisation, it is also the trade union for dentists and a scientific society. The BDA publishes extensive guidance on practice management.</td>
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<td>Membership of the BDA is not compulsory.</td>
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<td>There are also other, smaller, general dental practitioner associations and scientific interest groupings (in addition to the specialist societies).</td>
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<td>Guidance and advice on relationships and behaviour between dentists, and between dentists and their staff, is provided by the BDA and other associations.</td>
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<tr>
<td>Corporate dentistry</td>
<td>Understanding the legislation concerning dental body corporates</td>
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<td>All GDC registrants can own a practice and also incorporate their practice into a company, becoming a legal entity. However, in all cases the majority of directors must be dentists or dental care professionals.</td>
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Annex 4: Further information from NHS Employers

NHS Employment Check Standards

NHS Employers provides guidance and advice to NHS organisations on policies and procedures designed to prevent unsuitable people obtaining employment in the NHS. NHS employers should carry out the necessary pre and post appointment checks in accordance with NHS Employment Check Standards which outline the legal and mandated requirements for pre-employment checks in the NHS. The standards cover: verification of identity checks, right to work checks, registration and qualification checks, criminal record checks, and occupational health checks.

Induction programmes

A sound and comprehensive induction programme should be in place. This ensures that international dentists are able to settle into their new environment as quickly as possible. It helps raise confidence and provides a familiarity with the practices of the NHS. An induction should cover the contracting/employing organisation itself and its procedures, as well as a more general induction into living in the UK. NHS Employers has developed induction programmes and collected examples of other organisations’ programmes to be shared across the NHS.

In addition, the Department of Health (England) has produced ‘Guidelines for NHS Employers: Induction programmes for Consultants and GPs recruited from abroad’ (29), a best practice guide to help NHS organisations prepare induction programmes for new consultants and general practitioners recruited from abroad. It draws together ideas generated by deaneries, trusts and other employer organisations, and has been developed with the help of overseas doctors themselves and so deals with concerns they have identified. Whilst individual learning needs of dentists will vary from that of consultants and GPs, many issues outlined in this guide will be equally appropriate for dentists.

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2 For more information visit: [www.nhsemployers.org/RecruitmentAndRetention/InternationalRecruitment/Specific-guidance/Pages/SpecificGuidance-Dentists.aspx](http://www.nhsemployers.org/RecruitmentAndRetention/InternationalRecruitment/Specific-guidance/Pages/SpecificGuidance-Dentists.aspx)

Note: the NHS Employment Check standards ‘Safer Recruitment – a guide for employers was first published in March 2008 and re-published in June 2010

3 NHS Employers provide information on Induction Programmes on their website at: [www.nhsemployers.org/RecruitmentAndRetention/InternationalRecruitment/Pages/Induction-programmes.aspx](http://www.nhsemployers.org/RecruitmentAndRetention/InternationalRecruitment/Pages/Induction-programmes.aspx)