Council of European Dentists

MANUAL OF DENTAL PRACTICE 2014

Ireland

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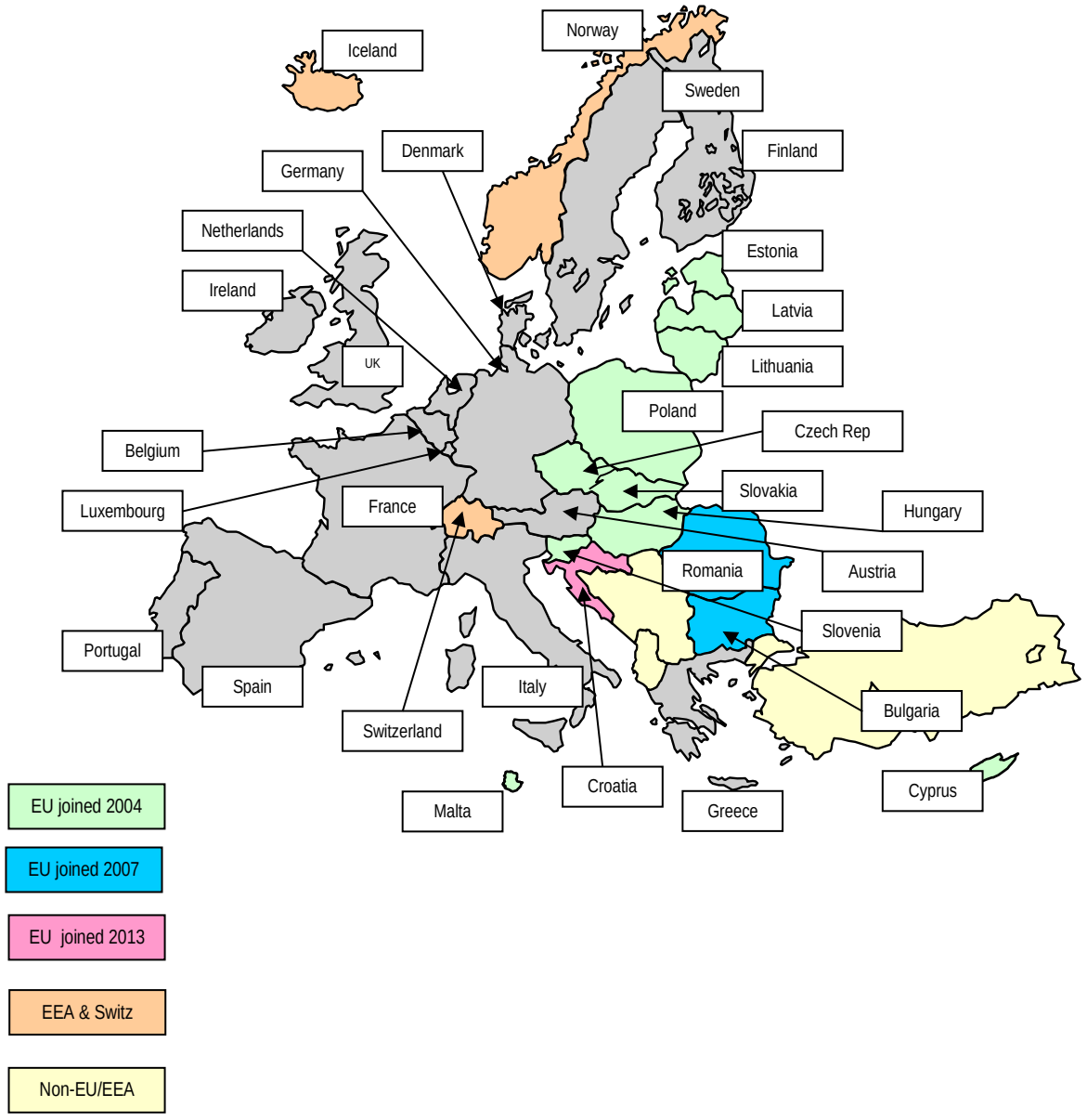
February 2014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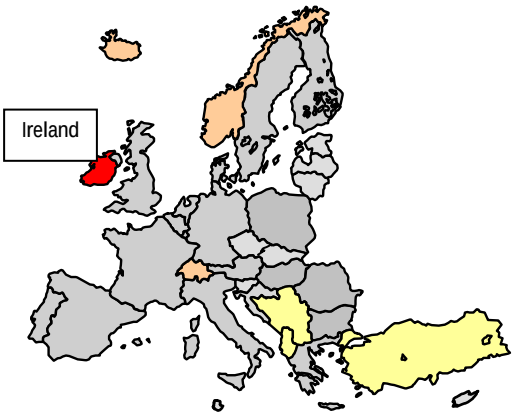

In the EU/EEA since	1973
Population (2013)	4,591,087
GDP PPP per capita (2012)	€31,351
Currency	Euro
Main languages	English Irish

Oral healthcare is provided through a complicated mix of publicly funded NHS schemes and fully private provision.

Number of dentists:	2,627
Population to (active) dentist ratio:	2,087
Members of Dental Association:	82%

There is a well developed system of specialists, and dental hygienists clinical dental technicians and orthodontic therapists also provide care. Continuing education for dentists is recommended but not mandatory.

Date of last revision: 26th January 2014

Government and healthcare in Ireland

The Republic of Ireland is one of the smaller countries of the European Union in terms of population. The capital is Dublin. Compared with most other European countries Ireland has a relatively high percentage of civilian employment in agriculture and also has a burgeoning computer software industry.

Ireland is a parliamentary democracy. The National Parliament (*Oireachtas)* consists of the President and two Houses: *Dáil Éireann* (the House of Representatives) and *Seanad Éireann* (the Senate) whose powers and functions derive from the Constitution of Ireland enacted by the People on 1 July 1937. The method of election to each House is different. The 166 Members of Dáil Éireann are directly elected by the people, by proportional representation. Of the 60 Members of Seanad Éireann some are nominated and some elected.

The sole and exclusive power of making laws is vested in the Oireachtas subject to the obligations of Community membership as provided for in the Constitution. The primacy of Dáil Éireann in regard to the life of the Parliament is recognised in that a general election to Seanad Éireann must take place not later than 90 days after the dissolution of the Dáil. In matters of legislation the Constitution provides that Seanad Éireann cannot delay indefinitely the passage of legislation. Bills to amend the Constitution and Money Bills i.e. financial legislation, can only be initiated in Dáil Éireann. Seanad Éireann can make recommendations (but not amendments) to Money Bills and these must be made within 21 days as against 90 days for non-Money Bills.

In addition to its legislative role, each House may examine and criticise Government policy and administration. However, Dáil Éireann is the House from which the Government (the Executive) is formed and to which it is responsible. Should the Government fail to retain the support of the majority of the Members of Dáil Éireann, the result can either be the dissolution of the Dáil and a General Election or the formation of a successor Government.

The Houses have separate constitutional identities. However, in recent years the setting up of a well organised system of Joint Committees (i.e Committees of both Houses sitting and voting together) has resulted in Members of both Houses having additional opportunities to participate to an even greater extent in specialised parliamentary work in several areas. The proceedings of the Houses and parliamentary committees are televised.

General healthcare is administered largely by the Department of Health. State healthcare expenditure grew by an average of 6.5% per year between 2000 and 2009. In 2010 state expenditure was €2,862 per head of population. This represented 9.2% of total health expenditure as a share of GDP

		Year	Source
% GDP spent on health	8.9%	2011	OECD
% of this spent by government	79.0%	2011	OECD

However, since then the share of state health spending has been decreasing rapidly. Cuts in government spending drove total health spending per capita down by changes to the system, a reduction in the number of healthcare workers, cuts in wages, as well as to the fees paid to healthcare professionals and pharmaceutical companies.

So, whereas in 2011 the state share of health spending was 79%, provisional figures indicate that it stood at 70% in 2013, while the share of out-of-pocket payments by households increased.

Thus, a significant proportion of healthcare is now privately funded. However, the private sector is partly subsidised through tax allowances for health insurance premiums.

The public healthcare system is governed by the Health Act 2004, which established a new body to be responsible for providing health and personal social services to everyone living in Ireland – the Health Service Executive (HSE). The HSE came into being officially on 1 January 2005. But, the HSE was being abolished in 2013 as part of the Government's reform programme.

All persons resident in Ireland are entitled to receive health care through the public healthcare system, which is managed by the HSE and funded by general taxation. A person may be required to pay a subsidised fee for certain health care received; this depends on income, age, illness or disability. All maternity services and child care up to the age of six years are provided free of charge. Emergency care is provided at a cost of €100 for a visit to the Accident and Emergency Department.

Everyone living in the country, and visitors to Ireland who hold a European Health Insurance Card, are entitled to free maintenance and treatment in public beds in HSE and voluntary hospitals. Outpatient services are also provided for free. However the majority of patients on median incomes or above, are required to pay subsidised hospital charges.

The Medical Card is available to those receiving welfare payments, low earners, those with certain long-term or severe illnesses and in certain other cases. The card entitles holders to free hospital care, GP visits, dental services, optical services, aural services, prescription drugs and medical appliances. In 2013, 31.9% of the population held a Medical Card. Those on slightly higher incomes are eligible for a GP Visit Card which entitles the holder to free general practitioner visits. For persons over 70 years who are not entitled to a medical card or GP visit card they instead receive an annual cash grant of €400, up to a certain income.

People who are not entitled to a Medical Card (68.1% of the population) must pay fees for certain health care services. In 2013, there was a €100 A&E charge for those who attend an accident and emergency department without a referral letter from a family doctor (a visit to which usually costs €50-75). Hospital charges (for inpatients) are a flat fee of €100 per day up to a maximum of €1000 in any twelve-month period, irrespective of the actual care received. Specialist assessments and diagnostic assessments (such as X-rays, laboratory tests, physiotherapy, etc.) are provided for free. If a person cannot afford to pay hospital charges, the HSE will provide the services free of charge.

Voluntary private health insurance

There a number of providers of voluntary health insurance.

The Voluntary Health Insurance Board (VHI) is the largest provider of voluntary private health insurance. It is a statutory body whose board is appointed by the Minister for Health. Laya Healthcare, Aviva, GloHealth and the Hospital Saturday Fund Health Plan (does not provide cover for hospital in-patient costs) also operate as voluntary private health insurance providers.

There are a number of long-established health insurance providers that deal only with particular groups of employees; membership is confined to employees and retired employees and their dependants. These schemes are known as restricted membership schemes. Examples include schemes for the police service and prison officers. Under their schemes insured persons and their spouses receive care in private and public hospitals, and outpatient specialist clinics, together with limited oral surgery and emergency dental trauma, optical and audiology services. Most members of the scheme (over 90%) also choose to pay enough contributions to cover the cost of private medical care.

General Medical Service from Health Service Executive (HSE)

The General Medical Service (or GMS) provides standard public, primary care services to medical card holders i.e. low-income families, those with chronic illness, all persons of 70+ and dependants of those working in another EU member state. The services are provided free of charge to the patient.

There is an annual predetermined budget by the Department of Finance and the Department of Health.

Oral healthcare

The majority of dental services are provided by dentists in the private sector, while the HSE is responsible for providing dental services to children and adults with special needs.

According to Department of Health statistics for 2011, 43% of adults attended a dentist in the previous 12 months.

		Year	Source
% GDP spent on oral health	0.33%	2004	OECD
% of OH expenditure private	47%	2004	CECDO

Public health insurance

Department of Social Protection Dental Treatment Benefit Scheme (DTBS)

All employees who make Pay Related Social Insurance (PSRI) contributions, and their dependent spouses/civil partners/cohabiters, are entitled to this scheme. This scheme is run centrally by the Department of Social Protection. The number of adults entitled to claim benefit under this Scheme was about 2 million in 2013 ie 45% of adults. Prior to 2010 a range of fully and partly subsidised routine dental treatments were available under the scheme. In 2010 this scheme was limited to one treatment – the annual oral examination.

Prior approval from the Department is not required under this Scheme. In 2013, 1719 dentists held a contract with the Department of Social Protection to operate the DTBS. €8.9 million was spent on the scheme in 2012, when 270,602 people claimed their benefit. The overall percentage uptake of the scheme is 13.53%.

Department of Health Dental Treatment Services Scheme (DTSS)

Dental care provided under this scheme is budget-limited. This scheme was introduced in 1994, as part of the national *Dental Health Action Plan 1994-98*, and covers about 30% of adults. A range of basic treatment items is available for eligible adults under this scheme. In 2010 the budget for it was capped at €63 million. Treatment available under the scheme was restricted to emergency treatment and high risk patients only. A limit of two emergency restorations per annum is allowed. Prophylaxis treatment is suspended, except for high risk patients. Prior approval for treatment is required for endodontic, prosthetic or periodontal treatment.

In 2012 394,000 patients were treated, with €63m in fees being paid to contracting dentists. In 2013, 1,429,560 patients were entitled to treatment under the scheme. Also, 1,594 dentists participated. The overall percentage uptake of the scheme in 2012 was 27.84%. The percentage uptake of the annual oral examination was 27.96%.

HSE Public Dental Service

Dental services for children and adults with special needs are provided by the HSE's Public Dental Service. The service is expected to target children at three stages in their development (in 2nd, 4th and 6th class in primary school) when children should be screened and provided with any follow-up treatment required. Their outstanding treatment need is addressed at that point. The overall strategy is based on this targeted approach together with the application of fissure sealants on first and second permanent molar teeth. In addition, emergency dental treatment should be available to all children up to 16 years. Pre-school children receive what amounts to an advisory service with emergency dental care available on demand.

Children and adults with special needs are also treated by the HSE Dental Service. Oral Health Promoters are employed to focus on at-risk groups, parents and carers with preventive advice.

The demand for this service currently far outweighs the resources in terms of the workforce available to provide the services.

Since March 2009, the number of dentists working in the Public Dental Service has reduced by nearly 20%. (From March 2009 to November 2012, the number of Whole Time Equivalents (WTE) reduced by 67.4 from 360.1 to 292.7).

This reduction in headcount, coupled with an increase in the target population has led to huge pressure on the service, resulting in targets not being met.

Private Care

The majority of oral healthcare is privately funded.

There are very few private insurance schemes to cover dental care costs. Those that do exist tend to be employer based, for example those for the police service and prison officers. Under these schemes the patient pays for treatment and then claims a partial subsidy.

There are a small number of free-standing private dental care plans in Ireland.

The cost of paying privately for a limited number of items of non-routine dental care or via insurance premiums is tax-deductible at a rate of 20% under current taxation law.

The Quality of Care

For treatment provided under a state scheme, the standard of dental care is mainly monitored by the funding body. The Central Payments Boards of the Department of Social Protection and the HSE do this in two ways. Firstly, the claims patterns of dentists are monitored to see if they differ significantly from existing practice norms. Secondly, the Department of Social Protection uses examining dentists to check the quality and quantity of dentists' work. These checks are done at random or in response to particular complaints. The treating dentist must be contacted beforehand and the examination arranged by mutual agreement. In addition each dentist's work is routinely monitored at least once in a 5 to 7 year period in order to assure the quality of the treatment carried out.

Complaints relating to private dental care, are normally addressed to the treating dentist directly in the first instance. If

the complaint or misunderstanding cannot be resolved, it is open to the patient to refer the complaint to the regulatory body, the Dental Council of Ireland or instigate civil litigation in the civil courts. Ultimately, the Dental Council has a statutory responsibility to promote high standards of professional education and to ensure high standards of professional conduct amongst dentists. A voluntary mediation service was established by the Irish Dental Association in 2012, the Dental Complaints Resolution Service, which has proved successful in resolving complaints.

Health data

		Year	Source
DMFT at age 12	1.10	2007	CECDO
DMFT zero at age 12	54%	2007	CECDO
Edentulous at age 65	41%	2007	CECDO

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

Additional data provided by the Irish Dental Association (IDA) for 2004 are:

DMFT at age 5 1.3
DMFT at age 8 0.4
DMFT at age 15 2.6
Mean no. of natural teeth present 16-24 yrs 28.1 (2007)
Mean no. of natural teeth present 35-44 yrs 25.2
Mean no. of natural teeth present 65yrs+ 8.5

Generally, epidemiological surveys are carried out by the HSE and the Department of Health. Public dental surgeons carry out the fieldwork.

Fluoridation

Water Fluoridation was introduced to the public water systems in Ireland in the 1960s. The amount of fluoride added to the drinking water in Ireland is controlled by law and must be in the range of 0.6 – 0.8 ppm fluoride.

There are no milk fluoridation or salt fluoridation schemes. A small number of supervised school-based fluoride mouth rinsing schemes operate in isolated areas such as the islands off the coast of Ireland.

It is recommended not to use fluoride toothpaste for children under 2 years of age in Ireland.

Parents are encouraged to supervise their children up to seven years of age while brushing their teeth so as to only use a pea size amount of paste and not to swallow it.

Education, Training and Registration

Undergraduate Training

Undergraduate training of five years duration may be undertaken in the two dental university schools in Cork and Dublin. Applicants must obtain the required number of points in the Leaving Certificate Examination. No other vocational entry is possible.

There are two schools, both publicly funded: Dublin Dental University School and Cork Dental University School.

Year of data:	2013
Number of schools	2
Student intake	86
Number of graduates	76
Percentage female	54%
Length of course	5 yrs

A small number of Irish students study dentistry in the UK.

Quality assurance of the curriculum is monitored and checked by the Dental Council of Ireland.

Qualification and Vocational Training

Primary dental qualification

The title on qualification is Bachelor of Dental Science (B Dent Sc) from Dublin Dental University School; and Bachelor of Dental Surgery (BDS) from Cork Dental University School.

Vocational Training (VT)

There is no mandatory post-qualification vocational training. A voluntary scheme which had been in operation for some years was suspended in 2011. A significant proportion of Irish graduates currently enter vocational training schemes in the UK.

Registration

In order to practice dentistry in Ireland one must be registered with the Dental Council of Ireland (the Competent Body). Full registration includes:

i. Graduates in dentistry from a university in Ireland.
ii. Nationals of EEA Member States who graduate within the EEA with a scheduled dental degree/diploma.
iii. Nationals of EEA Member States who qualify for registration under the provisions of the Directive 2001/19/EC.

Language requirements

For citizens of EU/EEA countries holding EU/EEA dental qualifications there are no formal linguistic tests or other tests in order to register to practice dentistry in Ireland. However, employers are free to conduct appropriate language tests.

Cost of registration (2013)	€ 200

Further Postgraduate and Specialist Training

Continuing education

The Dental Council obliges dentists to keep their professional knowledge and skills up-to-date and undertake continuing professional development (CPD). Course organisers apply for credit points for their courses and these are then allocated to course participants. A dentist who has accumulated a target number of points in a calendar year is entitled to a CPD Certificate. This is known as "Verifiable CPD".

The Dental Council recommends dentists complete and keep records of at least 50 hours of CPD per year, at least 20 of which should be verifiable CPD.

While the amount of CPD hours completed may vary from year to year, dentists should complete at least 250 hours of CPD every five years, of which a minimum of 100 hours should be verifiable CPD.

There is an extensive system for the delivery of continuing education, through courses provided by the Dental Schools, the Royal College of Surgeons, the Irish Dental Association, and various societies.

Specialist Training

There are two recognised specialties:

- Oral Surgery
- Orthodontics

To become a specialist, 2 years of general professional training must be undergone after primary qualification, and this is followed by 3 years of full-time specialist training. To be a consultant may involve a further 3 years of higher training. The training takes place in university teaching hospitals in Ireland, or other such recognised training establishments – often in the UK or other EU countries.

The trainees provide dental care during their training and would normally be paid as appropriate.

On completion of training as a specialist they normally receive a Certificate of Completion of Specialist Training in orthodontics or oral surgery, issued by the competent authority (the Dental Council of Ireland). Then, their name is entered onto the appropriate Specialist Register. They may also receive a diploma from one of the Royal Colleges of Ireland or the UK, such as a "Fellowship" or "Membership" or a Master's degree or PhD from a university.

Workforce

Dentists

Year of data:	2013
Total Registered	2,627
In active practice	2,200
Dentist to population ratio*	2,087
Percentage female	44%
Qualified overseas (2008 data)	634

* this refers to “active” dentists

Movement of dentists across borders

There were 110 of new registrants in 2012 - 60 female and 50 male. The total number of new registrants comprised of graduates from the following countries:

- 36 graduates from Ireland
- 22 graduates from Hungary
- 12 graduates from the UK
- 12 graduates from Romania
- 17 graduates from other EEA/EU countries
- 11 graduates from outside of EU.

There are a small number of unemployed dentists. No official statistics are available. An increasing number of younger Associates are working on a part-time basis in multiple practices rather than having one full–time position.

Specialists

In Ireland, two dental specialties are officially recognised by the regulatory body.

Year of data:	2008
Orthodontics	110
Endodontics	
Paedodontics	
Periodontics	
Prosthodontics	
Oral Radiology	
Oral Surgery	35
Dental Public Health	
OMFS	5

Oral surgeons work mainly in hospitals and universities. Most orthodontists work in private practice, although some work in hospitals, universities and the Public Dental Service.

There are other traditional specialist areas of dentistry such as Paediatric Dentistry, Periodontology, and Endodontics, where practitioners have undertaken further training and have limited their practices to their speciality.

Patients see specialists on referral only.

There are various associations and societies for specialists. These are best contacted through the Irish Dental Association.

Auxiliaries

The main types of dental auxiliary are as follows:

- Dental hygienists
- Dental technicians
- Clinical Dental Technicians
- Orthodontic Therapists
- Oral health educators
- Dental nurses

Year of data:	2013
Hygienists	458
Technicians	350
Clinical Dental Technicians	24
Orthodontic Therapists	5
Assistants (DSAs)	629
Non registered DSAs*	633

*estimated

Dental Hygienists

Hygienist training is undertaken at both Dublin and Cork Dental Schools, over a period of 2 years. To enter this training an applicant must have an appropriate Leaving Certificate result. Qualification is by way of a diploma, which is a registrable with the Dental Council before they can practise.

Hygienists may only practise under the supervision of a dentist. This does not mean that a dentist must be present throughout treatment but rather that a dentist will have prescribed the treatment plan and must be responsible for the treatment.

A hygienist is usually paid either on a percentage of income or by an hourly rate. HSE hygienists are paid a salary.

Dental technicians

Dental technicians are a recognised form of laboratory worker. Training is provided by a four-year apprenticeship, or a three-year course at the Dublin Dental Hospital, leading to a Diploma in Dental Technology. There is no register. All work must be done with the prescription of a dentist.

Technicians normally work in commercial laboratories, although some work in practices. They construct prostheses for insertion and fitted by dentists and they invoice the dentist for the work that is done. They would normally be salaried.

Laboratories have to be registered with the Irish Medicines Board. This requirement arises from the provisions of the EU Medical Devices Directive.

Clinical Dental Technicians

In 2008 the Dental Council approved the grade of Clinical Dental Technician (CDT). They are legally entitled to provide dentures directly to members of the public. CDTs are obliged to comply with the Dental Council's 'Code of Ethics and Conduct for Clinical Dental Technicians'. This Code was published in March 2010.

In order to quality as a CDT, a Postgraduate Diploma in Clinical Dental Technology must be attained. This course is available in Dublin Dental University Hospital. Applicants must possess a degree in Dental Technology or equivalent qualification. Entry to training in clinical dental technology would normally follow, as a minimum, a three-year period of professional experience in a dental laboratory. Applicants must have evidence of satisfactory sero-conversion for protection against Hepatitis B. Regulations also require testing for Hepatitis C for new entrants to the HSE. Applicants are required to undergo Garda (Police) Vetting

Oral health educators

Oral health educators give advice to individuals or groups on oral health care. This takes place with or without the supervision of a dentist. There is no registrable qualification for oral health educators although courses in Oral Health Promotion are available. There is no available data about their numbers.

Orthodontic Therapists

Orthodontic Therapists carry out certain parts of orthodontic treatment which may only be carried out under the supervision of a dentist registered in the Orthodontic division of the Register of Dental Specialists. Any such dental work must only be carried out after the orthodontist has examined the patient and has indicated to the orthodontic therapist the course of treatment to be provided.

As there are no programmes approved in Ireland for the purposes of registration in the Orthodontic Therapy Register, the Dental Council has decided that the procedure set out above will be applied to its consideration of any UK based training programme submitted for approval as a registrable programme in the orthodontic therapist register. This is to allow Irish dental nurses to obtain a UK qualification while undergoing their clinical training in Irish based Orthodontic practices.

Dental Assistants (Nurses)

Dental nurses assist the dentist at the chairside. Many undergo formal training in one of the dental schools. Others are trained 'on the job' and may or may not attain formal qualification through night school. There has been voluntary registration with the Dental Council, since 2002. Dental nurses are obliged to adhere to the Dental Council's 'Code of Ethics & Conduct for Dental Nurses'.

Practice in Ireland

Year of data:	2013
General (private) practice	1,800
Public dental service	333
University	50
Hospital	10
Armed Forces	5
Limited practice	150
Administrative	0
General Practice as a proportion is	68%
Number of general practices (2008)	700

"Limited practice" is where a dentist limits his/her practice to a single type of dentistry, for example: endodontics, paedodontics, periodontics, prosthodontics, for which there are no specialist registers.

To accept patients and receive remuneration under the Department of Social Protection Dental Benefits Treatment Scheme and the HSE Dental Treatment Services Scheme, dentists must enter into a contract with the Dental Section of the relevant Government Department.

Working in General Practice

Dentists who practice on their own or as small groups, outside hospitals or schools, and who provide a broad range of general treatments are said to be in *General Dental Practice*. Nearly three quarters of dentists work in this way.

Most dentists in general practice are self-employed and earn their living mainly through fees from patients, and partly from fees received under the government subsidised treatment schemes.

A general practitioner would normally treat about 20 patients a day.

Fee scales

For care carried out under the HSE scheme there is a standard fee scale covering different types of treatment. The patient pays nothing and the dentist claims the total fee.

For care (limited to the annual oral examination since 2010) carried out under the Department of Social Protection Scheme the dentist claims the total fee (€33) and the patients pays nothing.

Joining or establishing a practice

There are no rules which limit the size of a dental practice in terms of the number of associate dentists or other staff. Premises may be rented or owned, and may be in shops, offices, houses or purpose built premises, subject to planning permission from the local authority. There is no state assistance for establishing a new practice, so generally dentists must take out commercial loans or hire-purchase agreement from banks. Alternatively, a substantial minority of dentists work for a period in the UK in order to finance the establishment of their own practice on their return. There is no constraint on where a new practice may be opened.

There are no standard contractual arrangements prescribed for practitioners working in the same practice. Incorporated bodies are precluded from the practice of dentistry under the the Dentists Act 1985. This prohibition is expected to be abolished in the new legislation (expected to be introduced in 2014) which will govern dentistry in Ireland.

Working in the Public Dental Service

The HSE public dental service mostly provides services to primary school children, and also to others who are institutionalised, medically compromised or otherwise limited in their ability to access a general dental practitioner. The HSE employs salaried dentists (approximately 292.7 full time equivalents employed in 2013), including a small number of orthodontists (approximately 40.2 full time equivalents employed in 2013). These services are generally provided in HSE clinics but in some areas dentists in private general practice do sessional work.

The public dental service employs several categories of dentists such as *Clinical Dental Surgeons, General Dental Surgeons, Senior Dental Surgeons* and Senior Administrative Dental Surgeons with special skills in various specific disciplines, including treatment of patients with special needs. The manager of the dental service in each local HSE area, the *Principal Dental Surgeons* also has have administrative and management responsibilities. Working in the public dental service requires no additional training, but many have postgraduate qualifications. For senior dental surgeons however, three years experience in the public dental service or the hospital dental service is expected and five years for principal dental surgeons.

Within the public dental service there is a greater opportunity for job-sharing - working on a part-time basis with the retention of pension rights. There tends to be a higher proportion of female dentists working in the public dental service than private dental practice.

The quality of dentistry in the public dental service is assured through dentists working within teams which are led by experienced senior dentists. The complaints procedures are the same as those for dentists working in other situations. In addition, the HSE has its own complaints-handling procedure.

Working in Hospitals

A small number of dentists work in hospitals, other than the university dental hospitals. They are employed as salaried employees or on a private fee basis by the national or regional government, or one of the private health companies or religious orders which own some hospitals.

There are usually no restrictions on outside practice, and public health dentists and private practitioners often provide some care within hospitals.

Dentists who work within hospitals may be employed as *dental surgeons*, *senior house officers*, *registrars* or *consultants,* in the following specialist areas, Oral and Maxillo-Facial Surgery, Orthodontics and Paediatric Dentistry, Restorative Dentistry, Radiology and Oral Pathology. These are the traditional hospital and academic specialities that have existed for many years. As described earlier, to reach consultant level both basic specialty training (3 years), to obtain accreditation, and higher specialty training of 3 years, to obtain fellowship status, is required.

The quality of dental care in hospitals is assured through dentists working within teams under the direction of experienced consultants. The complaints procedures are the same as those for dentists working in other settings.

Working in Universities and Dental Faculties

A small number of dentists work full-time in the two university dental hospitals. About 100 dentists work part-time. Most full-time staff have contracts which exclude the possibility of private practice.

The main academic titles within an Irish dental faculty are those of *Professor*, *Senior Lecturer* and *Lecturer*. Those above lecturer level will usually have a *fellowship* (of one of the Royal Colleges of Ireland or the UK) and a PhD. There is a University Promotions Scheme, which sets standard procedures for making appointments. Apart from these there are no other regulations or restrictions on the promotion.

A typical full-time faculty member of staff will have as much time committed to administration and treating patients as to research and teaching.

The quality of clinical care, teaching and research in dental faculties is assured through dentists working within teams, and under the direction of experienced teaching and academic staff. The complaints procedures are the same as those for dentists working in other situations.

Working in the Defence Forces

Only a very small number of dentists serve full-time in the Defence Forces. No data is available about how many are female.

Professional Matters

Professional association and bodies

There is a single national association, the Irish Dental Association (IDA)

	Number	Year	Source
Irish Dental Association	1,700	2013	IDA

The IDA represents all sections of the profession, and about three quarters of active dentists are members. Its aims are to promote the science of dentistry, to maintain the honour and integrity of the profession, to promote the attainment of optimum oral health for Irish people and to represent the profession in all dealings and negotiations with Government, HSE and all other relevant bodies.

Ethics

Ethical code

All dentists in Ireland are obliged to adhere to the Dental Council's 'Code of Practice on Professional Behaviour and Dental Ethics'. It covers relationships and behaviour between dentists, contracts with patients, consent and confidentiality, continuing education, advertising and the quality of treatment. This includes a duty to provide emergency care for patients outside normal surgery hours.

Fitness to Practise/Disciplinary Matters

Any person can apply to the Dental Council for an inquiry into the fitness of a registered dentist to practise dentistry on the grounds of:

- alleged professional misconduct
- alleged unfitness to practise because of physical or mental disability

Each application is given due consideration and if there is a prima facie case for an inquiry such inquiry will be held. If, following an inquiry, a charge of professional misconduct is proven or the dentist is deemed unfit to practise by reason of physical or mental disability, the Council may suspend the dentist's registration, attach conditions to registration or erase his/her name from the Register. These sanctions are subject to approval by the High Court.

If a complaint by a patient regarding any aspect of State schemes is upheld, a financial penalty or a warning is the most likely form of sanction. In some more serious cases, a dentist may only carry out work after prior approval of all treatment plans. Occasionally, the dentist may get referred to the registering body, or lose their right to practise in the state-assisted system. At all stages dentists have a right of appeal within the complaints procedures, to the Minister of Health, via the HSE or to the Minister of Social Protection

Most Dental Associates are engaged on a self-employed basis. A dentist's employees, such as dental surgery assistants/dental nurses, enjoy the protections afforded by national and European employment laws.

Advertising

The Dental Council is obliged under legislation to give guidance to the dental profession generally on all matters relating to ethical conduct and behaviour. Dentists are obliged to adhere to the Dental Council's 'Code of Conduct Pertaining to Public Relations and Communications'. This permits advertising by the profession as long as it is factual and does not mislead the public.

The EU Directive on Electronic Commerce was implemented in January 2003.

Data Protection

Ireland fully implemented the Directive on Data Protection during 2003.

Corporate Dentistry

Corporate Bodies are precluded by law from engaging in the practice of dentistry.

Professional Indemnity

Liability insurance is provided for HSE Public Dental Surgeons and is compulsory for general practitioners participating in either the Department of Social Protection-or the Department of Health schemes.

The Dental Council's Code of Practice regarding Professional Behaviour and Ethical Conduct states that all registered dentists must hold appropriate professional indemnity cover (insurance).

It provides cover for advice, legal costs and unlimited indemnity. There are different prices for different types of dentist and a general dental practitioner pays approximately €6,000 annually. This will also cover them for a limited period whilst working abroad.

Tooth whitening

A Statutory Instrument was introduced in October 2012 giving effect to the European Communities (Cosmetic Products) (Amendment) Regulations 2012.

The legislation includes the following:

- Consumers may only be directly sold products containing a limit of 0.1% hydrogen peroxide;
- Products containing more than 0.1% and up to 6% hydrogen peroxide should only be administered by a dentist and should not be used on the under-18s;
- Products with more than 6% hydrogen peroxide (16.62% Carbamide Peroxide) are illegal;
- There is required information to be present on the label of tooth whitening products;
- Importing these products from outside the EU makes the Responsible Person legally accountable for compliance with the legislation.

The Irish Medicines Board and the HSE are responsible for overseeing the compliance with this legislation. Guidance on usage is also available from the Dental Council.

Dental hygienists in Ireland cannot administer whitening products containing more than 0.1% hydrogen peroxide.

The IDA has reported that there is some (continued) illegal practice by people such as beauticians etc.

Health and Safety at Work

A known Hepatitis B carrier may not work in a hospital or HSE facility in a clinical capacity. For all clinical workers an appropriate antibody titre is desirable. Hepatitis inoculation is highly recommended for GPs. Hospitals and HSE monitor their own staff.

Regulations for Health and Safety

For	*Administered by*
Ionising radiation	Radiological Protection Institute of Ireland
Electrical installations	Local government, Health and Safety Departments
Waste disposal	Local government, Health and Safety Departments
Medical devices	Irish Medicines Board
Infection control	Irish Dental Council

Ionising Radiation

Training in radiology is part of the undergraduate curriculum and no further training or continuing education or training is needed for dentists. The Dental Council recommends that dentists complete at least 5 hours in every 5 year cycle in radiation protection.

Qualified dental nurses and hygienists may train to provide these services but there is no validation of this training. Dental nurses who have registered with the Dental Council may take radiographs on completion of a course which has been approved by the Dental Council.

EU Directive 97/43/ Euratom was transposed into Irish Law by a Statutory Instrument of 2002. This law requires dentists to adhere to best practice in radiology. All dentists must acquire a licence from the Radiological Protection Institute of Ireland for an x-ray unit on their premises.

Hazardous waste

The EU Hazardous Waste Directive has been fully transposed into Irish law.

Financial Matters

Retirement pensions and Healthcare

For state-employed dentists, the dentist contributes about 5% of earnings, plus 1.5% widows and orphans contribution. Retirement age is 65 years. Full pension entitlement is predicated on 40 years service after which time a lump sum of 150% of final salary and an annual pension of 50% of final salary is paid.

All other dentists can arrange private pension schemes, contributing up to a maximum of 30% (depending upon age) of *net relevant income* to a *money purchase plan*. The normal retirement age in Ireland is 65 however this is not compulsory. Self-employed dentists may practise beyond 65 years of age.

Sickness benefit is available from the state in the case of an employed person, or from private income protection insurance in the case of a self employed person.

Taxes

There is a national income tax (dependent on salary – the lower rate is 20% and 41% is paid on incomes exceeding €32,800-€41,800 dependent on individual circumstances), Pay Related Social Insurance (PSRI) and Universal Social Charge.

VAT

VAT/sales tax is payable at 21% on some goods; including dental equipment and consumables. There is no VAT on healthcare services including dentistry. VAT at 23% is payable on toothpaste and tooth brushes.

Various Financial Comparators

Dublin *Zurich = 100*	2003	2012
Prices (including rent)	89.2	68
Wage levels (net)	66.1	59.6
Domestic Purchasing Power at PPP	76.5	74.1

Source: UBS August 2003 and November 2012

Other Useful Information

Main national association and information centre:	*Competent Authority:*
Irish Dental Association *(Cumann Fiaclóirí na hÉireann)* Unit 2 Leopardstown Office Park Sandyford Dublin 18 IRELAND Tel: +353 1 2950072 Fax: +353 1 2950092 Email: info@irishdentalassoc.ie Website: www.dentist.ie	The Dental Council of Ireland 57 Merrion Square Dublin 2 IRELAND Tel: + 353 1 676 2069 Fax: + 353 1 676 2076 E-mail info@dentalcouncil.ie Website: www.dentalcouncil.ie
Publication:	
Journal of the Irish Dental Association Unit 2 Leopardstown Office Park Sandyford Dublin 18 IRELAND Tel: +353 1 2950072 Fax: +353 1 2950092 Email: info@irishdentalassoc.ie Website: www.dentist.ie	

Dental Schools:

City: Dublin	City: Cork
Name of University: Dublin Dental University Hospital The Dean Dental School Trinity College Lincoln Place Dublin 2 IRELAND Tel: +353 1 612 7306 Fax: +353 1 671 1255 Email: info@dental.tcd.ie Website: www.dentalhospital.ie/ Dentists graduating 2012: 39 Number of students: 200	Name of University: Cork University Dental School and Hospital The Dean University Dental School and Hospital Wilton Cork IRELAND Tel: +353 21 454 5100 Fax: +353 21 434 3561 Email: dental@ucc.ie Website: www.ucc.ie/en/dentalschool/ Dentists graduating 2012: 29 Number of students: 220

Information collection and preparation

The revised EU Manual of Dental Practice (Edition 5) was commissioned by the Council of European Dentists[1] in April 2013. The work has been undertaken by Cardiff University, Wales, United Kingdom. Although the unit had editorial control over the content, most of the changes were suggested and validated by the member associations of the Committee.

About the authors[2]

Dr Anthony Kravitz graduated in dentistry from the University of Manchester, England, in 1966. Following a short period working in a hospital he has worked in general dental practice ever since. From 1988 to 1994 he chaired the British Dental Association's Dental Auxiliaries' Committee and from 1997 until 2003, was the chief negotiator for the UK's NHS general practitioners, when head of the relevant BDA committee. From 1996 until 2003 he was chairman of the Ethics and Quality Assurance Working Group of the then EU Dental Liaison Committee.

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

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

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

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

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

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

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

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

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

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

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

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The EU Dental Liaison Committee (DLC) commissioned the University of Wales to design and construct a manual of dental practice across the European Community, in 1995.

The original information, for the first edition of the Manual, was collected in early 1996, in three stages. Firstly, a questionnaire was circulated to the main dental associations in each of the 18 countries ie the 15 countries of the EU, plus Norway, Switzerland and Iceland.

The questionnaire collected data about the basic legal framework, the oral healthcare delivery system and the administrative structure within which dentists work. It covered any official oral health system recognised by government, private insurance and care plan schemes, and the organisation of dental practice including hospital and public dental services, dental faculties and auxiliary personnel.

After the initial exercise, validation interviews were conducted in 1996 to clarify and extend the information provided by the questionnaires. These interviews were broadly structured around the same topics as the questionnaire and lasted between 3 and 7 hours, depending on the complexity of the dental health system in the country.

The interview stage of the information collection process was essential for identifying important differences between countries, resolving potential ambiguities and exploring in detail those issues briefly covered by the questionnaire, which were more important for dental practice in a particular country. Given the non-standard nature of health systems and the variable organisation of dental practice, the interviews captured information which a "standard" data-collection instrument such as a questionnaire alone would have missed.

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

The first full edition of this review was published as a Manual of Dental Practice in the EU in 1997.

This process was repeated for the second edition, and the content was extended to include more information – such as information about women in dentistry, specialisation and remuneration trends, where appropriate and available. This was published in January 2000.

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

This third edition was revised and updated using two methodologies: for the new countries of the EU; new questionnaires were devised, based on an analysis of the information supplied by the existing countries in the first and second editions. Interviews were then conducted by the then authors, Dr Anthony Kravitz and Professor Elizabeth Treasure, with the representatives of the relevant countries, at various international meetings during 2003. The data and information for the existing EU countries were analysed and cross-checked for common information and then the individual country sections were marked by the authors for clarification, modification, expansion and revision, before being sent to the dental associations later in 2003.

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

The third edition, published in 2004, was presented in a new, modern style – a complete revamp of the two earlier editions.

The University of Wales became Cardiff University in 2005 and the DLC became the Council of European Dentists (CED) in May 2006.The CED commissioned Cardiff University in November 2007 to update the 2004 Manual and produce another version relevant to 2008 (edition 4) – to include Bulgaria (missing from the 2004 version) and Croatia, which was expected to join the EU in January 2009. The same process, with the same authors, was used for the 4th edition.

A further edition, 4.1 was produced in 2009, which embraced corrections of errors on 24 pages of the 405. All the data remained as supplied by October 1st 2008 and was not updated for edition 4.1.

For this 5th edition, Cardiff University was again commissioned. All the 32 countries involved with the 4th edition were approached in June 2013 (by email) and requested to provide new data – which all completed by November. For Romania the past Secretary-General of Collegiums contributed. No direct interviews were possible. Contacts in Monaco and Gibraltar were also approached with questionnaires in the Summer of 2013, and they are included for the first time.

All countries were then invited in January 2014 to update any data or information. Four countries did not respond to this request.