

Council of European Dentists

MANUAL OF DENTAL PRACTICE 2026

(Edition 6)

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Preface

This is the sixth edition of the Manual of Dental Practice, building on the initial publication commissioned by the Council of European Dentists (CED)¹ in 2000 and on subsequent revised editions published in 2004, 2008, 2014 and 2015.

The latest revised editions, published in 2014 with a partial update in 2015, were carried out by Cardiff University in the United Kingdom.

The sixth and newest edition builds on previous versions and maintains the essential structure and layout of the Manual. It however provides an in-depth revision of its content as well as significantly expands its scope to dentistry in the wider-European region. The decision to initiate the revision of the Manual, as well as the shortened structure, was adopted by the CED Board in September 2022 following the creation of a dedicated CED Board Task Force.

The CED Manual survey was launched at the end of 2021 and collected 44 responses from National Dental Associations, members of the CED and the European Regional Organisation (ERO) of the World Dental Federation (Fédération Dentaire Internationale (FDI)).

The work was carried out by the CED Office, with the participation and validation of Country Chapters by CED or ERO member National Dental Associations.

Acknowledgements

The CED would like to express its gratitude to all the staff from CED and ERO associations having contributed to the revision of Country Chapters and ensuring the inclusion of up-to-date and accurate data. The CED would also like to acknowledge and thank:

The dental associations of 37 countries, including 27 EU countries, 2 EEA countries, Switzerland and the United Kingdom, and 6 countries from the wider European region, South Caucasus and Central Asia.

Clara Luciani, Daniela Timuş, Elif Dincher and the Secretariat of the CED.

CED President Freddie Sloth-Lisbjerg; former CED Board Director; and currently sitting CED Board Directors.

Simona Dianišková, from the Slovak Chamber of Dentists and former President of the European Regional Organisation (ERO-FDI) 2022-2025.

Edoardo Cavallé, from the Association of National Italian Dentists (ANDI) and President of the European Regional Organisation (ERO-FDI) 2025-2026.

A special thanks to the staff of the CED and ERO national dental associations involved in proofreading and updating the individual Country Chapters.

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

The Fédération Dentaire Internationale (FDI)

The European Commission, including Eurostat

The EU Health Policy Platform

The Directorate-General for Communication, for EU country profiles

The World Health Organisation (WHO) and the European Observatory on Health Systems and Policies (particularly the Country reports)

The Organisation for Economic Cooperation and Development (OECD)

The International Monetary Fund (IMF)

The World Bank

Websites of national Ministries of Health, Ministries of Education, and social security or health insurance authorities

Disclaimer

Some of the data included in this edition was originally collected through a survey conducted in 2022 and later reviewed, revised and updated during the proofreading process in 2025-2026.

In the interest of maintaining accuracy and relevance, the Manual will remain as much as possible a living document, with small data updates upon request, as well as periodic revisions, to reflect changes in legislation, advances in oral health and dental practice.

Any request for minor changes or corrections should be submitted to the following address: ced@cedentists.eu

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Introduction

Background, scope and presentation of the review

According to the European Commission's report on the implementation of Directive 2005/36/EC on the recognition of professional qualifications, dentistry was the 5th most mobile regulated profession in the European Union between 2020-2025².

Alongside many other professionals, including the 4 most mobile regulated professions of doctor of medicine, nurse, secondary school teacher and physiotherapist, dentists and other dental professionals have been increasingly seeking opportunities to work and live in other countries. In line with current efforts by EU Institutions to improve the mobility and decrease barriers to free movement of healthcare professions within the EU and wider EEA countries, as well as to improve the recognition of skills and qualifications of professionals from outside the Union, national dental associations have experienced a considerable increase in the number of enquiries as well as mounting pressure for the recognition of EU and non-EU qualifications.

The problems and expense of answering these questions on an *ad hoc* basis, and the need for associations to conduct their national political negotiations in the context of international experience, resulted in the European Union Dental Liaison Committee (EUDLC, the previous name of the CED) commissioning the Dental Public Health Unit of the University of Wales Dental School in Cardiff (UK), in 1993, to produce a comprehensive reference document describing the legal and ethical regulations, dental training requirements, oral health systems and the organisation of dental practice in, at the time, 32 European (EU and EEA) countries.

The Manual primarily aims to provide comprehensive information for dentists, dental professionals and dental students who are considering working or studying in another country. It has also become a reference for governments, regulators, the media, professional associations, researchers and other stakeholders seeking to understand the main differences, similarities and distinctive characteristics of dentistry across Europe. Moreover, this edition enables a cross-comparison between the regulatory frameworks and harmonised practices in EU and EEA countries and the organisation and practice of dentistry in countries across the wider European region, the South Caucasus, and Central Asia.

The Manual provides a general insight into national general and oral healthcare systems, dental education and qualifications, registration, quality oversight, practice and regulation of the dental team. The data and information presented invites readers to further explore and compare the current functioning and development of dentistry, distinctive features, oral health needs and existing challenges across included countries and regions. It also seeks to support activities that promote the development of policies aimed at strengthening dental education, professional practice, and oral health care across borders.

It has been designed as a practical "handbook", in which information is easy to find and to understand. The 6th edition streamlines the previous content to focus on the key features of health and oral healthcare, structure of dental education and training, and the registration and professional practice requirements. The previous five editions were published under the title of the *EU Manual of Dental Practice*. To accurately reflect the edition's broader geographical scope and the collaboration between the CED and ERO, the title has been changed to the *European Manual of Dental Practice*.

Incorporated information covers the following:

An introduction to dental practice and regulatory frameworks in the EU, wider Europe and the neighbouring Asian region

The opening chapters outline the background and scope of work of the two main organisations representing dental practitioners in Europe; as well as the status of the dentist in the European Union, including the functioning of the EU and its role in the field of health and dentistry; the dentist's position in the wider Europe and neighbouring countries; an overview of the key EU Directives and regulations governing the dental profession.

The comparative analysis

Further chapters provide a simple comparative analysis of the different systems for the delivery of oral healthcare service, the nature of education, training and the constitution of the dental workforce, different practising arrangements, and other regulatory frameworks and systems within which dentists work.

The country chapters

The bulk of the Manual contains the detailed descriptions of individual oral health systems, and the ways in which dentists' study and practise in each 31 countries from the CED's member associations, as well as 7 countries from the European Regional Organisation's (ERO-FDI) member associations (as of 2026). The country chapters' scope therefore covers the EU27, EEA countries as well as Switzerland and the United Kingdom, and as of 2026, Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyz Republic and Türkiye.

² European Commission (2026) report from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on the implementation of Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications

Each country chapter includes:

- A very brief description of the country's political and institutional system, along with a general overview of the model, structure and functioning of its healthcare system.
- The main features of the oral health system, including how it is funded, how health and oral policy is decided, how the provision of oral health services is organised, if and what type of oral health services are covered under the public or social health system.
- A description of entry to and content of dental school (undergraduate) education and training, and the requirements for registration - including requirements for legal practice, the competent bodies managing the recognition of qualifications, language requirements, and any other conditions which need to be met on a case-by-case basis. Additionally, postgraduate education and training, including specialist training and postgraduate degrees is described, including the categories of specialties recognised in the country, training and practice requirements.
- A section also covers details and distinctive features of the dental workforce in the country, including recent trends and developments regarding the number and composition of dental professionals and the evolution of the dentist to population ratio. This includes details on practising specialists, and the recognition, responsibilities and mandated tasks of different dental auxiliaries.
- A final section for “*Other useful information*” section regroups the main useful contact details of competent authorities, main dental associations and other useful information centres, as well as of existing dental journals and all dental schools.

The Council of European Dentists (CED)

The Council of European Dentists (CED) is one of the leading voices of dentists in the European Union. It is a European not-for-profit association which represents over 350,000 dental practitioners across Europe through 32 national dental associations and chambers in 30 European countries. Established in 1961 as the EU Dental Liaison Committee to advise the European Commission on matters relating to the dental profession, later renamed Council of European Dentists, the CED's key objectives are to promote high standards of oral healthcare and dentistry, and effective patient-safety centred professional practice.

The CED serves as the primary voice for European dental professionals and oral healthcare policy, in dialogue with European Union institutions and other European stakeholders.

The organisation's core mission is to promote the interests of the dental profession in Europe, represent European dental professionals across the EU-27 and neighbouring countries, to promote high standards of oral health, dentistry, dental care for general health outcomes and to bolster effective patient safety-centred and evidence-based professional practice across Europe.

To achieve these objectives, it develops policy statements and position papers on topics such as professional regulation, patient safety, oral health promotion, digital health, education, dental materials and medical devices, sustainability, and workforce issues. Through its task forces and working groups, the CED contributes to European policy discussions while facilitating collaboration and the exchange of best practices among its member associations.

The European Regional Organisation (ERO) of the World Dental Federation (or *Fédération Dentaire Internationale - FDI*)

The European Regional Organisation (ERO) is the European regional body of the FDI World Dental Federation (or *Fédération Dentaire Internationale*). Founded in 1964 by European members of the World Dental Federation (FDI), it is a non-profit organisation established in accordance with the FDI Constitution, that brings together national dental associations from across the WHO European Region, providing a platform for cooperation and the exchange of knowledge on issues affecting the dental profession.

At the time of drafting the 6th edition of the Manual, the organisation comprised 47 member associations from 37 countries and aimed to cover the entirety of the WHO European Region.

ERO-FDI seeks to strengthen the dental profession by developing policy recommendations, promoting high standards of education and professional practice, and promoting the concept of dentistry as an independent profession based on the principle of freedom of choice in the relationship between dentist and patient. Its activities are carried out through a Board, a Plenary Session, and several specialised Working Groups covering the topics of Ageing Population, Continuing Medical Education in Dentistry, Digitalisation and Artificial Intelligence, Dental Practice, Integration, Liberal Dental Practice in Europe, Relations Between Dental Practitioners and Universities, and Oral Health and General Health.

ERO develops its activities under the leadership and vision of the FDI and promotes and supports European and national health policies that respect ethical principles and professional standards.

Definitions

Percentage of Gross Domestic Product (GDP) spent on all healthcare, or on oral health

This refers to the proportion of a country's overall wealth which is dedicated to healthcare spendings, or, spent on dentistry – through national health/social insurance AND private spending, if known (composed of private voluntary health insurance and out-of-pocket payments).

Private dental practitioners

Private dental practitioners are dentists who work in privately owned dental practices or other privately operated dental practices. They practice independently of state-funded systems and are not attached to a state-funded oral health program, public hospital or public dental clinic.

Dental care received through private dentists may, depending on existing schemes, be partly reimbursed or covered by the existing statutory health insurance scheme in the case of contracted private dentists. The remaining cost is paid entirely by patients, with sometimes the support of private (or complementary/voluntary) dental insurance, purchased by the patient.

Private dental practitioners commonly provide a wider range of treatments and choice of procedures and materials, can have shorter waiting times, and can have prices set by the dental practitioner.

Public dental practitioners

Public dental practitioners are dentists employed by publicly owned or publicly operated dental services, such as governments, municipal or public hospital dental services. They are fully or partly employed or contracted by a government or a state national health service. They usually practice in specific settings (in public clinics or dedicated health centres for example) by providing subsidised or free basic dental care. They either provide a complete package of oral healthcare services, or a set number and type of service (including in most cases routine dental check-ups, emergency care, some fillings and other set treatment as well as dental public health services) and exclude other categories of treatment.

Public dental care is also usually accessible to only eligible population groups (for example children, older adults, persons with disabilities, etc), through set fees.

General Practice - general dental practitioner

A general dental practitioner is a dental practitioner who provides primary dental care to patients and is usually the first point of contact for a patient seeking dental treatment. They are not acting in the capacity of a formally recognised specialist. A general dental practitioner works in general practice and provides a broad spectrum of preventive, restorative and cosmetic treatments to patients, and is responsible for routine dental check-ups, providing oral hygiene and overall oral healthcare.

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

- direct payments by patients, such as “co-payments” to cover the rate not reimbursed by state or social insurance schemes, or out-of-pocket payments in case of fully private dental care
- payments from state or social insurance schemes
- payments by private health insurance companies

Private (complementary/voluntary) health insurance for dental care

This refers to insurance for dental treatment which patients buy from independent insurance companies or funds not directly controlled by either the government or any social insurance scheme. Private health insurance may be used to cover part of the cost of private dental care, as well as any co-payments.

Co-payments

These are payments made by patients towards the cost of a dental service that is covered, usually partly, by either the state or a social insurance scheme. The cost remaining after the amount reimbursed by the scheme is a co-payment.

Vocational training

This refers to a period AFTER graduation in some countries, either before (or as a condition of) registration, or following registration with the competent authority, when the new dentist practises in a mandatory supervised environment such as a training practice or public clinic or hospital department, supervised by a licenced dental practitioner.

Rules around vocational training vary widely from country to country, including the mandatory nature of vocational training across European states. Some European countries do not require any type of vocational training before registering under the competent body.

The training period may - but not necessarily - include taking additional accredited courses in a dental school and further examinations before the dentist is authorised to practise in a non-supervised environment.

Cost of registration

This refers to the annual registration fee (if any) paid to the competent body responsible for registering dentists in a country. This is separate from any voluntary or mandatory membership fee paid to the relevant national dental association (which may or may not also serve as the competent authority).

Dental Specialists

Dental specialists are dentists who have completed a nationally recognised programme of specialist dental training following their basic qualification as a dentist and can practice the speciality under national rules and use the relevant specialist title in that country. Under Directive 2005/36/EC on the recognition of professional qualifications, specialist dental qualifications in orthodontics and oral surgery listed in Annex V are subject to automatic recognition across EU Member States, provided that the conditions laid down in the Directive are fulfilled.

EU member states commonly recognise other dental specialties at a national level, such as, but not limited to, periodontology, endodontics, implantology, prosthodontics, public dental health, dental imaging, pedodontics, oral medicine, etc.

The number and categories of nationally recognised specialties vary from country to country. These specialties are not subject to the European system of automatic recognition.

Oral maxillo-facial surgery

Oral maxillo-facial surgery is also widely recognised as a medico-dental specialty. The training requirements of oral and maxillofacial surgery vary between countries.

Depending on the national system, it may be regulated as a dental specialty, a medical specialty or a specialty requiring both a basic medical qualification and a basic dental qualification. Its regulatory status therefore depends on the applicable national legislation and specialist training framework.

Foreign-trained dentists

This term refers to any dentist having received their primary dental qualification in a country other than the given (host) country, even if they are nationals of that host country. This is therefore independent from the dentist's nationality.

The term foreign-trained dentists is distinct from third-country nationals below.

Third-country nationals

Third-country nationals here refer to dentists who are not a citizen or a national of a member country of the European Union. Third-country nationals who are practising dentists may, however, have obtained their dental qualification from an EU member state, and may therefore enjoy the right to free movement within the EU, as defined in the Schengen Borders Code³ (which could also apply to family members of an EU national exercising his or her right to free movement within the EU, people with long-term resident status, individuals with single permit to work in a Member State, holders of an EU blue card, seasonal workers and person with a refugee status).

It is important to note that different recognition processes for incoming dentists legally distinguish recognition processes for qualifications obtained outside the EU from those obtained from an EU-country, as explained below.

Third-country qualifications

A third-country qualification is a primary dental qualification obtained outside the European Union.

For example, a national of an EU member state having obtained their qualification from a country outside the EU, EEA, the United Kingdom (in certain cases only) and Switzerland, is referred to in this Manual as a dentist with a third-country qualification.

Different recognition procedures apply to the different situations described above.

Active dentists

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

Public dental services

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

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

Corporate Dentistry

Corporate dentistry refers to the provision of dental services through practices owned or managed by a corporate or other legal entity rather than directly by an individual dental practitioner or partnership of dental practitioners.

According to the CED, corporate dentistry encompasses organisations that usually set up dental offices in a number of locations, which can be in the same country or across different countries, recruit and engage dentists, and are usually run by investment companies.

The Board of the company may comprise non-dentists although usually at least one (if not all) of the members must be a dentist or a dental auxiliary. The company commonly employ the dentists (and dental auxiliaries) who provide the dental care.

³ Regulation (EU) 2016/399 of the European Parliament and of the Council of 9 March 2016 on a Union Code on the rules governing the movement of persons across borders

The Dentist in the European Union

Membership and objectives of the EU

The dentist working in one of the EU Member States is entitled to free movement and practice across all countries of the European Union, EEA Member States and Switzerland.

The European integration was launched on 9 May 1950, with the Treaty of Paris being signed on 18 April 1951, creating the European Coal and Steel Community (ECSC) in 1952.

On 25 March 1957, the 6 founding countries negotiated and signed two Treaties of Rome, thereby creating the European Economic Community (EEC) and the European Atomic Energy Community (Euratom). These collectively became known first as the EEC, then as the European Community (EC) and finally the European Union (EU).

Several waves of succession have followed from then, resulting in a gradual expansion of the European Union from its original six founding countries to 28 Member States by 1 January 2014. This number fell back down to 27 Member States, following the withdrawal of the United Kingdom on 31 January 2020.

At the time of writing of the 6th edition, the EU was currently comprised of 27 Member States, with accession negotiations underway between the EU and six candidate countries, including Montenegro, Serbia, Albania, North Macedonia, Ukraine and Moldova.

Membership of the EU

- Belgium, France, Germany, Italy, Luxembourg and the Netherlands (March 1957) – were the founding countries
- Denmark, Ireland and the United Kingdom (January 1973)
- Greece (1981)
- Spain and Portugal (January 1986)
- Austria, Finland and Sweden (January 1995)
- Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia (May 2004)
- Bulgaria and Romania (January 2007)
- Croatia (July 2013)
- Withdrawal of the United Kingdom in January 2020

On 1st January 1994, some of the privileges of the Community, for example the "freedom of movement", were extended through the Treaty on the European Economic Area (EEA) to the countries of the European Free Trade Area (EFTA). These remaining non-EU EFTA countries are Iceland, Liechtenstein and Norway, as well as Switzerland through the 1972 free trade agreement and the 1999 bilateral agreements.

The principal objectives of the Union are to:

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

The European Community Treaty (or Treaty of Rome) was amended on 1 July 1987, by the Single European Act (SEA). This restated the objectives of the EC by formalising the commitment

to the completion of the "Internal Market" by 1992. The Act also extended the competence of the Community to new areas such as environmental improvement and the strengthening of social cohesion and modified the decision-making process by extending the use of majority voting in the Council of Ministers.

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

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

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

- *European Parliament*, is elected by the citizens of EU Member States;
- *European Council* has the role of driving EU policymaking, headed by the President;
- *The Council of the European Union (commonly known as the "Council")* is composed of representatives of each Member State at ministerial level;
- *European Commission* is the executive body of the EU. It promotes the general interests and political direction of the EU, proposes legislation, implements EU policies and the EU budget, oversees the application of EU law;
- *Court of Justice of the European Union (CJEU)* ensures that EU law is interpreted and applied consistently and that EU institutions and Member States comply with EU law;
- *European Central Bank (ECB)* is responsible for monetary policy for the euro area;
- *European Court of Auditors* audits the EU's finances and examines whether EU revenue and expenditure are legally managed.

Five further bodies are part of the institutional system, as well as other specialised bodies and institutions (non-exhaustive list):

- *European Economic and Social Committee (EESC)* is an advisory body representing employers, workers and other organised civil-society interests, which gives opinions on EU policy and legislation;
- *European Committee of the Regions (CoR)* an advisory body representing regional and local authorities and is consulted on matters affecting them;
- *European Ombudsman* investigates complaints about maladministration by EU institutions, bodies, offices and agencies and promotes good administration;
- *European Investment Bank* contributes to EU objectives by financing public and private long-term investments;
- *European Central Bank* (responsible for monetary policy and foreign exchange operations).

Health in the European Union

The EU health strategy, at the time of writing of this 6th edition, was strengthened by the [European Health Union](#), launched in November 2020, following the first year of EU-response to the COVID-19 pandemic. The European Health Union aims to strengthen cooperation, coordination and preparedness at EU level, particularly in relation to serious cross-border health threats and future health emergencies. It has also supported greater cooperation on issues such as medicines, disease prevention, health systems and health data management.

The European Health Union contributed to strengthen the EU's role in the field of health and particularly for improving the Union's coordinated action in the context of health emergencies and for prevention, preparedness and response, in full compliance with the principle of shared competence in only some supportive areas of public health. It reflects a stronger emphasis on EU solidarity and coordinated action, while recognising that Member States remain primarily responsible for organising and delivering health services and medical care.

The European Health Union contributed to reinforce EU policy action, in particular in the fields of prevention, preparedness and response to health crises, ensuring available, affordable and innovative medical supplies, and wider and more targeted response to pandemics, including both widespread communicable and non-communicable diseases such as cancer, cardiovascular diseases etc.

According to the European Commission, the European Health Union enables to develop actionable initiatives and partnerships for the purpose of:

- Better protecting the health of the Union's citizens
- Improving the resources and capacity of Member States and the EU to prevent and respond to future pandemics

The Freedom of movement and acquired rights

The principle of freedom of movement of workers is a fundamental principle of EU law under the Treaty of the Functioning of the European Union (TFEU). As originally established, it prohibits "discrimination based on nationality between workers of the Member States (MS) in employment, remuneration and other conditions of work and employment" (Article 45 of the TFEU).

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

- accept offers of employment in any EU country;
- move freely within the Union for the purposes of employment;
- be employed in another EU country in accordance with the provisions governing the employment of nationals of that host country;
- remain in the country after the employment ceases, subject to conditions laid down by EU law.

EU workers are also entitled to equal treatment with nationals in employment and, subject to the applicable rules, in certain social and tax advantages.

- Improving the resilience of European health systems

In the aftermath of the pandemic, major EU initiatives were developed. A few examples can be mentioned here, including the revision of the EU Pharmaceutical legislation, the launch of Europe's Beating Cancer Plan, the launch of the EU Cardiovascular Health Plan, the development of the European Health Data Space, and the adoption of the EU's investment plan in health through the Global Gateway.

The European Health Union and the EU's wider health strategy has demonstrable effects on national dental and oral health policies in several key professional areas, including:

- Medical devices and dental materials, including oral healthcare products and clinical materials
- Digital oral health
- Clinical data management, data protection and Electronic Health Records (HER)
- Internal market and rules for professional practice
- Movement of dental practitioners and patients
- Dental education policies, including guidance around life-long education and continuing professional development
- Dental workforce, dental specialties and the wider dental team
- Oral health prevention and reduction of oral disease and wider disease risk-factors
- Waste management and sustainability
- Patient and professional safety
- Commercial practices and rules surrounding dental practices

Restrictions on the free movement of workers may only be justified on grounds of public policy, public security or public health.

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

Dentists benefit from the EU system for the recognition of professional qualifications. The current framework is principally Directive 2005/36/EC on the recognition of professional qualifications, as amended by Directive 2013/55/EU.

Any dentist who is an EU national and has an undergraduate or postgraduate dental degree or diploma obtained in a Member State that meets the minimum training requirements outlined in Section 4 of Directive 2005/36/EC (the Professional Qualifications' Directive) and which title is listed in Annex V.3.2 is entitled to practise in any country in the European Union.

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

Articles 4c and 4d of the Professional Qualifications Directive (PQD), define the role of the home Member State authorities.

Further details of the implications of this Directive for dentistry and the minimum training requirements for dentists are outlined in the section below on “Directives and Regulations involving the dental profession in the EU”.

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

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

Automatic recognition of a qualification does not remove the need to comply with the host country's rules for practising the profession. A dentist wishing to establish themselves in another EU Member State needs to apply to the relevant competent authority and obtain permission or registration before practising, as well as adhere to national codes of practice.

Dentists must also have the language knowledge necessary to practise their profession safely in the host Member State. Language checks may be required, according to the relevant national legislation.

Directive 2004/38/EC of the European Parliament and of the Council, adopted on 29 April 2004, established a comprehensive framework governing the right of EU citizens and their family members to move and reside freely within the territory of the Member States. It consolidated and replaced a number of earlier measures concerning free movement and residence.

Further details regarding rules and regulations surrounding the study, practice and oversight of dentistry are outlined in a section further below, “*Directives and Regulations involving the dental profession in the EU*”.

The dentist in the wider WHO Europe Region

The WHO European Region

The WHO Regional Office for Europe is the regional authority responsible for public health within the United Nations and the World Health Organisation (WHO). It is a regional entity of the WHO and is an institutional and geographic grouping of 53 countries, covering an extended region spanning across countries of wider Europe, South Caucasus and Central Asia.

This chapter provides a brief overview of the main trends and challenges in dentistry across the region, as well as any existing mutual regional agreements (MRA) or bilateral agreements regarding dentistry.

In 2023, 66.7% of countries out of all WHO European countries did not have a national oral health policy in place (World Health Organisation, 2023). According to the WHO, the European Region also demonstrated a high prevalence of oral diseases, including caries in permanent teeth, edentulism, and oral cancers.

According to WHO Europe, the average number of dentists in the WHO European Region was 6.7 dentists per 10,000 population based on the latest data available in 2022.

The structure and functioning of oral health systems, as well as of dental undergraduate, specialist and post-graduate education, and the specificities of dental practice and regulation naturally vary widely across countries of the region.

The EU Directives, Regulations, Recommendations and Guidelines outlined in the next chapter do not, however, apply to or guide dentistry in non-EU countries covered by this Manual, including those in wider Europe, the South Caucasus and Central Asia.

Movement of dentists across the Region

Dentists practising in a country within the WHO European Region not an EU Member State, an EEA country, Switzerland or the United Kingdom (in certain cases only for the UK, see below), are not covered by the automatic recognition regime for dental qualifications established under Directive 2005/36/EC.

Dentists having obtained their qualifications outside these countries are not entitled to automatic recognition or the associated rights of free movement, as explained in further detail below. Professionals wishing to practise in an EU Member State must therefore apply for the recognition of their dental qualification under the General System established by Directive 2005/36/EC.

Although no common recognition schemes apply across the countries of the WHO European Region, some regional and bilateral mutual recognition agreements (MRA) are in place for some countries.

An example of this is Kazakhstan's ratification in 2026 of the Asia-Pacific Regional Convention on the Recognition of Qualifications in Higher Education (Tokyo Convention). Although

the Convention does not, in itself, establish automatic or mutual recognition of higher education qualifications or dental diplomas, it establishes a framework for the fair, transparent and non-discriminatory recognition of qualifications between the States Parties. It promotes transparency, quality assurance, cooperation and the exchange of information in national recognition processes, while facilitating academic mobility and contributing to greater mobility of qualified professionals between participating countries.

Another relevant development is the regional initiative in Central Asia on the mutual recognition of higher education qualifications. In November 2025, the Government of Kazakhstan approved a draft multilateral Agreement between Kazakhstan, the Kyrgyz Republic, Tajikistan, Turkmenistan and Uzbekistan on the mutual recognition of higher education documents.

The draft Agreement facilitates the recognition of higher education diplomas issued by accredited higher education institutions in signatory States. It envisages that such recognition may provide access to professional practice, internships and further education in accordance with the field of practice, as indicated on the professional qualification. The draft also provides safeguards related to comparability of higher education requirements.

This regional initiative is particularly relevant to professional mobility in Central Asia. However, it should be distinguished from the UNESCO Tokyo Convention: the Tokyo Convention establishes an international framework and principles for fair, transparent and non-discriminatory recognition of higher education qualifications, whereas the Central Asian agreement is intended to establish more specific mechanisms for mutual recognition among signatory and participating states.

For dentistry, these instruments should not be interpreted as providing automatic recognition of qualifications, providing the immediate right to practice dentistry. Recognition of an academic qualification and authorization to practice a regulated health profession remain distinct matters and may continue to be subject to national professional and regulatory requirements.

Common trends and challenges

The training, practice and regulation of dentistry vary considerably across Europe, South Caucasus and Central Asia, reflecting the diverse political, geographical, cultural, economic and social realities of each country.

However, drawing on the chapters published in the Manual at the time of drafting the 6th update, this section provides a very broad overview of some key common trends and characteristics of the region⁴:

⁴ For further detail, please refer to individual country chapters.

Public-private model with a strong role for private dentistry

Although mixed systems with public dentists alongside private dentists exist in the region, dental care is predominantly delivered by private dentists, with a dominance of private practices.

Limited public coverage for oral and dental healthcare

Out-of-pocket spending remains the main source of funding for oral health care for the adult population. In most countries, oral healthcare services are excluded from the benefits packages provided through state-funded healthcare systems or statutory social health insurance.

By contrast, Türkiye provides, for example, a comprehensive package of oral and dental care services to its general population under the general health insurance scheme of the national social security (SGK).

An important rural – urban divide

A common observation across these countries is a starker geographical, and particularly rural-urban divide, with frequent shortages of general and specialist dentists in rural and remote areas. This includes geographically isolated and mountainous communities in some South Caucasian and Central Asian countries, with lack of availability and accessibilities of dental professionals and oral healthcare services.

For example, this was the case, at the time of drafting of this edition, of Georgia, Kazakhstan, the Kyrgyz Republic, and Armenia.

Geographic inequalities are also often paired with an ageing dental workforce and the rural exodus of healthcare professionals to urban and more populated areas.

Community dentistry and National Oral Healthcare Programmes

As a result of these pronounced geographical inequalities, greater emphasis is placed on community and family dentistry, and on the development of national oral healthcare programmes. In many of these countries, state-run dental programmes are developed to improve access to basic dental care and preventive services for rural, remote and marginalised communities.

Programmes include the implementation of mobile dental units as well as school programmes for the delivery of annual health check and basic restorative services.

Dental education - a mixed public and private model

Countries demonstrate diversified structures and models of undergraduate dental education. Dental programmes and dental curricula show distinctive features depending on the country.

However, a majority of countries' dental programmes included 5 years of undergraduate study, with some exceptions, such as Kazakhstan (6 years of study) and Kyrgyzstan (in some faculties only).

However, in comparison with relevant EU and EEA countries, an important growth of private dental schools and dental programmes is observed. In some countries, such as Georgia, the Kyrgyz Republic and Armenia, private institutions account for the majority of dental schools, compared with public universities and faculties.

Türkiye counted a total of an estimated 105 dental faculties, with approximately 30 private dental schools, at the time of the drafting of this update.

Strong and centralised governmental regulation and oversight

In the non-EU/EEA countries covered by the Manual, the regulation and oversight of dental education and professional practice are generally highly centralised.

As a common pattern between these countries, the Ministries of Health and, sometimes, other government authorities play a central role as Competent Authorities for the professional registration, the provision of licenses, the recognition of qualifications, the delivery of educational standards, and the accreditation, regulation and oversight of undergraduate education, specialist training and continuing professional development (CPD).

This contrasts with the more decentralised system in some countries, where national dental associations may act as Competent Authorities.

Membership to relevant national or regional dental associations is also generally not mandatory.

Some CPD courses are, however, often delivered by the relevant dental association.

Well-established dental specialties

Dental specialties are widely developed and recognised across all covered countries. The organisation, titles and scope of training and practice of dental specialists may however widely differ.

A number of commonly recognised specialties exist across the region, including orthodontics, prosthodontics or orthopaedic dentistry, therapeutic or restorative dentistry, paediatric dentistry and oral or maxillofacial surgery. Regional specificities include the recognition of the titles of oral pathology and aesthetic restorative dentistry, orthopaedic dentistry and surgical stomatology.

Some countries also recognise additional specialties or sub-specialties, such as Armenia and Georgia. Differences remain in the number and categories of recognised specialties, the titles used, the duration and structure of specialist training, and the distinction between dental and medical specialties.

Mandatory Continuing Professional Development

CPD is legal requirement for dentists in a majority of covered countries of the Region, including Georgia, Kazakhstan, Kyrgyzstan, Azerbaijan, and Armenia.

This includes the obligation for dentists to complete a minimum number of hours or credits of training every determined number of years, determined individually by countries. In Türkiye, CPD is highly promoted but not legally mandatory.

A diversified and widely used dental auxiliary workforce

Most countries heavily rely on dental auxiliaries. They play an important role in supporting dental practices in most of the countries covered, including in rural and underserved areas.

These include dental technicians, dental chairside assistants, and laboratory technicians. Dental hygienists are, on the other hand, not commonly recognised in most countries.

The education and scope of practice of dental auxiliaries vary widely across countries.

In the case of Kazakhstan, no categories of dental auxiliaries are officially recognised.

International guidelines and initiatives

Unlike within the European Union, no common legislation aligns dental training or the practice of dentistry across WHO European States.

However, international guidelines may guide countries in various areas, including for strengthening national oral health systems, expanding or developing universal health coverage in public healthcare schemes, for framing the use of hazardous or environmentally damaging dental materials or products, and for guiding countries in the development of the national dental educational programme or dental curricula.

Without intending to provide a comprehensive list, the outline below provides some examples of existing recommendations, targets, tools and guidelines:

- Recommendations under the WHO European Region summary on the [Global oral health status report: towards universal health coverage for oral health by 2030](#) (2023)
- The [WHO Global strategy and action plan on oral health 2023-2030](#) (2024)
- The report on [Developing the global oral health monitoring framework report](#) (2025)
- The [WHO guideline on environmentally friendly and less invasive oral health care for preventing and managing dental caries](#) (2026)
- The Association for Dental Education in Europe (2025). [The Graduating European Dentist Curriculum](#). (with resources and a contemporary curriculum for undergraduate dental education).

Directives and Regulations involving the dental profession in the EU

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

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

Decisions

A "decision" is binding on a particular Member State or company, to whom it is addressed. It is directly applicable. The Decision may apply to one country only.

Recommendations

Recommendations are non-binding, with no direct legal consequences, and are issued by the European Commission. According to the Commission, a Recommendation allows the institutions to make their views known and to suggest a line of action without imposing any legal obligation on those to whom it is addressed.

Opinions

These are statements from any of the EU Institutions (European Commission, Council of the European Union, or Parliament, the Committee of the Regions or the European Economic and Social Committee) that are non-binding. These statements impose no legal obligations, and are used to give opinions from a specific regional, economic or social viewpoint on a specific law being made.

Education, Professional Qualifications and Workforce

The Professional Qualifications' Directive - recognition of professional qualifications (EC/2005/36)

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

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

The automatic recognition system for EU dentists

The PQD enables the free movement of professionals for seven professions (at the time of drafting of the 6th edition), including dentistry.

It establishes rules under which the competent authority of a host Member State will automatically recognise the professional qualification of dental practitioner obtained in one or more Member States. This automatic recognition is granted for qualifications meeting the Directive's minimum training requirements and common standards, and as listed under Annex V, point 5.3.2.

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

It therefore allows the holder of this qualification to pursue the dental profession in another Member State. It applies to all dental qualifications obtained in a dental school in one of the 27 EU Member States, EEA Member States (Norway, Iceland and Lichtenstein), and Switzerland (through the [EU-Switzerland Agreement on free movement of persons](#)).

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

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

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

Exception:

In the case of the United Kingdom, the EU system of automatic between EU countries and the UK is no longer in place since 1 January 2021, following the Brexit vote in January 2020 and the withdrawal of the UK from the European Union and the end of the transition period.

However, the United Kingdom continues to recognise relevant EEA dental qualifications under a [near-automatic system](#), following the UK-EU Trade and Cooperation Agreement (TCA). The recognition of UK dental qualifications in EEA countries varies, is no longer automatic, is based on any profession-specific mutual agreements between these countries as well as national rules.

Third-country qualifications under the Professional Qualifications Directive

Professional qualifications obtained in a third country may also be recognised by the host Member State under certain conditions specified in the Directive (Articles 2(2) and 3(3) of the PQD). In case of dentistry, the initial recognition requires to respect the minimum training conditions laid down in Title III Chapter III sections 1 (and specifically article 21) and 4 (article 34 and 35).

Articles 2(2), 3(3) and 10 of the Directive provide a route for the recognition of professional qualifications obtained outside the EU. Under Article 2(2), a Member State may recognise such qualifications, provided that, in the case of dentistry, the minimum training conditions laid down in the Directive are met. Another Member State may recognise that qualification under the Directive's general system, provided that the holder has acquired at least three years' of certified professional experience in the Member State that initially recognised the third-country dental qualification.

Substantial legal revisions – Directive 2013/55/EU of the European Parliament and of the Council of 20th November 2013 (Amendments to Directive 2005/36/EC)⁵

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

The main features of the amended Directive include (some of these features are explained in more detail below):

1. **Creation of a [European Professional Card](#):**
The European Professional Card is however not applicable in the case of dentists (as of 2026). It is already employed for the recognition of qualifications of nurses responsible for general care, pharmacists, physiotherapists, mountain guides and real estate agents.
It is an electronic certificate issued by the professional's home Member State, intended to facilitate automatic recognition in the host Member State. This system implies that the regulated professional does not need to upload documents

multiple times in case he/she/they submit several different applications.

2. **Introduction of the principle of partial access to certain professions** (not applicable to professionals benefiting from automatic recognition of their professional qualifications such as dentists);
3. **Recognition of professional traineeships** carried out in another Member State or in a third country, when providing proof of a professional traineeship for accessing a license to a regulated profession;
4. **Clarification and update of training requirements** for professions under the automatic recognition regime. This includes changes to the minimum duration of training for dental practitioners, by authorising regular updates of training requirements by the European Commission through delegated acts.
5. **Measures for a better use of existing instruments** such as the **Internal Market Information (IMI)** system.
6. **Introduction of an Alert Mechanism** for Competent Authorities of Member States, serving as a single mandatory EU-level mutual warning system. This tool enables Member States to send and receive alerts through the [Internal Market Information System \(IMI\)](#) regarding professionals, including dentists, who have been prohibited or restricted from pursuing professional activities in a given Member State.
7. **Delegation of powers to the European Commission for the adoption of delegated acts** for the adaptation of minimum training requirements as well as for the recognition of new specialties for the professions of dentists and doctors.
8. **Introduction of transparency safeguards** to be followed by Member States. This includes the obligation for Member States to list all regulated professions and report them to the European Commission through the IMI system, as well as to provide proof of the necessity, proportionality and non-discriminatory nature of regulating a given profession.

European Commission Delegated Acts - Technical updates

At the time of drafting the 6th edition of the European Manual, the latest update of the Directive that implied changes to professional training requirements for the dental profession, was adopted through a [Delegated Act on 4 March 2024 \(2024/782\)](#), with legal effects entering into force in June 2024.

Other Delegated Acts were adopted on 10 April 2025, implying a change in requirements for other professions ([Delegated Directive 2025/1223](#)), followed by a further act adopted on 30 July 2025 ([Delegated Directive 2025/2187](#)). This Act, in line with the Directive, updates the list of evidence of formal qualifications recognised in each country, that apply for automatic recognition under Annex V of the Directive, including those of dental practitioners.

Commission Delegated Directive (EU) 2024/782:

⁵ <http://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:32013L0055>

Adopted in March 2024, it amended the Directive's **minimum training requirements for professions** such as nurses responsible for general care, **dental practitioners**, and pharmacists.

Among others, this Delegated Directive updated and expanded the list of mandatory topics of study to be included in the undergraduate study programmes, to reflect the latest scientific and technical advancements in the field of dentistry.

This led to the inclusion of the following new topics of study under Annex V.3(1):

- Implantology
- Gerodontology,
- Interprofessional collaborative care
- Dental public health
- Practice management
- Genetics and genomics
- Immunology
- Regenerative dentistry
- Digital technology in dentistry

It also highlighted and incorporated into Article 34(3) the requirement that basic dental training must ensure adequate knowledge of digital dentistry and focus on enabling a good understanding of its use and safe application in practice.

The articles of the revised Directive relating to the dental profession do not so far, however, specify a required or recommended set of competencies or skills that a dentist should demonstrate upon graduation. Nor do they provide a comprehensive framework regarding practice and clinical training or define specific minimum requirements for the number of clinical hours to be completed during undergraduate dental education.

Important provisions for dentistry under the Directive

Minimum training requirements under the Automatic Recognition system

For general dental practitioners

Admission to training as a dental practitioner (basic dental training) presupposes the possession of a diploma or certificate from a secondary school giving access to dental schools in university or higher institutes of an equivalent level in a Member State.

The system of automatic recognition is based on harmonised minimum training requirements. Basic dental training must comprise at least 5 years of study, which may in addition be expressed with the equivalent ECTS credits⁶, and include at least 5,000 hours of full-time theoretical and practical training. This

entails that the programme must include, at minimum, the study topics described in point 5.3.1 of Annex V (of the PQD). This guarantees that the graduate dentist has acquired the knowledge, skills and competences required to practise as a dentist.

Under Article 22(a) of the PQD, Member States may authorise part-time training, provided that the overall duration, level and quality of the training are not lower than those of continuous full-time training. The conditions and organisation of the part-time training is determined by the Member State.

The PQD provides a minimum programme of subjects to follow, outlined under point 5.3.1 of Annex V, which leaves room for the Member States to draw up more detailed study programmes, in line with the national competence of Member States regarding educational matters.

The list of subjects can be amended, as well as new subjects introduced, by delegated acts to the extent required to adapt them to scientific and technical progress, as explained above.

Practical and clinical training requirements

Regarding practical and clinical training, the Directive does not prescribe a formal number of training hours, procedures or skills required that must be completed for the award of the undergraduate dental qualification. However, it requires basic dental training to include “*suitable clinical experience under appropriate supervision*”. The organisation, planning and detailed content of undergraduate practical and clinical training under supervision are determined by each Member State, in accordance with Member States’ competence in the field of education.

The requirements and structure of undergraduate professional experience and clinical training therefore may vary across Member States.

Following the basic undergraduate dental training, aspiring dentists will obtain a formal training qualification which has been issued by the relevant Member State competent body, bearing the titles described in the PQD, which will enable them to practise their profession in any Member State.

Articles 23 and 37 of the PQD establish the conditions under which dental practitioners can see recognised their professional qualifications which were obtained before their country joined the EU or before the relevant reference dates specified in the Directive. This is known as the “acquired rights’ regime.

Where the evidence of formal qualifications granting access to the activities of dental practitioners and specialised dental practitioners does not meet all the minimum training requirements set out in Articles 34 and 35, Member States must recognise such qualifications as sufficient where they attest to successful completion of training that began before the reference dates laid down in Annex V, points 5.3.2 and 5.3.3, and where

The PQD introduced the concept of “expressed with the equivalent ECTS credits” in 2013 through the substantial legal revision of the Directive. The Professional Qualifications Directive therefore allows the duration of training programmes to be expressed, in equivalent ECTS credits. This does not affect the other minimum training requirements for automatic recognition, such as the prescribed duration of study or the minimum number of hours of theoretical and practical training where applicable. One academic year normally corresponds to 60 ECTS credits, with one ECTS credit representing approximately 25–30 hours of learning.

⁶The European Credit Transfer and Accumulation System (ECTS), introduced by the Bologna process, is widely used by higher education institutions across the European Union, including in programmes leading to qualifications required for the exercise of regulated professions, such as dentistry. At the time of drafting of this Manual edition, all EU Member States had implemented the ECTS system into their national educational system. While some countries continue to sometime use a mixed system, composed of a national credit system alongside ECTS, ECTS serves as the common framework for describing, comparing and recognising higher education programmes across the European Higher Education Area (EHEA).

they are accompanied by a certificate confirming that the holder has been effectively and lawfully engaged in the relevant professional activities for at least three consecutive years during the five years preceding the award of the certificate.

Specific provisions concerning acquired rights for dental practitioners are set out in Article 37 of the PQD.

For dental specialists

Full-time specialist dental training must have a minimum duration of three years and must be supervised by the competent authorities or bodies. Specialist dental courses must have the involvement and be supervised by dental specialists in the field of the specialty in question.

It must involve the personal participation of the dental practitioner undergoing specialist training in the activities and responsibilities of the establishment where the training takes place.

Admission to specialist dental training requires successful completion of basic dental training as referred to in Article 34 of the PQD, or possession of the evidence of formal qualifications referred to in Articles 23 and 37.

The Commission is empowered to adopt delegated acts, in accordance with Article 57c of the PQD, to adapt the minimum duration of specialist dental training where necessary to take account of scientific and technical progress.

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

Continuous Professional Development

Under Article 22(b), Member States will promote the continuous professional development of professionals who benefit from the principle of automatic recognition for the 7 professions covered under the Directive, including dental practitioners.

Lifelong learning or continuous professional development (CPD) is of particular importance for a large number of professions. It is comprised of all general education, vocational education and training, non-formal education and informal learning undertaken throughout life, resulting in an improvement in knowledge, skills and competences, and may include professional ethics (see Article 3 (1) (l) on the definition of lifelong learning).

According to the Directive and to the founding Treaty on the Functioning of the European Union (TFEU), the competence for educational matters, including the conception and organisation of continuous professional education remains the national responsibility of each Member State.

Recital 39 further states that it is for MS to “adopt the detailed arrangements under which, through suitable ongoing training, professionals will keep abreast of technical and scientific process”.

Transparency

Article 59 of the Directive (as introduced by Directive 2013/55/EU) established a required transparency and mutual evaluation exercise to be carried out by Member States.

It involves examining the justification of regulating the professions in question (for example the dental profession), against the principles of necessity, proportionality and non-discrimination.

It also requires Member States to update the Commission with any changes to the list of qualifications falling under the automatic recognition regime and concerned by the Directive. Accordingly, Member States must notify the European Commission through the online Internal Market Information System (IMI) of any changes in the nationally recognised diplomas and qualifications of dental practitioners falling within the scope of the Directive.

Alert mechanism (Article 56a)

Article 56a establishes an alert mechanism between Member State Competent Authorities to inform other Member State Competent Authorities, through the Internal Market Information (IMI) system, acting as an EU-level mutual warning system.

Established in 2013 and mandatory since 2016, this tool requires the Competent Authorities of a Member State to inform other Member States of a professional's restricted right to pursue certain regulated professional activities, including dentistry, such as whether his or her activities have been restricted or prohibited, even temporarily, by a national authority or court.

The alert must be transmitted no later than three days after the adoption of the decision restricting or prohibiting the professional activity.

The mechanism applies to the categories of professionals specified in Article 56a. Alerts are to be submitted for “substantial reasons”, such as when professionals have demonstrated professional misconduct, are subject to ongoing disciplinary measures or have criminal convictions. Alerts may also be issued in cases involving the use of falsified professional qualifications, following a court decision.

Some alerts may also be issued for administrative reasons, such as the non-payment of registration or professional fees.

Member States may consult the EU alert mechanism during the recognition procedure for dental qualifications. However, it was not a mandatory requirement (at the time of drafting of this document).

According to the [special report](#) of the European Court of Auditors, published in 2024, a limited number of Member States had submitted alerts through the IMI alert mechanism for the dental profession.

More information and guidance on the implementation of the alert mechanism can be found on page 33 of the [European Commission's User Guide for Directive 2005/36/EC](#), as well as extensive information on the implementation and use of the alert mechanism under the IMI system for Competent Authorities in the DG Internal Market's [Guidelines and User Manual](#).

Principle of the free provision of services⁷

Article 5 of the PQD

Article 5 of the PQD establishes the principle of the free provision of services. This provision establishes the principle that Member States must not restrict for any reason relating to the professional qualification, the free provision of services in another Member State if the service provider - a dental practitioner - is legally established in an EU Member State as a dental practitioner.

Whether the provision of services is considered "temporary and occasional" is assessed on a case-by-case basis by the competent authorities of the host Member State. In making this assessment, they consider factors such as the duration, frequency, regularity and continuity of the services provided.

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

Exemptions to register under the host Competent Authority

One of the key features of the free provision of services under the PQD is that dental practitioners providing services on a temporary and occasional basis are generally exempt from any requirement to register with, or become a member of, a professional organisation or competent authority in the host Member State (Article 6(a)).

However, where necessary to ensure the application of professional, ethical or disciplinary rules, the host Member State may provide for automatic temporary registration with the competent authority or pro forma membership of the relevant professional organisation or body. Such registration or membership must not delay the provision of the service or impose any additional costs on the dental practitioner.

Where applicable, the competent authority in the host Member State informs the relevant professional organisation or body after receiving the declaration and supporting documents referred to in Article 7 of the PQD.

First provision of services (for temporary and occasional practice in another Member State)

Following the previous provision, under Article 7 of the Directive, Member States may require dentists falling under the automatic recognition system, who wish to provide services on a temporary and occasional basis in another Member State than their country of practice, to submit a declaration before providing services for the first time, including declarations of insurance covers or protection measures taken to ensure professional liability.

As dentists benefit from automatic recognition of their qualifications, this procedure generally does not involve an assessment of their professional qualifications, but only the submission of the required declaration and any relevant supporting documents.

These supporting documents may include:

- (i) proof of the service provider's nationality,

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

Deadlines

Article 51 of the Directive sets out the time limits for processing applications for the automatic recognition of dental qualifications.

The competent authority must acknowledge receipt of the application within one month and inform the applicant of any missing documents. Once the application is complete, a reasoned decision must be taken within three months. Any refusal, or failure to take a decision within the prescribed time limit, must be open to appeal under national law (Article 51 of the Directive).

Recognition of traineeships

To support the free movement of professionals, Article 55a of the PQD provides that, when a graduate applies for access to a regulated profession in their home Member State, professional traineeships completed in another Member State or in a third country must be recognised in accordance with the conditions laid down in the Directive.

Member States may establish guidelines on how professional traineeships are organised and recognised, and these guidelines must be made publicly available. They may also set a reasonable limit on the proportion of a traineeship that can be completed abroad, provided that this does not create unnecessary barriers to professional mobility.

Knowledge of languages

The knowledge of one official language of the host Member State is necessary in order for the professional (ie dental practitioner) to start practising in the host Member State.

However, the control of the language by the host Member State can only be carried out after the recognition of the professional qualification. The Directive notes that it is important for professions with patient safety implications, such as dentistry, that a language control is exercised before the professional accesses such a profession.

However, language controls have to be proportionate for the job in question and should not aim at excluding professionals from the labour market in the host Member State. Language proficiency requirements can also only apply to one of the Member States' official languages.

⁷ The principle of the free provision of services is explained in the Lisbon Treaty. The freedom of establishment, set out in Article 49 of the Treaty and the freedom to provide cross border services, set out in

Article 56, are two of the "fundamental freedoms" which are central to the effective functioning of the EU Internal Market.

The professional should be able to appeal against such controls under national law.

The existence, scope and specificities of language requirements vary between EU Member States and are established at national level.

Partial access – the case of dental auxiliaries

The PQD applies to professionals who want to pursue the same profession in another Member State.

The principle of partial access does not apply to professionals benefiting from automatic recognition under the PQD, including dental practitioners. It may, in some cases, apply to dental auxiliaries, such as dental hygienists or dental therapists where these are regulated, subject to the conditions laid down in Article 4f.

However, there are cases where the activities concerned by an auxiliary profession with a larger scope of activities in the host Member State. If the differences between the fields of activity are so large that in reality a full programme of education and training is required for the professional to compensate for shortcomings, the professional is entitled to request partial access to the profession.

The Member State must access each request on a case-by-case basis and may grant partial access if the following conditions are fulfilled:

- (i) the professional is fully qualified in the home Member State to carry out the professional activity for which partial access is sought in the host Member State;
- (ii) the differences between the professional activity legally pursued in the home Member State and the regulated profession in the host Member State are so substantial that compensation measures would amount to requiring the applicant to complete the full education and training programme needed to access the regulated profession in the host Member State;
- (iii) the professional activity can be separated from other activities falling under the regulated profession in the host Member State.

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

Use of professional and academic titles

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

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

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

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

General system for the recognition of professional qualifications

The general system serves as a fallback for professions not covered by the automatic recognition system based on minimum training requirements (for example in the case of dental auxiliaries, or dental professionals with third-country qualifications), and for cases where a professional does not meet the conditions for automatic recognition under Chapter III of Directive 2005/36/EC (the Professional Qualifications Directive, PQD).

The conditions for recognition under the general system are set out in Article 13 of the PQD. Where the competent authority of the host Member State identifies substantial differences between the applicant's qualifications and the training required nationally, it may require the applicant to complete either an adaptation period of up to three years or an aptitude test.

The host Member State must, in principle, offer the applicant the choice between an adaptation period and an aptitude test. The host Member State can only derogate from this requirement in the cases specifically provided for under Article 14(3) of the PQD.

To facilitate comparison of qualifications, Article 11 classifies professional qualifications into five levels, ranging from an attestation of competence to a higher education diploma. In exceptional cases, other qualifications may also be treated as corresponding to one of these levels.

Please refer to Articles 10-15 of the PQD for further details.

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

Chapter IIIA introduces common training principles to facilitate automatic recognition for professions that are not already covered by the automatic recognition system based on minimum training requirements. Professions such as dentists, which already benefit from automatic recognition under Chapter III, are excluded from this regime (Article 49a(2)(e)).

However, common training frameworks may also cover dental specialties that are not subject to automatic recognition under the PQD (Article 49a(7)).

At the time of the drafting of the 6th edition of the Manual, this applied to all dental specialties recognized at a national level other than orthodontics and oral surgery.

Common training principles may take the form of:

- common training frameworks, consisting of a common set of minimum knowledge, skills and competences required for a profession; or
- common training tests, consisting of a standardised aptitude test available in participating Member States and reserved for holders of a particular professional qualification.

Where a common training framework has been established, professional qualifications acquired under that framework benefit from automatic recognition in participating Member States. Article 49a(5) sets out the circumstances in which a Member State may be exempt from applying such recognition.

Representative professional organisations at Union level, as well as national professional organisations and competent authorities from at least one third of the Member States, may submit proposals for common training frameworks and common training tests to the Commission.

Commission Recommendation on the recognition of qualifications of third-country nationals (Recommendation EU 2023/7700)

Only dental qualifications obtained from a dental school in one of the 27 EU Member States, EEA Member States (Norway, Iceland and Lichtenstein), and Switzerland (through the EU-Switzerland Agreement on free movement of persons) are subject to automatic recognition under the Professional Qualifications Directive (EC/2005/36). These are usually nationals of Member States exercising free movement rights under Union law and falling under the scope of the Directive for automatic recognition.

Practitioners not covered under the Directive, must apply for the recognition of their professional qualification under the general system and the Member States' specific rules and procedures.

This non-binding Recommendation provides Member States with guidance and recommendations to simplify and accelerate the recognition of the qualifications and skills of third-country nationals. It applies third-country nationals who are in the process of obtaining a visa or a work and residence permit in an EU country, or who legally reside in the EU, and may also be relevant for EU nationals having acquired their qualification in a third country.

It encourages Member States to adopt a skills-first approach when accessing the recognition of qualifications. It generally intends to address workforce shortages in certain priority professions, including some regulated healthcare professions, by facilitating and accelerating recognition and attracting more skilled professionals.

Member States are encouraged to simplify and facilitate recognition procedures, including through electronic procedures. It calls for reducing administrative burdens, simplifying translation requirements, strengthening cooperation between Member States for comparing and aligning recognition standards and processes, encouraging collaboration with third country for authentication of qualifications, and aligning recognition procedures with the processes and standards established under the Professional Qualifications Directive.

Directive on Patients' Rights in Cross-border Healthcare (2011/24/EU)

The 2011 Directive on patients' rights in cross-border healthcare seeks to clarify patients' existing rights of access to healthcare services within other EU Member States.

For oral healthcare, this might apply for example in the situation where a patient decides or needs to travel to another Member State for planned dental treatments.

The Directive therefore sets out the conditions under which a patient may travel to another EU country to receive health care, including dental care, and then receive reimbursement from his home country at the same level as under the home national health system. It covers healthcare costs, as well as the prescription and delivery of medications and medical devices.

The scope of the Directive covers the right to treatment, with the right for patients to be reimbursed to the amount covered under their home country's social insurance system. It also establishes systems to ensure the quality and safety standards of the treatments received, as well as regular monitoring. The Directive also created European reference networks and ensures health technology assessment, data protection (under the General Data Protection Regulation, GDPR), as well as consumer liability (which rules are laid out under Directive 85/374/EEC regarding liability for defective products).

Clinical Data Management and Digital Regulations

The General Data Protection Regulation (GDPR)

Operating a dental clinic or practicing as a dentist within the EU requires full compliance with the GDPR (General Data Protection Regulation - Regulation (EU) 2016/679)⁸. Dentists process sensitive health data, such as patient IDs, X-rays, intraoral photographs, medical histories, and treatment records, which fall directly under the "special category data" status under the GDPR

Article 9. According to these strict rules, obtaining a patient's explicit consent is a legal requirement for collecting, storing, and sharing this sensitive data.

Consequently, no third party that is not directly involved in the patient's treatment can access this data without the patient's specific and prior authorization. Every step of handling patient data, from encoding information in the clinic's appointment software databases, to secure encryption and storage of patient records in digital or physical environments, must comply with the

⁸ <https://eur-lex.europa.eu/eli/reg/2016/679/oj/eng>

"privacy by design" principle. Non-compliance with GDPR requirements may lead to severe administrative and financial penalties for both dental clinics and individual practitioners.

The European Health Data Space (EHDS)

The EHDS (European Health Data Space - (EU) 2025/327) represents a paradigm shift in European healthcare, directly transforming how dental practitioners access medical records⁹. Unlike GDPR's traditional framework, which strictly relies on patient consent for every data transfer, EHDS introduces the concept of "Primary Use." Under these rules, if a patient seeks dental treatment within the EU, the practicing dentist can immediately access the patient's electronic health records, past X-rays, and medication history across EU borders without requiring separate GDPR consent. This eliminates administrative delays, ensures continuity of care, and legally prioritizes patient safety and immediate treatment over rigid data lockdowns.

While EHDS simplifies data sharing for direct medical treatment, it enforces legally protected boundary regarding "Secondary

Use" (such as health data utilization for research, innovation, and AI training). The framework strictly prohibits commercial third parties, such as private insurance companies or unauthorized corporate entities, from exploiting this ecosystem to modify premiums or engage in discriminatory profiling.

Dental Practice, Dental Materials and Patient Safety

EU Medical Devices Regulation (MDR)

The European Union Medical Device Regulation (EU MDR 2017/745)¹⁰ is a comprehensive legislative framework designed to enhance the safety, quality, and clinical performance of medical devices circulating on the EU market. Replacing the former Medical Device Directive (MDD), the MDR shifts the regulatory approach from a point-in-time approval to a full lifecycle management model, covering everything from design and clinical evaluation to post-market surveillance.

Regarding dentistry, the MDR applies to a wide range of products used by dentists in clinical practice, including dental instruments, implants, restorative materials, imaging equipment, software qualifying as a medical device, and custom-made devices. Manufacturers are responsible for ensuring that their products comply with the applicable safety and performance requirements, while distributors and importers also have specific obligations throughout the supply chain.

The MDR introduced more stringent requirements compared with the previous regulatory framework, including enhanced clinical evidence, stronger post-market surveillance, improved traceability through the Unique Device Identification (UDI) system, and increased oversight by notified bodies. These measures aim to improve transparency and strengthen confidence in the safety and performance of medical devices across the EU.

AI Act

As dental practices increasingly integrate artificial intelligence, ranging from AI-driven panoramic X-ray diagnostics to automated orthodontic treatment planning, compliance with the EU AI Act becomes vital. The AI Act regulates technologies based on their risk level, and many diagnostic tools used in dentistry fall under the "High-Risk" category. This means that dentists cannot simply deploy any AI software blindly; they must ensure that the tools they use are CE-certified under Medical Device Regulations and fully compliant with AI Act standards regarding data transparency, human oversight, and algorithmic accuracy to prevent misdiagnosis.

Healthcare professionals, including dentists, play an important role in the effective implementation of the MDR by reporting serious incidents, contributing to vigilance activities where appropriate, and ensuring that medical devices are used in accordance with manufacturers' instructions and applicable regulatory requirements.

In December 2025, the European Commission published a proposal for a targeted revision of the Medical Devices¹¹ Regulation (MDR) and the In Vitro Diagnostic Medical Devices Regulation (IVDR). The proposal aims to simplify the regulatory framework while maintaining a high level of patient safety. Key measures include reducing unnecessary administrative burdens, increasing the use of digital procedures, introducing more proportionate conformity assessment requirements, supporting innovation, particularly for SMEs and breakthrough technologies, and improving the efficiency and predictability of the regulatory system. As the proposal is subject to the ordinary legislative procedure, its provisions will only become applicable once it is adopted by the European Parliament and the Council.

⁹ https://health.ec.europa.eu/ehealth-digital-health-and-care/european-health-data-space-regulation-ehds_en

¹⁰ <https://eur-lex.europa.eu/eli/reg/2017/745/oj/eng>

¹¹ https://health.ec.europa.eu/publications/proposal-regulation-simplify-rules-medical-and-vitro-diagnostic-devices_en

The Mercury Regulation and phase-out of dental amalgam (Regulation 2024/1849)

The use of dental amalgam is prohibited in the European Union since 1 January 2025, except when deemed strictly necessary by the dental practitioner following a patient's specific medical needs. An 18-month derogation was introduced for Member States meeting certain conditions, where low-income individuals were considered socio-economically disproportionately affected by the phase-out and to allow a longer adaptation period for patients, oral healthcare professionals and national insurance schemes.

This derogation was available to Member States in which dental amalgam was the only publicly reimbursed material at a rate of at least 90 % under national law for patients who were not eligible for other reimbursed dental filling materials, and where persons with low income were socio-economically disproportionately affected by the phase-out date of 1 January 2025. Member States making use of the derogation were required to provide and make publicly available a reasoned explanation and notify the European Commission by 31 August 2024. This derogation extended the phase-out for these countries until 30 June 2026.

The import and manufacturing of dental amalgam is prohibited since 1 July 2026, except to cover specific medical needs.

The revised European Parliament and Council Regulation adopted the revised Mercury Regulation in June 2024 (amending the 2017 Regulation (EU) 2017/852), entering into force on 30 July 2024.

On a global level, dental amalgam is to be phased out by 2034, following the decision adopted at COP-6 of the Minamata Convention.

EU Pharmaceutical Directive and Regulations

The Council and European Parliament reached a provisional political agreement on the pharmaceutical package in December 2025. At the time of drafting this 6th edition, the new legislation was expected to be formally adopted and to enter into force in 2026, with the new rules becoming applicable from November 2028.

This new pharmaceutical legislation replaces the outdated EU legislation on:

- the pharmaceutical legislation on medicinal products for human use (composed of a Regulation and a Directive)
- the legislation on medicines for children and for rare diseases (composed of two Regulations)

The new package also introduces targeted amendments to several EU regulations, including the Advanced Therapy Medicinal Products (ATMP) Regulation, the Clinical Trials Regulation and the Regulation extending the mandate of the European Medicines Agency (EMA).

The revised EU Pharmaceutical Legislation aims to ensure the availability, accessibility and affordability of safe and effective

medicines across the EU, while strengthening innovation, competitiveness and guarantee a security of medicinal supply.

For the dental profession, the new framework could impact European dentists in relation to the prescribing and use of medicinal products, with measures aimed at promoting a more appropriate use of antimicrobials, including their availability and security of supply.

The reform introduces measures to help address medicine shortages, promote the development of medicines addressing unmet medical needs, reduce regulatory burdens and environmental impacts, and strengthen measures to combat antimicrobial resistance through a One Health approach.

EU action on antimicrobial resistance (AMR)

Past estimates have pointed out that dentists account for approximately 10% of all antimicrobial prescribing. EU action on antimicrobial resistance has provided important guidance to Member States for developing initiatives and guidelines to promote antimicrobial stewardship, for encouraging safer prescribing practices and for strengthening infection prevention and control (IPC) in dental practices.

The EU demonstrates an important role for providing common guidelines to fighting AMR through a One Health approach (human, animal and environmental health), as well as carrying out important AMR monitoring and surveillance responsibilities. The broader scope of EU interdisciplinary measures and initiatives contribute to decrease the impact of AMR in oral health.

Key EU instruments help guide Member State in their actions against AMR, including the 2017 EU One Health Action Plan against AMR, as well as the 2023 Council Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach.

The Recommendation calls for stronger national AMR action plans, surveillance and monitoring, infection prevention and control, and prudent use of antimicrobials, while promoting awareness, research and innovation.

From the side of dentistry, the EU introduces guidelines for improved antimicrobial stewardship, applying safe and preventative prescribing practices, and encouraging awareness raising towards patients.

The EU also establishes several targets, including the goal of a 20% reduction in human antibiotic consumption between 2019 and 2030.

Several EU Regulations and Directives integrate these recommendations across the three pillars of the One Health approach, for example regarding cross-border threats to health, regulations on veterinary medicinal products, medicinal products and pharmaceuticals, feed for farmed animals and aquaculture.

In parallel, the European Joint Action on Antimicrobial Resistance and Healthcare-Associated Infections (JAMRAI-2), at the time of the drafting of this Manual) is a core instrument of coordinated action across Europe. The action brings together national authorities, expert organisations, stakeholders and Member State representatives. It aims to encourage and boost the creation of National Action Plans against AMR, improve surveillance and monitoring of AMR and antimicrobial

consumption, strengthen infection prevention and control, promote AMS and prudent use; improve awareness, education and training, enhance cooperation and foster research and development, innovation incentives and access to AMR medical countermeasures; and acting in global fora and internationally.

Occupational health and the European Directive for prevention from sharp injuries in the hospital and healthcare sector (2010/32/EU)

Directive 2010/32/EU recognises that health and safety of workers is an important issue and is linked with the health of patients and remains in force.

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

For dentistry, this is particularly relevant to exposure arising from dental needles, scalpels and other sharp instruments, including injuries that may result in exposure to blood or other potentially infectious material.

It requires employers and practitioners to use an integrated approach based on risk assessment, prevention, training and information, awareness, safe working practices, appropriate equipment and procedures for reporting and following up incidents.

An [EU strategic framework on health and safety at work 2021 – 2027](#) was also adopted addressing wider professional and occupational safety

Cosmetics Regulation (amended Regulation 2026/78)

The Cosmetics Regulation (Regulation (EC) 1223/2009) on cosmetic products replaces Directive 76/768/EEC since July 2013.

As a binding Regulation, it is directly applicable uniformly across EU Member States, with no space for interpretation. It establishes the main EU framework for the safety, composition and placing on the market of cosmetic products.

Regarding dentistry, the Regulation, although with limited impact on dental practice, introduces specific rules for tooth-whitening products containing hydrogen peroxide. The Cosmetics Regulation was amended in 2026 through an Omnibus package VIII by Commission Regulation (EU) 2026/78, amending Annexes II to V listing certain substances classified as carcinogenic, mutagenic or toxic for reproduction.

Sustainability and Waste Management

The role of the European Chemicals Agency (ECHA)

A dental practice uses a number of dental materials and products, including those used for infection prevention and control and sanitisation such as disinfectants and ethanol cleaning products, patient safety and treatment, and professional safety.

The European Chemicals Agency (ECHA) plays a role in regulating and providing information on the chemical substances contained in or used in these products under EU chemicals legislation as well as publishing decisions or scientific opinions on the classification and risks of chemical products. The European Commission may then act upon this opinion and draft a formal legal Act. ECHA covers the Registration, Evaluation, Authorisation and Restriction of Chemicals (REACH) Regulation, the Classification, Labelling and Packaging (CLP) Regulation and the Biocidal Products Regulation (BPR).

ECHA provides information on substances subject to restrictions or other regulatory measures, which can help dental professionals and manufacturers identify applicable requirements and safer alternatives.

It delivers opinions and reviews of the classification of chemicals incorporated into certain products used in dental clinics. As examples that can be cited here, ECHA proceeded in reviewing the classification of sodium fluoride under the CLP Regulation in 2026-2027, and evaluated hazard labels for ethanol in hand disinfectants and hygiene products in 2026 under the EU Biocidal Products Regulation.

REACH Regulation 1907/2006

Regulation (EC) 1907/2006 relates to the [Registration, Evaluation, Authorisation and Restriction of Chemicals \(REACH\)](#). It frames the registration, evaluation, authorization and restriction of chemicals used by companies, through data collection and assessment. It aims to protect human health and the environment from the risks posed by chemical substances.

Dental practices commonly use products containing chemicals, such as dental materials, cleaning and disinfecting products and other substances used in clinical practices.

[REACH](#) requires companies to identify and manage the risks associated with chemicals placed on the EU market, including the requirement to prove the safe use of these chemicals and hazardous substances throughout the supply chain.

CLP Regulation

The [CLP Regulation](#) (Regulation (EC) 1272/2008 on classification, labelling and packaging of chemicals) plays a critical role in the daily physical operations of a dental practice, governing how hazardous chemical substances are identified and handled. Dental clinics routinely utilize a wide array of chemical mixtures, including heavy-duty surface disinfectants, cold sterilizants, chemical bonding agents and high-concentration professional fluoride applications like sodium fluoride. Under CLP rules, any product containing hazardous

chemicals must feature standardized warning pictograms, signal words and Safety Data Sheets.

Biocidal Products Regulation (BPR)

The [Biocidal Products Regulation](#) (Regulation (EU) 528/2012) governs the introduction of biocidal products on the market as well as their use, with the aim of ensuring a high level of protection for human and animal health and the environment. It establishes rules for approving active substances in biocidal products, authorising the supply and use of biocidal products, and the supply of products that have been treated with biocidal products.

Dental practices commonly use biocidal products such as ethanol- and other biocidal-containing clinical surface disinfectants, instrument disinfectants and sterile equipment and endodontic and treatment products used for infection prevention and control, such as mouth antiseptic and disinfectant.

Under the Regulation, biocidal products must contain approved active substances, must be authorised before being placed on the EU market, and they must be proven effective for their intended use.

Waste Framework Directive (Directive 2008/98/EC)

The Waste Framework Directive establishes the EU legal framework for waste prevention and management. This includes the principles of the waste hierarchy and the protection of human health and the environment.

Dental practices generate a range of waste, including general, recyclable and potentially hazardous healthcare waste such as contaminated materials, sharp objects, pharmaceutical products, chemical and hazardous product waste.

Under the Directive, waste must be managed safely and without endangering human health or the environment, with hazardous waste subject to additional requirements for its handling, record-keeping and disposal.

Urban Wastewater Treatment Directive (Directive (EU) 2024/3019)

The Urban Wastewater Treatment Directive (Directive EU/2024/3019) establishes rules for the collection, treatment and discharge of urban wastewater, with environmental and health protection aims.

Dental practices generate wastewater from clinical activities, cleaning and sanitation, which may contain chemical substances and other pollutants. The Directive is therefore relevant to dentistry in the context of the proper management and discharge of wastewater, particularly for pollutants or micropollutants from clinical dental materials released into urban wastewater.

Prior to the EU phase-out of dental amalgam (see Regulation (EU) 2024/1849 above), this Directive required the use of amalgam separators to capture waste mercury particles that could otherwise be discharged from dental practices into wastewater and subsequently enter public sewage systems.

Advertising and Commercial Practices

Digital Services Act (Regulation 2022/2065)

The [Digital Services Act](#) establishes a harmonised EU framework for digital services, including rules to make online services safer and more transparent and to address illegal content and products.

It is relevant to dental practices and manufacturers that advertise or sell dental products and services online. The Regulation imposes obligations on providers of intermediary services and online platforms, including requirements concerning transparency, illegal content and the protection of consumers. It has applied generally since 17 February 2024 and proceeds to substantially amend the previous E-Commerce Directive 2000/31/EC.

Jurisdiction Rulings

European Court of Justice ruling on orthodontic treatment - Case C-115/24 UJ v Österreichische Zahnärztekammer

The Court of Justice of the European Union (CJEU) clarified that when international companies offer remote or hybrid orthodontic treatments (e.g., aligner therapy where scans are done locally but the treatment is planned abroad), they must abide by the professional and operating rules of the host member state to protect public health and patient safety.

This case law provided essential guidance for healthcare providers and digital-health platforms offering teledentistry or telemedicine services across EU borders.

The sections below are currently being finalised

Healthcare and Oral Healthcare Across the EU/EEA

The Education and Training of Dentists

Dental Workforce

Dental Practice in the EU and wider European Region