CECDO SURVEY 2003 - 2005 FINAL VERSION

How Does Oral Health Care Workforce Planning Take Place in Each EU/EEA Member State?

This report has been written for inclusion on the CECDO website. It has not been written in the format of a scientific paper. It provides full tables of results together with a brief: background to the survey, description of the methodology and conclusions. The results are not discussed. It is hoped to publish the survey as a scientific paper in the near future.

Introduction

One of the conclusions from a workshop on oral health care workforce planning, held in Syros, Greece during the May 2003 CECDO conference, was that there appeared to be no published information on the methodologies for oral health care workforce planning in the member states of the European Union and European Economic Area (EU/EEA). CDOs agreed that they needed this information to help them to understand current and possible future problems relating to the oral health care workforce. They also agreed that because EU/EEA qualified dentists and other dental workers, who are EU/EEA citizens, are legally permitted to work in their chosen profession anywhere within the EU/EEA, over or under production of dentists or other dental workers in one EU/EEA member state can have consequences for all other member states.

It was therefore agreed to survey the current situation for oral health care workforce planning in EU/EEA member states and other countries represented at the CECDO.

Methodology

During 2003, a questionnaire was drafted and e-mailed to all members of the CECDO for comment and suggested amendment. The resulting questionnaire was then distributed to all members of CECDO, again by e-mail. Initial results were presented during the June 2004 CECDO meeting in Oslo, Norway. A number of the responses were incomplete and some answers were ambiguous. The investigators (Dr Agustsdottir and Professor Eaton) were asked to review the data and where necessary contact the respondents in order to clarify the ambiguities and obtain a full data set. The revised results were subsequently sent to all CECDO members for checking for a second time. During the CECDO business meeting in Madrid in June 2005, it was agreed that CDOs should notify the investigators of any remaining errors by 16 July 2005 and that the investigators should then produce a brief report for the CECDO website and subsequently a full scientific paper (for approval by CECDO members prior to its submission).

Full responses have been obtained from all EU/EEA member states with the exception of Liechtenstein and Luxemburg. As neither Liechtenstein nor Luxemburg have dental schools and therefore do not produce additional dentists or dental hygienists for the

EU/EEA workforce, it was decided not to try to obtain responses from these two member states. Responses from two non EU/EEA member states (Albania and Israel) whose CDOs are members of the CECDO are included in the results.

With the exception of question 1 (What is the name of the country that you represent?), the questions, as they appeared in the questionnaire, are displayed at the head of each table.

Results

Question 2
What is your Position? (Chief Dental Officer, etc)

Albania	Deputy CDO
Austria	CDO
Belgium	Member of the Advisory Council to the Ministry of Health
Cyprus	Director of Dental Services, Ministry of Health
Czech Republic	CDO
Denmark	CDO
Estonia	CDO
Finland	CDO
France	National Councillor, Ordre National des Chirurgiens - Dentistes
Germany	Head of Professional Department of Dental Association
Greece	CDO
Hungary	Director of National Institute of Stomatology
Iceland	CDO
Ireland	CDO
Israel	CDO
Italy	Dental Liaison Committee Delegate
Latvia	CDO
Lithuania	Consultant in Dentistry, Ministry of Health
Malta	Chairman of Dentistry
Netherlands	CDO
Norway	CDO
Poland	University Professor in Dentistry
Portugal	CDO
Slovakia	CDO
Slovenia	Vice Dean of Medical Faculty, Representative of Slovenia
Spain	CDO
Sweden	CDO
Switzerland[1]	Regional CDO
United Kingdom[2]	CDO

[1] CDO for the Canton of Zurich
[2] CDOs of Wales and N. Ireland (with input from Adviser to CECDO)

Responses to questions 3a, 3b, 3c, 4 and 5 appear in tables in XLS files which accompany this Word file

Question 6

Are there any concerns regarding oral health care workforce planning in your country?

- Recently, the four countries within the UK have each conducted independent oral health care workforce reviews. It will be crucial to co-ordinate these reviews and those in other EU/EEA in the future.
- Yes. With increasing numbers of people retaining their natural dentition into old age there is an increasing demand for treatment although the younger age cohorts have far lower treatment needs. This "bulge" in treatment needs will extend into 2021 at least. Another concern is planning for Wales when dentists from within the UK and from the widening Europe have freedom of movement. This makes predictions very difficult
- I have yet to see a model for dental workforce planning that is robust and scientific
- Yes, although the dental profession and we (Dental Officers at the Ministry) alert the politicians to the lack of control of the workforce, no one seems to have the political will to do something.
- Yes, currently there are too many dentists in Iceland, but very few dental hygienists.
- Looking at the experiences in the past it can be stated that workforce planning in health in general, as well as in oral health care, is not very effective. However, the planning as such plays an important role in societal developments. It sometimes creates a 'self-fulfilling prophecy'.
- My own concerns, and again in health care in general, relate mainly to the fact that measures are taken with regard to the workforce at a certain moment under the influence of disturbed demand-supply balances, mostly due to the actual economic situation of the country, whereas the results of these measures will be noticed much later (for specialist-training for example it will take 15 years between the moment of a decision and the 'delivery' of the professional). Nobody is able to predict the economic situation at that time.
- Yes, too many technicians and not enough dental hygienists.
- Potential problems with lack of finance and workforce planning not based on health need.

Question 7

If there is not a system for oral health care workforce planning in your country, please explain:

a) What has prevented it?

- There are things that cannot be easily controlled, such as dentists who graduate from schools outside Iceland.
- Lack of a suitable model to subscribe to.
- Dental care performed by free dental practices
- One important factor is that until 1975 we had no dental schools and, therefore, a great lack in dentists. So it is only now that, for the first time, the administration has to face the problem. (Portugal)
- Swiss people are used to being free; any restrictions have been / are politically rejected
- The absence of a dental school, the absence of regulations regarding the establishment of dental clinics in Cyprus
- Ministry of Education, Ministry of Health.... (They don't have any interest in the dental education and in the health work for planning.)
- The politicians have not been a real support for us. They think that the oral health care is not a priority in the overall heath care system.
- Yes, there is actually a governmental reflection

b) Is one likely to be introduced in the foreseeable future?

- Yes, it is likely that there will be a collaboration between the Ministry of Health and the University of Iceland to try and predict the situation for the next decade.
- Yes if an appropriate model is recommended by WHO.
- No (twice)
- It seems that there is no intention for any intervention from the administration
- Restrictions in licensing medical doctors are discussed; no restrictions for dentistry (95% private practice; only 5% social dental welfare or insured dentistry)
- Yes it is. Now it is becoming a real problem so we have more arguments to work with the politicians and the other actors to support us in planning the workforce in oral health care.

c) Is there anything else you would like to add?

- There should be international collaboration on developing a dental workforce planning model that would have widespread acceptance. Unless there is a suitable

model that is proven it is likely to be a waste of money and time going through the motions.(Rep. of Ireland)

- There is no study, as far as I know about the workforce in oral health in relation with demand. What I hear is that many or even most of the recently graduated dentists are working only one or two half days. But the applications for the dental schools have not yet decreased in the public schools. But these may be influenced by the fact that they try to change to medicine later. (Portugal)
- In Switzerland we have too many dentists in the wrong places competing for too few patients , some problems with over-treatment are evident. But: In Switzerland we do not find dentists for rural regions. In Switzerland we have a ratio of 2 dentists to 1 dental hygienist; appropriate would be a 1:1 ratio. Therefore hygienists earn very high salaries (3000 Euro 1st year), are booked out over month and stress the dentists. THAT IS A REAL FREE MARKET.
- In the Public Sector we do Workforce Planning in relation to our identified needs (dentists, dental assistants, dental laboratory technicians) (Cyprus)
- Sometimes the very same dental profession seem to be unwilling to control the numbers of dentists, because they expect their children to become dentists as well.(Greece)
- The intake of students at Polish dental schools is determined by the Ministry of Health, but schools may take additional, fee-paying students at their own discretion.
- Thank you for this survey, It is an important matter. (Netherlands)
- Planning is not restricting. Quality is the name of the game. Restriction of professions is prohibited by law. (Israel)

Conclusions

As mentioned in the introduction to this document, this report is designed to give a brief background to the survey and the outline of the methodology used. It does not seek to discuss the results in any detail, merely to ensure that they are readily available to CDOs to inform their decision making in the future. However, at the time of the survey (2003 – 2005) the following key points emerge from the results:

- In ten of the 27 EU/EEA member states that responded to this survey there is no government appointed CDO.
- Control of the number of training places for dentists is the most frequently employed method of controlling workforce numbers. However, in four EU/EEA member states, which have dental schools, there is no such control.
- In two EU/EEA member states there are restrictions on the numbers of licences for practice for dentists.
- In six EU/EEA member states there are restrictions on the number of contracts of employment given to dentists by either state or private insurance companies.
- In 13 EU/EEA member states oral health care workforce planning is revised every five years or less.

- To date, in 7 EU/EEA member states (plus Albania) there has never been a plan for the oral health care workforce.
- In the member states where oral health care workforce planning takes place, the Government and Universities are nearly always involved.

Dr Helga Agustsdottir and Professor Kenneth Eaton 29 August 2005