Letter dated:
31 January 2007

From:
Danish Dental Association
(*Dansk Tandlægeforening*- DTF)

To:
European Commission
DG Health and Consumer Protection
(Health services consultation)
B232 8/102
B-1049 Brussels
Belgium

File Ref. No: tv-EU-2007-01

Subject: Consultation regarding Community action on health services

The Danish Dental Association (DTF) is an organisation representing the interests of all categories of dentist in Denmark.
The DTF works to promote a public image of dentistry as a healthcare profession which attaches great value to quality, credibility, professionalism, service and dialogue, and which provides a high degree of patient satisfaction.
The Association currently represents just over 6 000 members, employed in private practice or in public dental services.

The DTF is grateful for the opportunity to contribute to the EU's future action in the field of health.

Cheap is not best
Danish dentists are already aware that patients in Denmark travel abroad for dental treatment. The reason for this is not because the treatments cannot be provided in Denmark.

In general, the DTF feels that patients must be allowed to decide for themselves where they wish to be treated. The DTF feels that the best and safest approach to oral health is for patients to consult the same dentist on a regular basis. This may be difficult if there is a considerable distance between the patient and the dentist.
We are therefore opposed to the idea of patients "shopping around" for treatment because we feel that the best oral health is achieved through ongoing dental care with an emphasis on prevention.

We support the Commission's objective and will try to answer the questions to the best of our ability.

Question 1: What is the current impact (locally, regionally and nationally) of cross-border healthcare on accessibility, quality and financial sustainability of healthcare systems, and how might this evolve?

Current situation
Locally, patients rarely change dentist. A recent survey shows that about 85% of the population did not change dentist in the last year.

The proportion of cross-border dental services is deemed to be relatively low, but has been increasing in recent years.
Public financial assistance towards the cost of dental treatment in other Member States is currently available, but the non-subsidised treatments appear to attract the greatest patient interest, i.e. where patients must meet the cost of the treatments themselves.
It is therefore financially attractive to receive treatment in countries where the cost of living is generally lower, which means that one-off treatments for crowns, bridges, etc, are also cheaper.

Analyses of the *influences on the quality* of treatment do not exist, but the DTF feels that the aspects listed below may play a role.

Where dental treatment is concerned, patients often require several consultations to ensure that the treatment is successful and, for this reason, a week's holiday in conjunction with a major dental procedure cannot produce optimum results.

A patient's medical history can also affect quality of service. Patients are not always aware of the precautions they should take, and the attending dentist is unable to access their records.

Communication between the patient and the health professional is important for achieving optimum treatment. Quality can therefore be affected if the patient and the therapist do not speak the same language. Limited linguistic skills may prevent essential information being relayed. In Denmark, great importance is attached to health professionals keeping patients properly informed, and to the patient understanding and accepting the treatment etc. (cf. Chapter 5 of the Danish Health Act (*Sundhedsloven*) on informed consent and patients' involvement in decisions).

If there is a considerable distance between the patient and the place of treatment, it would be difficult to remedy any complications that may arise after the patient has returned home. Treatment carried out close to where a patient lives makes it easier to deal with any complications.

Patients may not have any right of redress as they have in Denmark, where they are well-protected, also in the case of adverse events.

Patients being treated abroad may be exposed to over- or under-treatment, as the attending healthcare provider is not responsible for the patient following the treatment. On the other hand, there is a financial incentive to give the patient as much treatment as possible. Time may also play a role as there is often a limited period in which to carry out the treatment(s).

The DTF feels it is important that patients are informed of these drawbacks prior to making a decision to travel abroad for treatment.

The *financial implications* are considered to be limited as there is no government reimbursement for the typical treatments carried out abroad.
However, subsidies for treatment abroad are increasing. See the reply to Question 2.

The future for cross-border dental care is difficult to evaluate. Information is available about the possibility of being treated abroad and some people travel with the specific purpose of receiving treatment.
A balance of sorts may well exist - patients are aware that they have the option of treatment abroad, and those wishing to take the risk, as mentioned under Question 1, have the possibility of travelling abroad.

Professional mobility

Only very few Danish dental practitioners travel abroad to work. According to the Danish Board of Health (*Sundhedsstyrelsen*), about 20 dentists travel abroad annually (based on figures for 2004-2006). Fewer than 20 dentists per year enter the country, so the DTF has decided not to deal with the issue of mobility for dentists. It is also anticipated that the Directive on the recognition of professional qualifications will regulate the mobility of professionals in the EU. The effects of the Directive will soon be clear (see reply to Question 6).

Question 2: What specific legal clarification and what practical information is required by whom (e.g. authorities, purchasers, providers, patients) to enable safe, high-quality and efficient cross-border healthcare?

Nowadays, patients are legally entitled to travel abroad for treatment which may even be subsidised by the government.
However, there is no control over what treatments are subsidised by the government when they are carried out abroad. In Denmark, the Agreement on Dental Care (*Overenskomst om tandpleje*) contains a detailed breakdown of each service and its subsidy status. Furthermore, there is an annual audit to establish how many times each service has been provided by individual dentists. The statistics are compared on a

regional and national basis. Society does not have the same degree of control over public funds when it come to treatment abroad.

Patients should, however, make informed choices so that the risks, as mentioned in the reply to Question 1, are taken into consideration.

Question 3: Which issues (e.g. clinical oversight, financial responsibility) should be the responsibility of the authorities of which country? Are these different for the different kinds of cross-border healthcare described in Section 2.2. above?

The DTF feels that the host country should be responsible for the clinical care and the professional competence of healthcare personnel. This applies to patients as well as professional mobility.

The DTF does not have a definitive answer to the question of who should have financial responsibility (see reply to Question 9).

Question 4: Who should be responsible for ensuring safety in the case of cross-border healthcare? If patients suffer harm, how should redress for patients be ensured?

With respect to dental healthcare, patients themselves can opt to be treated abroad. The patient is responsible for his or her choice, which should of course be made on an informed basis – weighing up the financial benefits and the risks. The best way to protect the patient is by ensuring a high level of quality for health services. This can be attained by means of a high level of education and continuing professional development.

Quality should also be ensured by means of good communication between patient and dentist. Denmark has an established complains system which allows patients to file complaints about professional performance, as well as financial and contractual issues. The system ensures that patients are able to assess whether a dentist has fulfilled his or her obligations in accordance with the law and the Agreement on Dental Care. Patients are therefore able to have circumstances they are not entirely happy with examined free of charge.

Dental practitioners are obliged to take out insurance to cover all patient treatments carried out in Denmark. The DTF's Patient Insurance Scheme adjudicates in compensation cases in accordance with the Danish Patient Insurance Act. Compensation covers injury caused by registered health professionals working in the regional dental services, in dental services for children and young people, and community dental services, or on behalf of these.

The insurance covers damages of DKK 1 000 and over, c.f. Order No 1099 of 12 December 2003 on the referral of cases pursuant to the Danish Patient Insurance Act to

the Danish Dental Association's Patient Insurance Scheme and the Board of Appeal for Dental Injury (*Bekendtgørelse om henlæggelse af behandling af sager efter lov om patientforsikring til Dansk Tandlægeforenings Patientskadeforsikring of Tandskadeankenævnet*).

In addition, compensation claims of less than DKK 1 000 are covered by professional indemnity insurance. Hence patients are covered for all treatment in Denmark.

The DTF would like to see a system like this implemented in all Member States.

Question 5: What action is needed to ensure that treating patients from other Member States is compatible with the provision of balanced medical and hospital services accessible to all (e.g. by means of financial compensation for their treatment in "receiving" countries)?

Most dental treatments that are carried out abroad are primarily paid for by the patients themselves. This is therefore not considered relevant to health care provision in Denmark.
The DTF is concerned about the fact that there are no checks on subsidy payments for treatments carried out abroad (see reply to Question 2).

Question 6: Are there further issues to be addressed in the specific context of health services regarding movement of health professionals or establishment of health providers in other Member States not already addressed by Community legislation?

The Directive on the recognition of professional qualifications (2005/36) comes into force in October 2007, when less stringent requirements will be introduced for the temporary establishment of healthcare professionals.

In the case of temporary establishments, the DTF is concerned about how quality of treatment can be ensured in respect of those dentists who only stay in Denmark for a short period.

Question 7: Are there other issues where legal certainty should be addressed in the context of each specific health of social protection system? In particular, what improvements do stakeholders directly involved in receiving patients from other Member States – such as healthcare providers and social security institutions – suggest in order facilitate cross-border healthcare?

The DTF has no comments.

Question 8: In which ways should European action help support the health systems of the Member States and the different actors within them? Are there areas not identified above?

As the Member States are often faced with challenges of a similar nature, it may be expedient to establish a committee to collate knowledge within the field and define the challenges that exist within the health care field. This will make it easier to define the extent to which the EU should support cross-border healthcare services, and when it would be inappropriate.

Question 9: What tools would be appropriate to tackle the different issues related to health services at EU level? What issues should be addressed through Community legislation and what through non-legislative means?

The following issues, which have also been discussed above, should be resolved by means of legislation:

- compulsory redress scheme; and
- compulsory insurance for accredited health professionals.

The following issues can be tackled without recourse to legislation:

- the need for concerted action so that raining for dental professionals meets the same high standard throughout the EU;
- the possibility for the attending dental practitioner to obtain information about a patient's medical history;
- ensuring that the patient and the dentist/health professional can communicate satisfactorily;
- information for patients and health professionals about the risks associated with treatments in another country;
- documentation on the continuing professional development courses attended by a health professional, and their length.

Yours faithfully,

Susanne Andersen
President

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