National Report

Country: **Germany**
Association: **German Dental Association (Bundeszahnärztekammer -BZÄK)**
Venue: **Yerevan, Armenia**
Year: **2010**

I Changes in the association and its organisation

none

II Trends and developments

a. in professional politics

- Private scale of dental fees
  BZÄK is still requesting a restructure or a new fixing of the private scale of dental fees (private Gebührenordnung für Zahnärzte - GOZ), whose last amendment has been made in 1988, thus more than 20 years ago. This private scale of dental fees does not only fix the dental fees of private patients but also the fees for privately paid additional services of patients covered by the Legal Health Insurance – services for which the demand is steadily increasing. Since 1988, neither the fees nor the specification of services have been changed or adjusted to the economic development. However, in the meantime medical innovation and progress and also improved techniques have indeed led to an extraordinary and intense development of dentistry.

  Therefore, the dental profession has prepared an own proposal for a modern prevention-orientated scale of services including a calculation of costs based on dental management economics; this paper is entitled „Honorarordnung für Zahnärzte -HOZ (Scale of fees for dentists)“. At the moment, there are strong negotiations with the Federal Ministry of Health with the aim to adopt a new private scale of fees taking into account the ideas, opinions, and expectations of the dental profession.

- Competition
  In the last years, the health policy in Germany strengthened the competition amongst health insurances on the one hand and the medical/dental profession on the other hand. Legal bases and concepts have been developed to allow such a competition. Hitherto, the typical dentist was established in his own dental surgery, however since 2007 further forms of professional dental exercise have been established: Dental exercise as employed dentist is made easier, the establishment of a branch dental surgery is permitted and joint dental surgeries local-wide, thus in different communities, are possible. This indeed is a chance for new possibilities of dental exercise, but at the same time the establishment

of large , i.e. „mega“, practices and dental practice chains financed by international capital investors have been made easier.

The managed competition in matters of dental health insurance has been extended: there are now so-called fees for optional services, which can be offered by the health insurances, and there are new forms of direct contracting, these are individual agreements, thus managed care, between different health insurances and groups of insured or groups of dentists. With the signature to such an agreement, the insured is committed to see only dentists who are recommended by their health insurance (loss of the free choice of practitioners) or dentists are committed only to use specific materials in order to decrease the costs, for ex. prosthetics from China (restriction of therapeutic freedom).

The answer of the dental profession to an increased competition in the health sector is: the introduction of a fixed amount paid by the health insurance for prosthetic services, regardless of the therapy chosen by the patient and provided by the dentist; the difference between the basic service and a more sophisticated service is paid privately by the patient. This system of a fixed amount – introduced in 2005 for prosthetics – is permanently evaluated and has proved to be effective. It is a possibility for patients covered by the Legal Health Insurance to profit from the technical progress in dentistry, it is socially fair and transparent and it also has financial advantages for the dental profession. This scheme of a fixed contribution in prosthetics is also a model for other fields of dental care.

- Quality assurance
  Since 2004, an internal quality management of the dental practice or clinic as well as an external quality assurance are a statutory regulation and responsibility. Until the end of 2010 for the first time, the implementation of measures of quality management in dental surgeries have to be proved. External quality assurance shall be done by using quality-indicators for procedures and outcomes by a comparison of different dental surgeries (benchmarking); furthermore, an obligatory guideline for dentistry shall be prepared and a general quality assurance guideline for all health providers as hospitals, out-patients’ medical surgeries and out-patients’ dental practices will be adopted soon.

b. in health and social politics

Parliamentary elections have been held in autumn 2009 and as result there was a change of government: now we have in Germany a coalition of the Christian Democrat Party (CDU) and the Liberal Party (FDP), the Federal Health Minister is now a medical practitioner. The new Federal Government is planning a basic health reform with the introduction of a capitation fee not dependent on the income instead of contributions based on the insured’s wages. However, the adoption of such a conception and the realisation of such a basic reform are more than uncertain.

c. In education, continuing education and postgraduate education

- Education
  Since years a new dental licence regulation including a modern curriculum and structure of the basic dental education (Registration Code for Dentists, Approbationsordnung für Zahnärzte) is requested, however since months the negotiations in this matter are stopped. Although the dental profession, the dental educators, and the Federal Ministry of Health have accepted the draft of a new dental license act, the federal „states“ (Länder) block the passage of the reform of dental studies because the reform aims for ex. at the establishment of smaller groups in clinical education, but this would lead to increased costs. The “Länder“ only will accept a reform of the dental education if it is self-financing and implementing the objectives of the Bologna Process. However, the dental educators and the dental profession in Germany agree in rejecting the two-tier structure of the dental education – i.e. bachelor and master studies. Nevertheless, they appreciate other objectives of the Bologna Process, for ex. educational modules, the promotion of educational mobility, transparency, and quality.

- Continuing education
  In 2004, obligatory medical and dental continuing education was introduced in Germany. Within a period of 5 years, dentists must establish proof of 125 scores of a participation in continuing education. On 30/06/2009 all dentists were asked for the first time to prove their participation in obligatory continuing education with 125 scores. At the closing date, nearly 99 % of the whole dental profession has proved its participation in obligatory continuing education, sanctions are not known.

- Specialist training
  BZÄK has prepared a model of a new regulation in specialist training with the possibility to obtain an „in-job-qualification“ (to study while working) and a modularisation of the educational topics and also with the possibility to have taken into account modules of postgraduate master studies. This applies to both specialist training fields in Germany: orthodontics and oral surgery, which are also EU-wide recognized specialist trainings. The discussion on the introduction of further disciplines in specialist training in Germany is turned down for the time being. At the moment it is discussed whether a specialist for general dentistry shall be introduced.
  At the time being, 23 different dental postgraduate master studies are offered by universities and academies in Germany, however with a non-uniform structure.

III Changes in the health insurance system see II a. and b.

IV Changes in dental fees none

V Further topical information none

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