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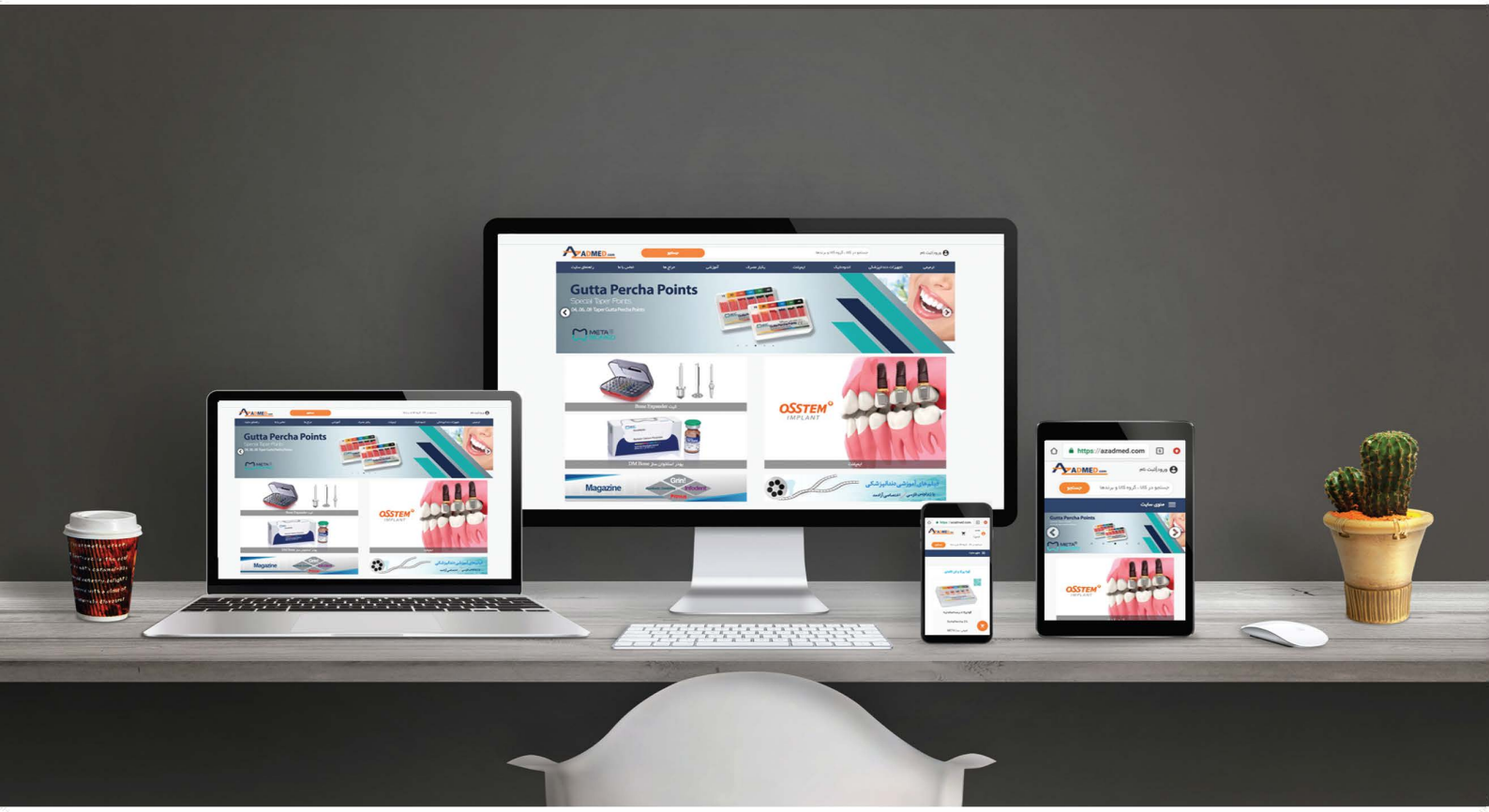

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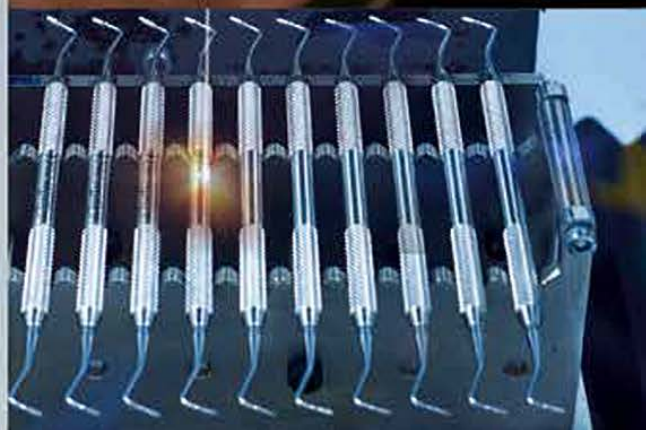

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An ISO 9001 certificate proves that your quality management system (QMS) has been certified against a best practice standard and found compliant. Certificates issued by a third-party certification body let customers know they can trust that you have implemented the necessary internal processes to meet obligations, producing numerous benefits for any company. ISO 9001 is in fact a worldwide standard for quality, administered by the International Organization for Standardization (ISO) based in Switzerland. Currently in use by over one million organizations around the world, obtaining ISO 9001 certification puts your company in a very select group and opens-up new markets where you were virtually unable to do business. When the ISO 9001 standard was created over 22 years ago it was mostly seen as a tool for manufacturing organizations. Although there was a specific standard for services, it was not until recent years, since the introduction of the process approach, that ISO 9001 has finally proven that it is the best standard to help any kind of organization improve its processes. So, whether an organization provides only services or not, it stands to gain tremendously from this clearly laid out standard, which focuses on the processes of the organization regardless of what a company makes or provides!

Haven't you ever been asked whether you are ISO 9001 certified? Let me list just few of the gains. A quality management system standard is really all about quality so, of course, one result of adopting it should be an improved level of quality for the entire organization — every process and every product. Continued customer satisfaction is the ultimate goal of a QMS and quality means that whatever you produce will work as your customers expect; you will meet not only their stated requirements but their implied requirements, too. Quality means far fewer complaints and if your quality management system is working correctly, you should know what your customers expect and you should be providing it, resulting in increased customer satisfaction. On top of this, implementing an ISO 9001 Quality Management System can empower employees, providing them with clear expectations (quality objectives and job descriptions), the tools to do their job (procedures and work instructions) and prompt, actionable feedback on their performance (process metrics). The result? An improved company culture and a more professional staff! Control of your processes is another target! Control comes from having a clear target to shoot for (objective), collecting data on the process (metrics) and understanding how to adjust the process (procedures and work instructions) to maintain the target output. If your ISO 9001 QMS is working, you should be increasing operational and product consistency. Having the right objectives, metrics and procedures, management and employees should be able to focus better on what's important. Yet, this isn't always the case, it's easy to lose focus over a time period. Well, the ISO 9001 QMS has a way to ensure the company stays focused, and that's quality auditing, requiring the company to periodically audit its quality processes. Regular process audits and as-needed audits, when done correctly, provide the objective feedback needed to correct any deviations from the quality path and keep the company focused on its goals.

Currently in use by over one million organizations around the world, obtaining ISO 9001 certification puts your company in a very select group and opens-up new markets where you were virtually unable to do business.

However, no process and no one is perfect... why else would the standard devote a clause to "continual improvement"? A well-run QMS does enable your company to approach perfection. As your processes improve and you achieve your target objectives with greater regularity, you will see tangible results. Your process waste will decrease. Waste is money lost forever. Waste results from poor quality and inefficiency. Inefficiency results from variation and inconsistent processes. Reduce variation, improve consistency, and you'll have less waste... and more money. **All this to say that we, at *Infodent International,* are ISO 9001:2015 certified and proud it!**

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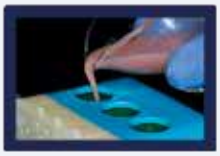

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Optical microscope
image of microleakage test
(dye penetration test)
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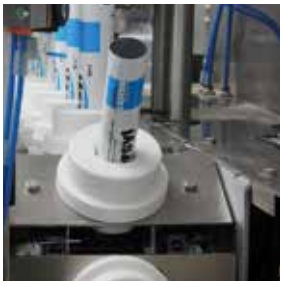

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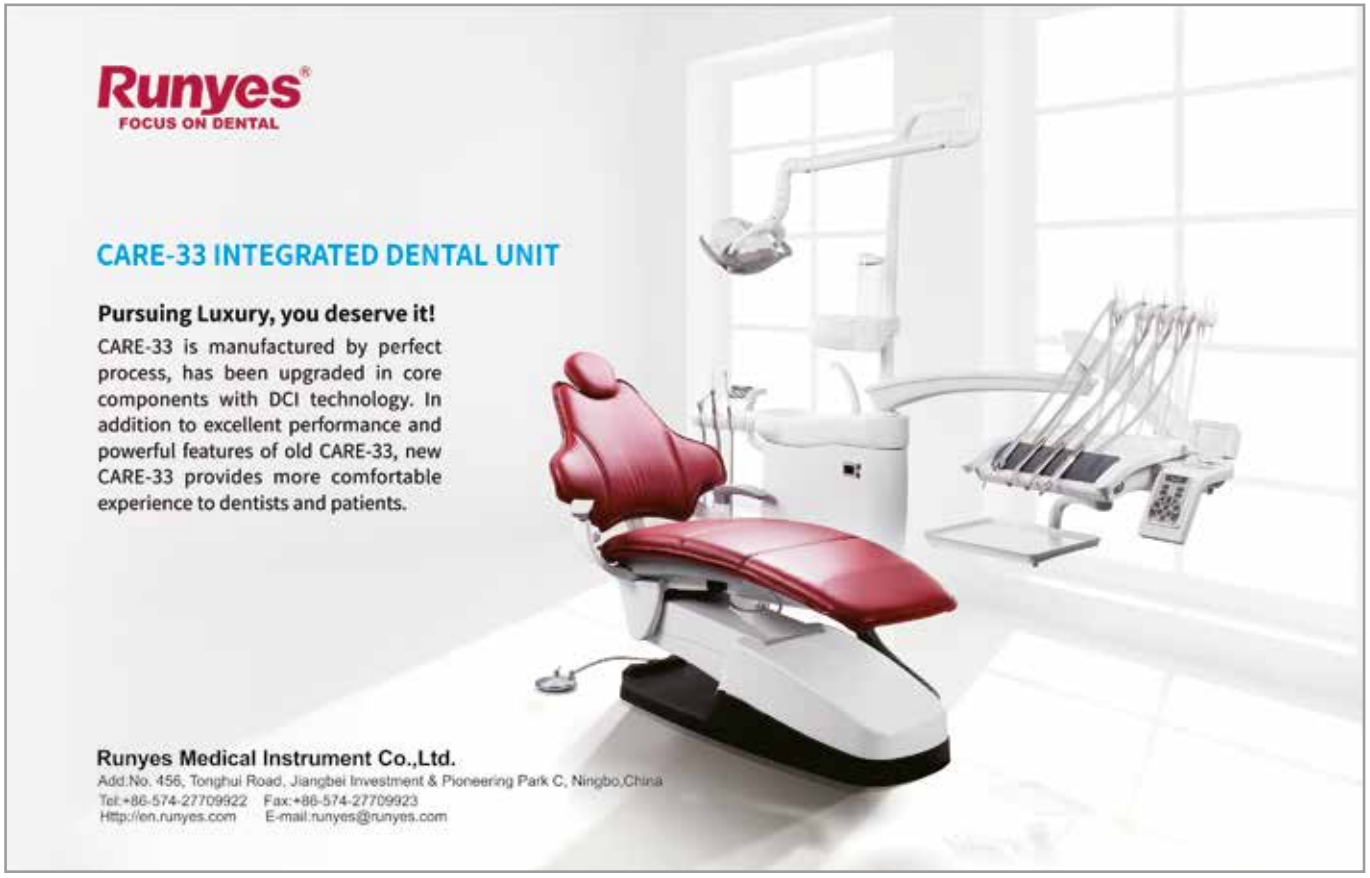

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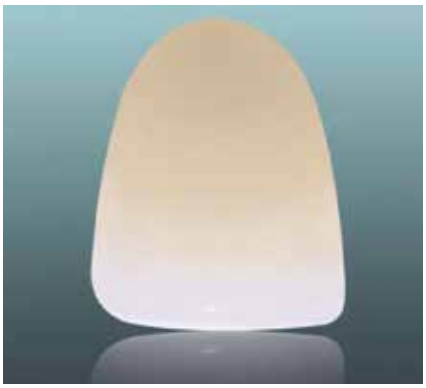

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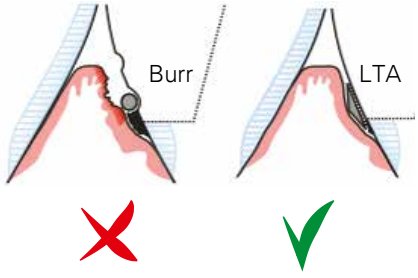

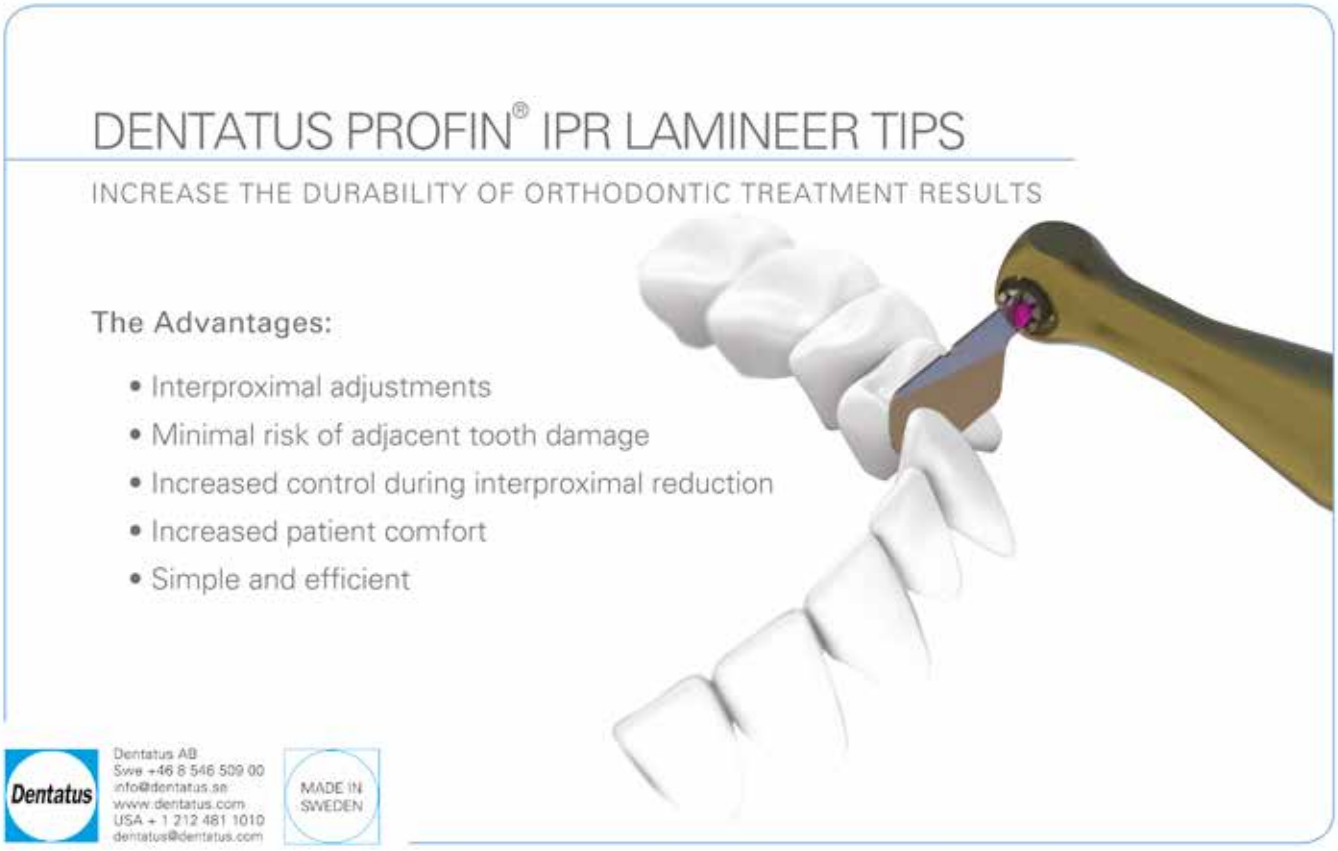

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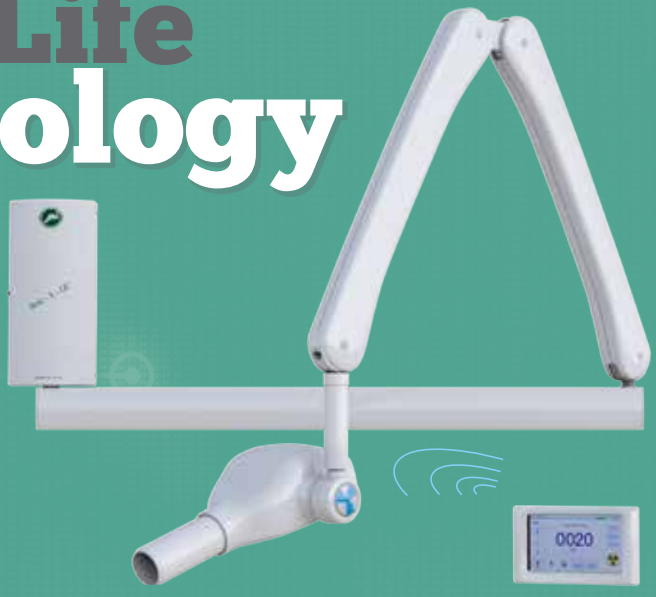

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The concentrated growth factor (CGF)
The advanced breakthrough in regenerative medicine

What makes the innovative CGF (Concentrated Growth Factors) technique different and more advanced than the conventional regenerative techniques (PRP, PRGF, PRF, etc.)? - A question that is frequently asked by fellow clinicians and patients that favour the natural, personalised approach in medicine.

Regenerative medicine is one of the most dominant objectives of today's rehabilitation therapies. The ability to reconstruct lost or damaged tissues has been intensively researched as an important aspect of modern medicine. In dentistry, the research of growth factors applicable to bone regeneration techniques has been significant and a large number of studies recognise that the best tissue regenerative stimulus are present amongst the autologous growth factors (GFs), which have clinically proven to induce regeneration and tissue healing. Therefore many techniques were developed for this purpose (e.g. Tissucol, PRP, PRGF, PRF, etc.) aiming to achieve the appropriate biostimulation, which demonstrated degrees of success in many clinical scenarios.

Research and clinical studies concluded that in addition to stem cells or the premature cells that can differentiate into osteo- or fibroblasts, there are several factors involved in tissue regeneration (Growth Factors GFs), such as Bone Morphogenetic Proteins (BMP), Platelet Derived Growth Factor (PDGF), Insulin-like Growth Factors (IGFs: IGFI and IGF-II), Osteoprotegerin (OPG), Transforming Growth Factors (TGF), Fibroblast Growth Factors (FGFs), and other cytokines particularly type IL1 and TNF- powerful stimulants for bone reabsorption.

As it is recognised that many of these factors are naturally circulating in our blood and bearing in mind the ultimate regenerative characteristic of those factors, The CGF technique was developed to achieve the optimal phase separation and concentrate the factors for maximum recruitment and biostimulation of those cells (Concentrated Growth Factors 2006, IAIO).

The process starts with collecting patients' venous blood, and then applying the centrifuging process, in which the temperature and speed are specifically controlled for every stage ensuring the separation of each protein. This controlled process, with alternated and controlled speed and gravitational acceleration of approximately RCF770 (always below RCF1.000), results in the optimal separation with significantly high concentration of growth factors, thus making the CGF advanced and more specific.

The CGF is characterized by the existence of four phases:

1. SERUM: Upper phase; the lightest and most liquid part of the blood (fibrinogen-free with only few cells). It represents a fundamental element of the CGF protocol that amalgamates grafts and supplies many biochemical components and activators. The serum is used to wash the cavity, to cover and protect all the regenerated portions

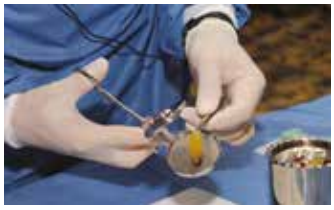
2. FIBRIN Buffy Coat: Interim phase represented by large and dense polymerized fibrin block, which is obtained by comprising threedimensional polymer networks with interwoven fibres that develop during centrifuging, allowing a volume growth of these fibres in all directions, in a single phase in the form of gel.

This development ensures control of many components, determining numerous therapeutic actions, such as:

- Plasma and platelet cytokines: repair, anti-inflammatory and painkilling effect during repair (TNF-a);
- Platelets: transmission of the signals and release of the GFs. The most important are the PDGF-BB, TGFI3-1 and IGF-1

Furthermore the fibrin gel blocks with excellent resistance can be used as:

- Cavity fillers
- Membrane supports
- Autologous membranes
- Biological particles to be mixed with another filling material.



This translates into simplified work, superior regenerative induction and greater versatility of use of the fibrin block, ranging from the use of the whole block to the particles or membrane.

3. **Liquid phase containing GFs**: It is demonstrated that the liquid phase contains not only GFs, but also white cells and stem cells able to differentiate into specialized cell types.

4. **Lower red phase:** a dense, dark, reddish, gel-like coagulation consisting of concentrated red and white blood cells and clotting factors, that can be added to an autologous or heterologous bone when filling very large cavities.

We can therefore contemplate that the application of CGF in regenerative medicine should be conceived as a multifactor stimulation system. In fact, all the phases and components are used according to specific requirements. This versatility and multipurpose application makes it stand out among other techniques.

In addition to its significant applications in oral surgery, periodontology and tissue augmentation, the CGF system has shown noteworthy outcomes when used in facial aesthetics procedures. The CGF therapy is an advanced, powerful anti-ageing treatment for the ultimate natural approach to facial rejuvenation; it is toxin and animal product free and simply uses the patient's own blood.

The treatment is evidently effective in all aspects of facial aesthetics such as Mesotherapy (the liquid-phase LPCGF), the newly developed protocol for collagen induction (ICF), as well as non-surgical facial augmentation, lips enhancement and lip line couture, treating smile lines, the forehead, cheeks, neck, décolletage, hands, knees and elbows and other unwanted folds and wrinkles on the face in a similar fashion to dermal fillers, however achieving natural results, and more importantly not involving the injection of foreign chemical substances into the skin. As a result, the rare but potentially serious allergic reactions and inflammation seen with these products do not occur following the injection of CGF, not forgetting the cost effectiveness of using the autologous system to replace traditional fillers and homologues products. The autologous CGF is a relatively new biotechnology auto-graft, that evidently demonstrates significant stimulation and acceleration of soft-tissue and bone, healing and formation. The efficacy of this therapy lies in the local delivery of a wide range and high concentration of growth factors and proteins, mimicking and supporting physiologic wound healing, reparative tissue process and local infiltration therapy, taking the practice of regenerative techniques to a sophisticated higher level.

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Urban population

81%

GDP

1,559,623,393

current USD,
World Bank 2015

Total population

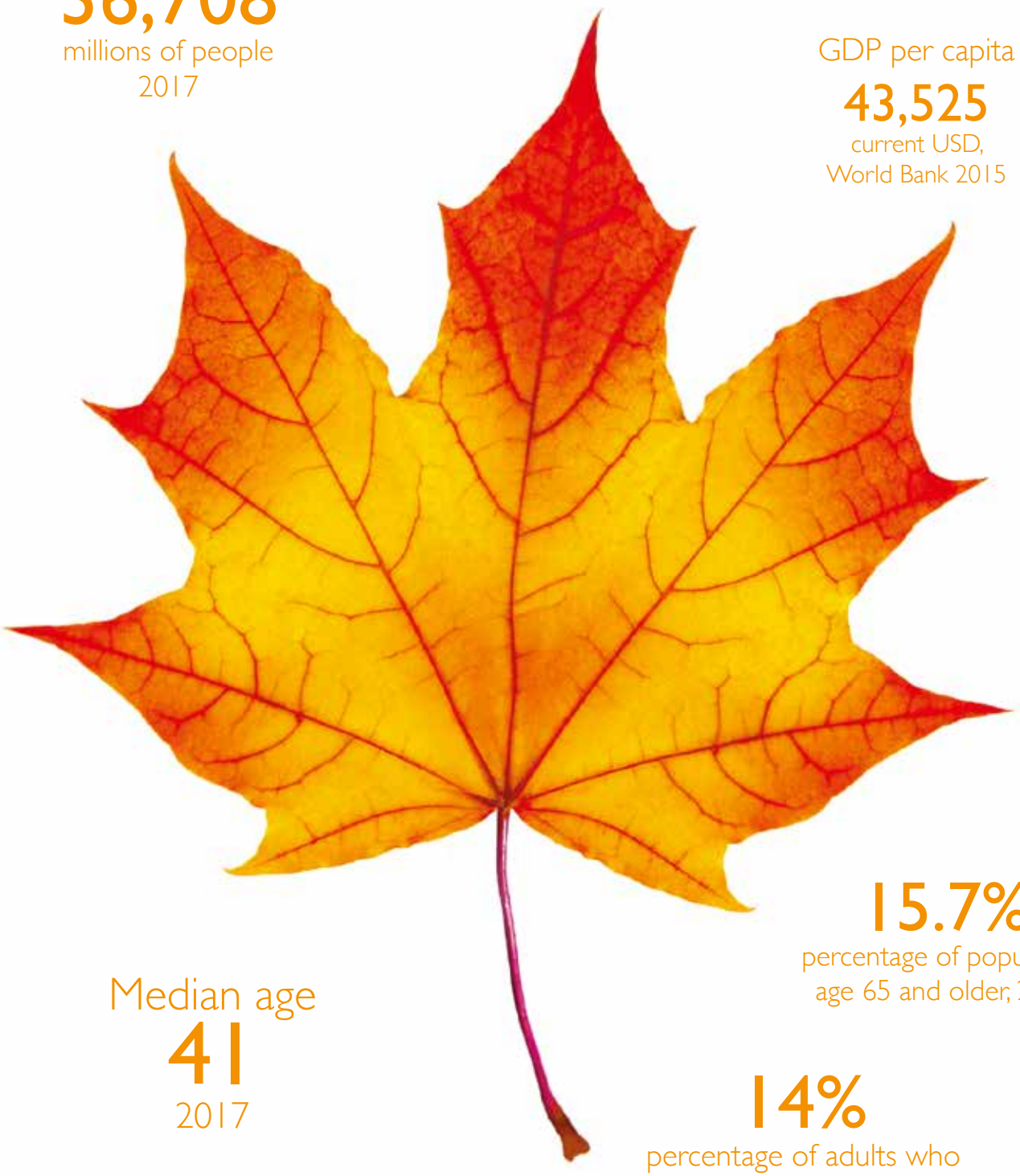
36,708

millions of people
2017

GDP per capita

43,525

current USD,
World Bank 2015



15.7%

percentage of population age 65 and older, 2014

Median age

41

2017

14%

percentage of adults who report being daily smokers, 2014

Focus

The Privilege of Equal Access Within Canadian Healthcare

Author: Silvia Borriello
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Given Canada's internationally lauded history of high-quality healthcare system grounded in values of equity in access and solidarity, it is surprising that its national system of health insurance does not include services such as drugs, vision and dental care. Nonetheless, despite its separate position, statistics demonstrate that Canada has among the best access to dental care in the world with very good levels of oral health.

DO YOU KNOW THAT

The provinces and territories of Canada are sub-national governments within the geographical areas of Canada under the authority of the Canadian Constitution. Together, the 10 provinces and 3 territories make up the world's second-largest country by area. Provinces receive their power and authority from the *Constitution Act, 1867*, whereas territorial governments have powers delegated to them by the Parliament of Canada.

In modern Canadian constitutional theory, the provinces are considered to be sovereign within certain areas based on the divisions of responsibility between the provincial and federal government within the Constitution Act 1867, and each province thus has its own representative of the Canadian "Crown", the lieutenant governor. Unlike the provinces, the territories of Canada have no inherent sovereignty and have only those powers delegated to them by the federal government and as a result, have a commissioner instead of a lieutenant governor.

COMPARATIVE HEALTH INDICATORS, 2016

	CANADA	U.S.A.
Prevalence of obesity (BMI>30)	26 % (2014)	38 % (2014)
Life expectancy at birth (years)	82.8	78.5
Healthy life expectancy at birth (years)	73.2	68.5
Chronic bronchitis	6.3	4.0
Probability of dying from any of cardiovascular disease, cancer, diabetes or chronic respiratory disease between age 30 and exact age 70 (%)	9.8%	14.6%

Sources: https://international.commonwealthfund.org/countries/canada/ and WHO 2018

Healthcare in Canada is delivered through thirteen provincial and territorial systems of predominantly publicly funded healthcare, informally called Medicare, guided by the provisions of the Canada Health Act of 1984 which sets standards for "medically necessary" hospital, diagnostic and physician services. **The system is highly decentralized with provinces (10) and territories (3) having primary jurisdiction in terms of governance, organization and service delivery with medically necessary hospital, diagnostic and physician services free at the point of service for all residents.** The federal government, from its side, co-finances provincial and territorial programs which must adhere to the Canada Health Act, which states that to be eligible to receive full federal cash contributions for healthcare, each provincial and territorial healthcare insurance plan needs to be: publicly administered, comprehensive in coverage, universal, portable across provinces and accessible (for example, without user fees). Furthermore, the federal ministry of health, Health Canada, plays a role in promoting overall health; food and drug safety; medical device and technology review and funding and delivery of certain health services to certain groups of people (aboriginal groups, members of the Canadian Forces, veterans, inmates in federal penitentiaries and eligible refugee claimants).

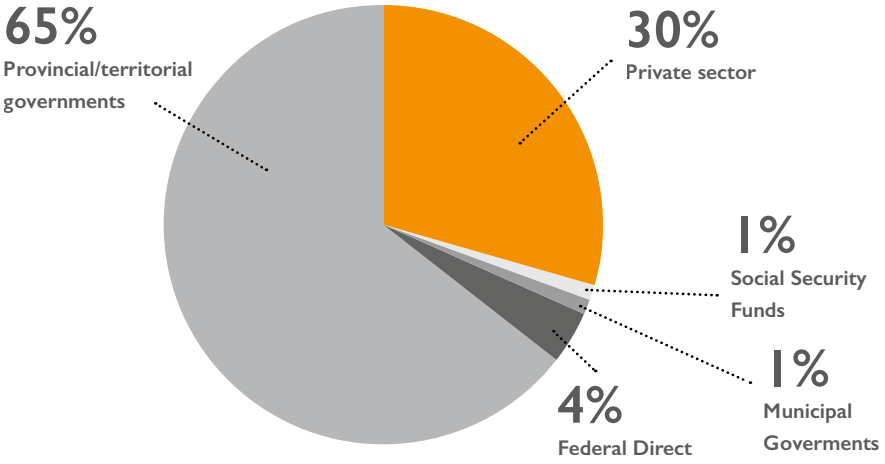
There is no nationally defined statutory benefit package; most public coverage decisions are made by provincial and territorial governments in conjunction with the medical profession and each province and territory has some reasons to determine what is considered essential and where, how and who should provide the services, resulting in a wide variance in what is covered across the country by the public health system, particularly in more controversial areas, such as midwifery or autism treatments. An expansion of the publicly funded basket of services and coordinated effort to reduce variation in outcomes between provinces and territories would hinge on more engaged roles for the federal government and the physician community than have existed.

Most publicly funded healthcare services are delivered privately through private for-profit, private non-profit as well as public organizations and by physicians who receive remuneration from provincial ministries of health. **Despite the reforms made over the past four decades in response to changes within medicine and throughout society the basics within Canada's healthcare system remain the same: universal coverage for medically necessary healthcare services are provided based on need, rather than ability to pay.** Nonetheless, in the setting of geographical and population diversity, long waits for elective care demand the capacity and commitment to scale up effective and sustainable models of care delivery across the country; furthermore, profound health inequities experienced by Indigenous populations and some vulnerable groups also require coordinated action and a need to be more effectively addressed.

The provinces and territories administer their own universal health insurance programs, covering all provincial and territorial residents in accordance with their own residency requirements.

More than 70% of healthcare in Canada is financed through general tax revenues. In 2016, total and publicly funded health expenditures were forecast to account for an estimated 11.1% and 8.0% of GDP, respectively; by that measure, 69.8% of total health spending came from public sources. The provinces and territories are most directly responsible for raising most of the financing, but the federal government contributes with an annual cash transfer on a per capita basis through the Canada Health Transfer. The provinces and territories administer their own universal health insurance programs, covering all provincial and territorial residents in accordance with their own residency requirements.

TOTAL HEALTH EXPENDITURES BY SOURCE OF FINANCE, 2010 FORECAST



Note: *Although the graph notes that provincial/territorial governments pay for 65% of health expenditures in Canada, the federal government supports provincial/territorial expenditures through fiscal transfers.*
Source: *Canadian Institute for Health Information. National Health Expenditure Trends, 1975 - 2010. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html*

Hospitals account for the largest share of healthcare spending. Spending on drugs has accounted for the second-largest share since 1997, making up 16% of spending in 2010. The third-largest share of healthcare expenditures is accounted for by spending on physicians, which made up 14% of spending in 2010.

Almost all essential basic care is publicly covered, including primary care physicians, specialists and hospital services. The coverage includes prevention and treatment of common diseases and injuries; basic emergency services; referrals to and coordination with other levels of care, such as hospital and specialist care; primary mental healthcare; palliative and end-of-life care; health promotion; healthy child development; primary maternity care and rehabilitation services.

Universal health coverage: Financial protection Proportion of population with total household expenditures on health > 10% and > 25% of total household expenditure or income, latest available data, 2007–2015

	> 10%	> 25%
CANADA	2.6%	0.5%
U.S.A.	4.8%	0.8%

Proportion of total government spending on essential services (education, health and social protection) as a % of general government expenditure, 2015

CANADA	19.1%
U.S.A.	22.6%

Source: *World Health Statistics (WHO), 2018*

HEALTHCARE EXPENDITURE AND SOURCES OF FINANCING

Total healthcare expenditures (THCE), 2015 est.	**US$ 219.2 Billion**
Private-sector healthcare expenditures, 2015 est.	**US$ 64.2 Billion**
Total health expenditure per capita (2015)	**US$ 4,508**
Total per capita spending on drugs, 2015, est.	**US$ 959**
Total per capita spending on physician services, 2015, est.	**US$ 946**
Total per capita spending on oral healthcare, 2015, est.	**US$ 378.60**
Total out-of-pocket healthcare spending per capita, 2014 est.	**USD 644**
Total public healthcare expenditure, 2016 est.	**69.8%**
Private health insurance as % of THCE, 2014, est.	**12%**
Out-of-pocket payments as % of THCE, 2014, est.	**14%**

Source: *The Commonwealth Fund / WHO, 2018 / Canadian Dental Association*

IN BRIEF

GOVERNMENT ROLE - Regionally administered universal public insurance program that plans and funds (mainly private) provision

PUBLIC SYSTEM FINANCING - Provincial/federal general tax revenue

PRIVATE INSURANCE ROLE - 67% buy complementary coverage for noncovered benefits (e.g. private rooms in hospitals, pharmaceuticals, dental care, optometry)

Health services not covered by Medicare are largely privately financed and they vary depending on the province and territory but dental or vision care, cosmetic surgery and some forms of elective surgery are not considered essential. Pharmaceutical benefits are only available to the elderly, disabled or low-income earners, although all prescription drugs provided in hospitals are covered publicly, with outpatient coverage varying by province or territory. User fees for ambulance services vary considerably across provinces, private rooms in hospitals are also usually not covered. Individuals and families who do not qualify for publicly funded coverage may pay these costs directly, be covered under an employment-based group insurance plan or buy private insurance (although provinces and regions provide partial coverage for children, those living in poverty and seniors). Private insurance in Canada is therefore complementary and both the federal and provincial governments are involved in regulating the private health insurance market, but Canadian regulation of the design of insurance products, their pricing and their sale, are relatively weak by international standards.
Private health expenditure accounts for around 30% of healthcare financing with out-of-pocket payments making up more than 50% of expenditures. At the same time, private health insurance is responsible for roughly 12-13% of total health expenditures. In 2014, out-of-pocket payments represented about 14% of total health spending, going mainly toward prescription drugs (21%), nonhospital institutions, mainly long-term care homes (22%), dental care (16%), vision care (9%), and over-the-counter medications (10%).

PROVIDER OWNERSHIP

PRIMARY CARE - Private sector

HOSPITALS - Public/private mix (proportions vary by region), mostly not-for-profit

PROVIDER PAYMENT

PRIMARY CARE PAYMENT - Mostly fee-for-service (45% to 85%, depending on province), but some alternatives (e.g., capitation) for group practices

HOSPITAL PAYMENT - Mostly global budgets, case-based payment in some provinces (does not include physician costs)

DELIVERY SYSTEM FOR PRIMARY CARE

REGISTRATION WITH GP REQUIRED - Not generally, but yes for some capitation models

GATEKEEPING - Yes, mainly through financial incentives varying across provinces (e.g., in most provinces, specialists receive lower fees for patients not referred)

BENEFIT DESIGN

CAPS ON COST-SHARING - No

EXEMPTIONS & LOW-INCOME PROTECTION - There is no cost-sharing for publicly covered services; protection for low-income people from cost of prescription drugs varies by region

Source: *https://international.commonwealthfund.org/countries/canada/*

Canada's universal healthcare system is known as a single payer system, where basic services are provided by private doctors (they have been allowed to incorporate since 2002), with the entire fee paid for by the government. They are generally paid through fee-for-service schedules that itemize each service and pay a fee to the doctor for each service rendered. These are negotiated between each provincial and territorial ministry of health (for primary and specialist care) and the provincial and territorial medical associations in their respective jurisdictions. In some provinces, such as British Columbia and Ontario, payment incentives have been linked to performance. Physicians are not allowed to charge patients prices above the negotiated fee schedule.Those in other practice settings such as clinics, community health centers and group practices are more likely to be paid through an alternative payment scheme, such as salaries or a blended payment (e.g., fee-for-service payments plus incentives for providing certain services such as the enhanced management of chronic diseases etc.). Nurses and other health professionals are generally paid salaries that are negotiated between their unions and their employers.

Primary care - The traditional model of primary care in Canada has been based on individual, self-employed family physicians (often known as general practitioners or GPs), providing primary medical services in private practices remunerated on a fee-for-service basis, although there has been a movement toward alternative forms of payment such as capitation. In 2014–2015, fee-for-service payments made up 45% of payments to GPs in Ontario, compared with 68% in Quebec and 84% in British Columbia. **In the last decade, provincial and regional ministries of health have renewed efforts to reform primary care focusing on moving from the traditional physician-only practice to group practice, interprofessional primary care teams that provide a broader range of primary healthcare services on a 24-hour, 7-day-a week basis.** The networks of GPs working together and sharing resources varies across provinces in the composition and size of teams. In 2014, 46% of GPs reported to work in a group practice, 19% in an interprofessional practice and 15% in a solo practice. Patients are free to choose and change their family physicians, they can access specialists directly, but it is common for family physicians to act as gatekeepers and refer patients to specialty care. Many provinces pay lower fees to specialists for non-referred consultations.

Preventive care and early detection are considered critical in Canada and yearly checkups are recommended by public campaigns. Several are the programs, for seniors, those with disabilities, awareness campaigns for back injuries and many others, funded by the government to create public health awareness and to reduce healthcare costs.

In 2016, there were 230 practicing physicians per 100,000 population, about half of whom were general practitioners and the rest specialists, totaling 84,063 doctors, 92% of which working in urban areas.Total gross clinical payments to physicians in 2015–2016 increased 3.4% over the previous year to $25.7 billion. Fee-for-service payments accounted for 72% of gross clinical payments and alternative payments accounted for 28%. **Recent reports indicate that Canada may be heading toward an excess of doctors, though communities in rural, remote and northern regions, and some specialties, may still experience a shortage.** The gross average salary in 2016 was $339,000 per physician. Out of the gross amount, doctors pay for taxes, rent, staff salaries and equipment.

	CANADA	U.S.A.
Average Annual number of physician visits per capita, 2014	7.6	4.0
Density of nursing and midwifery personnel (per 1000 population), 2016	9.8	/

Source: *World Health Statistics (WHO), 2018 / https://international.commonwealthfund.org/countries/canada/*

Number of Family Medicine and Specialist Physicians, by Jurisdiction, Canada 2016

JURISDICTION	FAMILY MEDICINE	SPECIALISTS	TOTAL PHYSICIANS
Newfoundland and Labrador	682	633	1,315
Prince Edward Island	152	127	279
Nova Scotia	1,215	1,242	2,457
New Brunswick	960	775	1,735
Quebec	9,823	10,447	20,270
Ontario	15,417	15,600	31,017
Manitoba	1,423	1,325	2,748
Saskatchewan	1,241	1,041	2,282
Alberta	5,320	4,974	10,294
British Columbia	6,189	5,358	11,547
Yukon Territory	68	10	78
Northwest Territories	25	8	33
Nunavut	7	1	8
Canada	**42,522**	**41,541**	**84,063**

Notes:
-includes active physicians in clinical and non-clinical practice (e.g., research and academia) who have an MD degree and a valid mailing address.
-excludes residents, physicians in the military, and semi-retired physicians
-excludes non-registered physicians who requested that their information not be published as of December 31
Source: *Scott's Medical Database, 2016, Canadian Institute for Health Information https://www.cihi.ca/en/physicians-in-canada*

Average payment to family medicine physicians (2016)	$275,000
Average payment to medical specialists (2016)	$347,000
Average payment to surgical specialists (2016)	$461,000

Source: *Scott's Medical Database, 2016, Canadian Institute for Health Information https://www.cihi.ca/en/physicians-in-canada*

Outpatient specialist care - **Most outpatient specialist care is provided in hospitals, but there is a trend toward providing services in private non-hospital facilities, although this has not yet become the dominant mode of delivery.** In 2014, 65% of specialists reported to work in a hospital, compared with 24% in a private office or clinic. Specialists are mostly self-employed and paid fee-for-service, with a variation across provinces and territories. Those working in the public system are not permitted to receive payment from private patients for publicly insured services. There are few formal multispecialty clinics.

Canada's provincially and territorially based Medicare systems are cost-effective because of administrative simplicity. In each province and territory, physicians and specialists bill provincial/territorial governments directly, although some doctors are paid a salary by a hospital or facility. **There are no direct payments from patients to physicians so there is no need for patients who access healthcare to be involved in billing and reclaim.** There are no deductibles on basic healthcare and no cost-sharing for publicly covered services (insured physician, diagnostic, and hospital service). User fees are extremely low or non-existent. In general, user fees are not permitted by the Canada Health Act, but physicians may charge a small fee to the patient for reasons such as missed appointments, doctor's notes and for prescription refills done over the phone. Some physicians charge "annual fees" as part of a comprehensive package of services they offer their patients and their families. Such charges are completely optional and can only be for non-essential health options.

Hospitals - **Hospital care is delivered by publicly funded hospitals, most of which are independent institutions incorporated under provincial Corporations Acts and are required by law to operate within their annual global budgets, negotiated with the provincial or territorial ministry of health or regional health authority.** However, several provinces, including Ontario, Alberta and British Columbia, have considered introducing activity-based funding for hospitals. Hospital-based physicians generally are not hospital employees and are paid fee-for-service directly. Hospitals are a mix of public and private, predominantly not-for-profit, organizations, often managed locally by regional authorities or hospital boards representing the community. In provinces with regional health authorities, many hospitals are publicly owned, whereas in other provinces, such as Ontario, they are predominantly private nonprofit corporations. There are no data on the number of private for-profit clinics (which are mostly diagnostic and surgical). Canada (except for the province of Quebec) is one of the few countries with a universal healthcare system that does not include coverage of prescription drugs. Every provincial government has a prescription drug plan that covers outpatient prescription drugs only for designated populations (elderly or indigent), with the federal government providing drug coverage for eligible aboriginal groups. **More than 60% of prescription medications are paid for privately in Canada, through employment-based private insurance or paid for out-of-pocket.** Pharmaceutical costs are set at a global median by government price controls.

Ultimately, there is a clear trend in Canada for the consolidation of tertiary care in fewer and more specialized hospitals, as well as the spinning off of some types of elective surgery and advanced diagnostics to specialized clinics.

Regardless of this activity, overall, among the OECD countries, Canada ranks very low in the public financing of dental care.

Oral Healthcare system - Given Canada's internationally lauded history of privileging equal access to healthcare, health policy analysts are often surprised that Canada's national system of health insurance (Medicare) does not include dental care. **Only a small proportion of the population (around 5.5%) is covered by public dental insurance, almost all targeted to socially marginalized groups and delivered in the private sector through public forms of third-party financing.** For publicly financed dental care, this breaks down in specific ways: the federal government finances dental care for specific groups, such as state-recognized Aboriginal groups and the country's Armed Forces, both due to historical custom and fiduciary responsibilities; the provinces finance dental care for such groups as low-income children, social welfare recipients, the disabled and those with craniofacial disorders; and through cost-sharing agreements with the provinces, municipalities finance care for low-income children and social welfare recipients, and independently for groups such as low-income seniors. Regardless of this activity, overall, among the OECD countries, Canada ranks very low in the public financing of dental care. **Dental care is almost wholly privately financed, with private dental insurance covering around 62.6% of the population, mostly by way of employment-based benefit plans.** By the end of 2011, 87,500 group insured contracts provided 13.1 million workers and dependents with dental care benefits, while 31.9% of Canadians self-reported having neither public nor private dental insurance. Dental insurance plans coverage helps to pay for preventive and main-tenance services and root canals, periodontal cleaning and scaling. It may also extend to major restorative procedures, such as crowns, bridges, dentures, braces

2016 Commonwealth Fund International Health Policy Survey, Comparative Figures

Access to care:
-able to get same-day/next-day appointment when sick: Canada: 43% / U.S.A. 51%
-very/somewhat easy to get care after hours: Canada 63% / U.S.A. 51%
-Waited two months or more for specialist appointment: Canada 30% / U.S.A. 6%
-Waited four months or more for elective surgery: Canada 18% / U.S.A. 4%
-Experiences access barrier because of cost* in past year: Canada: 16% / U.S.A. 33%
(*Access barrier because of cost defined as at least one of the following: Did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care)

Overall views of healthcare system:
Which of the following statements comes closest to expressing your overall view of the health care system in your country?'
A. "the system works pretty well and only minor changes are necessary to make it work better": Canada: 35% / U.S.A. 19%
B. "there are some good things in our health care system, but fundamental changes are needed to make it work better": Canada: 55% / U.S.A. 53%
C. "Our health care system has so much wrong with it that we need to completely rebuild it": Canada: 9% / U.S.A. 23%

Source: *https://international.commonwealthfund.org/countries/canada/*

and orthodontic services. Many plans typically reimburse most of the charges for primary dental care, plus 50% for major procedures to a maximum amount in any year and orthodontic services to a lifetime maximum. The benefits may also be subject to a deductible amount for which the insured is responsible. Research shows that access to dental care may be getting more difficult for the middle-income segment of the Canadian population as well. Middle-income workers have experienced significant changes in their work environments, which includes decreases to both the amount and availability of employment-based dental insurance. In addition, the provision of public dental benefits does not always ensure access to dental care for those who are covered, since there are often complicated insurance-related barriers to accessing dental treatment. **Nonetheless, when considering access to oral healthcare for entire populations, statistics show that Canada has among the best access to oral healthcare in the world.** The figures below reveal that all countries face similar challenges regarding access to oral health for the poorest segments of society, regardless of whether oral healthcare is publicly or privately delivered.

Percentage of Population Visiting Dentist in Past Year

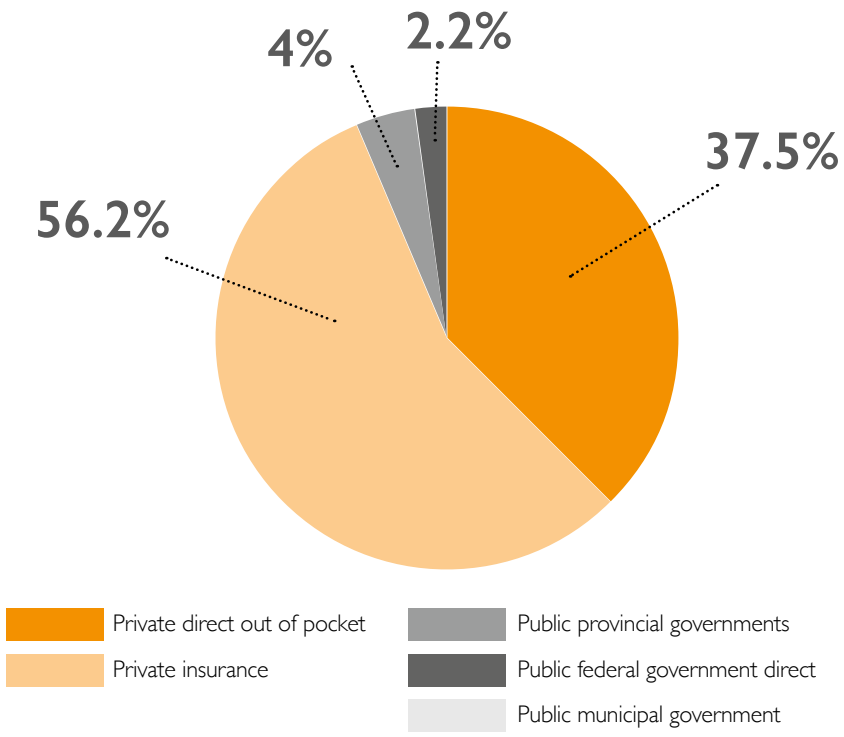
	POOREST	AVERAGE	RICHEST
France*	63.9	74.9	82.3
Czech Republic	50.3	71.0	77.8
United Kingdom	58.1	68.8	74.5
Slovak Republic	47.6	68.8	76.3
Canada	**46.5**	**64.6**	**78.5**
Austria	51.6	61.0	70.2
Finland	51.3	58.6	68.5
Belgium	39.8	58.1	69.5
Slovenia	42.6	56.1	64.4
New Zealand	43.8	51.2	59.8
Estonia	31.0	48.0	55.8
Spain	34.5	44.9	57.8
United States	26.2	42.4	56.9
Poland	26.8	42.3	54.6
Hungary	28.1	37.5	50.5
Denmark**	28.1	35.3	40.0

visits in past 2 years/visits in past 3 months.*
Source: *Health at a Glance 2011, OECD Indicators, 2011 (taken from Canadian Dental Ass. website https://www.cda-adc.ca/stateoforalhealth/canada/)*

Consequently, the major portion of payments for oral healthcare comes from private sources, either out-of-pocket (approx. 40%) or through private dental insurance (approx. 60%). According to the Canadian Dental Association, it is estimated that total expenditures on dental services in Canada in 2015 amounted to $13.6 billion, with the private sector making up the largest component of spending, estimated at $12.7 billion (93.8% of total spending), while public-sector expenditures were estimated at $846 million (6.2% of total spending).
On a per capita basis, the latest data available showed that total per capita expenditure on oral healthcare was estimated at $378.60 in 2015 (compared to $959 on drugs and $946 on physician services). Private per capita spending on dental services was estimated at $355 and public per capita spending at $23.60.

Independent practitioners operating their own practices deliver nearly all oral healthcare. A dental healthcare team of professionals supports dentists in their work, including dental hygienists, dental assistants and dental technologists. In select jurisdictions, dental therapists and denturists have legislated practice and offer services independent of dentists, such as basic dental treatment and preventive services as well as patient assistance and referrals. Dental hygiene is the 6th largest registered health profession in Canada with 29,246 registered dental hygienists (in 2016) working in a variety of settings, with people of all ages, addressing issues related to oral health. **There are around 21,109 dentists in Canada with a dentist/population ratio of 1/1,622,** meaning that for every dentist in Canada there are 1,622 people. A minority of these professionals practice in public health settings, with information collected from provincial, municipal and federal health jurisdictions showing that 47 public health specialists, 66 clinical dentists, 152 therapists and 453 dental hygienists were part of the public health workforce in 2007/2008. The distribution of dentists varies widely by province. **Currently, there is widespread debate regarding the "over- saturation" of dentists in Canada with a generally declining ratio over-time, signifying that there are increasing numbers of dentists relative to the population, suggesting greater overall availability of oral healthcare. Reports suggest that there is a growing per-capita pool of dentists in specific jurisdictions, primarily large urban centers like Toronto, Montreal and Vancouver, an "over-concentration" of dentists in urban areas with rural and remote areas having proportionally fewer dentists, making access to oral care in these regions more challenging.** Recently, there has been a shift towards the corporatization of dentistry in Canada. In the US, corporate interests own 30–40% of all dental offices. In Canada this figure is 2% but steadily rising. It has been predicted that corporate practices will potentially find it increasingly easier to buy existing dental practices and to recruit the workforce needed to operate them. As a result, the future of solo practices in the current environment is set to decline.
To practice as a dentist, an individual must obtain a license from one of the dental authorities in Canada. Each province/territory has a dental regulatory authority/licensing body that establishes regulations and requirements for the licensure of general practitioners within its jurisdiction, although the Royal College of Dentists of Canada plays the role of setting standards for postgraduate specialty practice. The requirements to obtain a license are similar across the country but can vary slightly from one jurisdiction to another. To obtain a license, the applicant must hold a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DDM) degree from an accredited program, pass the National Dental Examining Board of Canada Written Examination and Objective Structured Clinical Examination as well as be registered with the pertinent regulatory body. In addition to a dental regulatory college, each jurisdiction also has a dental association. Membership in the provincial/territorial and national dental associations is a necessary component of licensure in all provinces except Ontario and Quebec. Also, in the territories, membership in the Yukon Dental Association and the Northwest Territories & Nunavut Dental Association is not mandatory for registration and licensing.
In 2010, Health Canada published a report on the dental health of Canadians, based on the Canadian Health Measures Survey (CHMS) conducted by Statistics Canada.

Dental Service Expenditures in Canada, 2015



In this chart, for illustrative purposes private insurance refers to all sources of private insurance including employment and non-employment related dental coverage
Source: *Health Expenditure Trends, CIHI, 2015 (taken from Canadian Dental Ass. website www.cda-adc.ca/stateoforalhealth/servicescanada/)*

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DO YOU KNOW THAT

Canada is a Constitutional Monarchy - Queen Elizabeth II is still the Head of State of Canada, a former British colony. Below a list of roles still served by "Elizabeth the Second, by the Grace of God, of the United Kingdom, Canada and Her other Realms and Territories, Queen, Head of the Commonwealth, Defender of the Faith" (her official full Canadian title).

- **She's the Head of State.** Technically speaking, Queen Elizabeth is the Sovereign of the parliamentary democracy and constitutional monarchy of Canada.
- **Government Officials and New Citizens Swear an Oath to Her.**
- **The Governor General is Appointed by Her.**
- **She Stays Neutral.** Because she is considered to be the personification of the state of Canada, she is meant to remain neutral on all matters of politics.
- **She Supports Many National Organizations.** The Queen is a patron of a number of Canadian organizations, including the Canadian Cancer Society, the Canadian Red Cross Society and the Royal Canadian Humane Association.
- **The Entire Royal Family Upholds Canadian Traditions and Ceremonies.** Most important anniversaries or celebrations are attended by the monarch herself, while other members of the royal family may attend lesser events in her place.
- **She Plays a (symbolic) Role in Canada's Armed Forces.** The Queen acts as Colonel-in-Chief of numerous Armed Forces regiments, such as the King's Own Calgary Regiment and The Canadian Grenadier Guards.
- **She Stays Informed on Political Matters.** The prime minister and the ministers in his cabinet are all appointed by the governor general on behalf of Queen Elizabeth.
- **Her Signature is Necessary for Certain Government Approvals.** The Queen must apply her royal sign-manual, or signature, as well as the Great Seal of Canada to patent letters, specific appointment papers of the governor general, the creation of additional Senate seats and any change in her Canadian style and title.
- **She can Grant Immunity from Prosecution.**

Dentists and Other Oral Healthcare Providers, Latest Data Available

Dentists (2013)	**21,109**
Population/dentist ratio (2016)	**1,622/1**
Dental hygienists (2016)	**29,246**
Dental assistants	**26,000 - 29,000**
Dental technicians	**NA**
Dental therapists	**300**
Denturists	**2,200**

*** NA= not available**

Source: *Canadian Dental Ass. https://www.cda-adc.ca/stateoforalhealth/ http://ncohr-rcrsb.ca/knowledge-sharing/working-paper-series/content/garbinneumann.pdf*

The results showed that 75% of Canadians visit a dental clinic annually and 86% do so at least once every 2 years. Overall, the survey indicates that Canadians have very good levels of oral health with significant decreases in levels of dental decay over the past 40 years. While Canada's oral healthcare measures are generally above average compared with countries around the world, there are inequities in oral care. Particularly, Canadian families and individuals with lower incomes and of lower socio-economic status, those without dental insurance, older Canadians and Indigenous Canadians experience worse overall oral health outcomes than the general population.

According to the report, the mean DMFT at age 12 was 1.02 and 38.7% of 12-year-old children had 1 or more permanent teeth affected by caries. Overall, dentate adults have an average of 0.58 teeth with untreated decay, 2.14 teeth extracted, and 7.95 teeth filled.

The level of edentulism (no teeth) among Canadians has fallen from 23.6% in 1970–72 to 6.4% in 2007-09. Approximately 2 out of 3 Canadians have no clinical needs as identified by dentist-examiners in the CHMS. **The CHMS also showed that the rate of annual visiting to obtain oral healthcare is greatly influenced by income and insurance; 83.8% of people from the most affluent and 82.3% of privately insured families visited a dentist compared to 60.0% of people from the lower income category and 59.3% of non-insured families.** At the same time, avoiding visit a dentist because of costs is an issue for more than 17% of Canadians, and this percentage can be higher among young adults with no insurance (49.9%) and lower incomes (46.7%), as well as among adults aged 40–59 years with no insurance (42.3%).

Among main sources:

- Extracts from "The Canadian Health Care System", The Commonwealth Fund
- https://international.commonwealthfund.org/countries/canada/
- The Government of Canada, for details on healthcare: https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html
- Extracts from "The State of Oral Health in

Outcome from the CHMS Survey

- **Roughly 80% of Canadians have a dentist**
- **Percentage of children with at least one decayed tooth, 23.6%**
- **Percentage of adolescents with at least one decayed tooth, 58.8%,**
- **Average number of decayed, missing or filled teeth (per child), 2.5**
- **34% of dentate Canadians 6-79 years of age had some sort of treatment need identified**
- **47% of lower-income Canadians had a need identified, compared to 26% of the higher-income group**
- **1 out of 3 Canadians has a need and only 1 out of 6 says they cannot address this need because of financial reasons**
- **Overall, Canadians from lower-income families were found to have two times worse outcomes compared to higher income families in many measures.**
- **84% of Canadians report their oral health as good or excellent**
- **5.5% of Canadians have untreated coronal cavities**
- **Most Canadians (73%) brush twice or more a day and over a quarter (28%) floss 5 times a week.**

Source: *Canadian Dental Ass. website - https://www.cda-adc.ca/stateoforalhealth/snap/*

For a detailed report on the State of Oral Health in Canada:
Canadian Dental Association (CDA)
1815 Alta Vista Drive - Ottawa, Ontario, Canada
K1G 3Y6 - Phone: 613-523-1770
www.cda-adc.ca/stateoforalhealth

Canada", Canadian Dental Association, https://www.cda-adc.ca/stateoforalhealth/
https://www.cda-adc.ca/stateoforalhealth/snap/
https://www.cda-adc.ca/en/services/internationally-trained/economic/
https://www.cda-adc.ca/en/services/internationally-trained/terms/
https://www.cda-adc.ca/en/services/internationally-trained/economic/
- Extracts from "A Comparative Analysis of Oral Healthcare Systems in the United States, United Kingdom, France, Canada, and Brazil" By Daniela Garbin Neumann and Carlos Quinonez., http://ncohr-rcrsb.ca/knowledge-sharing/working-paper-series/content/garbinneumann.pdf
- Canadian Institute for Health Information
- https://www.cihi.ca/en/dentists
- "Why was dental care excluded from Canadian Medicare?" by Carlos Quinonez Quiñonez NCOHR Working Papers Series 2013, 1:1, http://ncohr-rcrsb.ca/knowledge-sharing/working-paper-series/content/quinonez.pdf
- The Canadian Dental Hygienists Association, https://www.cdha.ca/cdha/The_Profession_folder/Resources_folder/The_Canadian_Institute_for_Health_Information_CIHI_folder/CDHA/The_Profession/Resources/CIHI.aspx
- https://www.statista.com/statistics/686355/number-of-licensed-dentists-in-canada-by-province/
Scott's Medical Database, 2016, Canadian Institute for Health Information - https://www.cihi.ca/en/physicians-in-canada
https://www.cihi.ca/en/infographic-a-profile-of-physicians-in-canada-in-2016
- World Health Statistics (WHO), 2018
- https://www.thelancet.com/journals/lancet/article/IIS0140-6736(18)30181-8/fulltext

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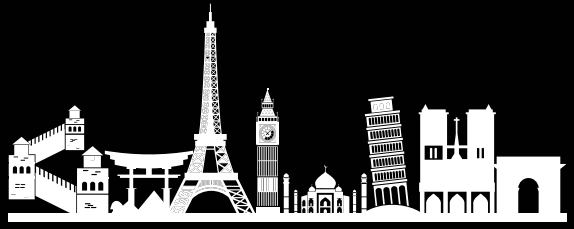
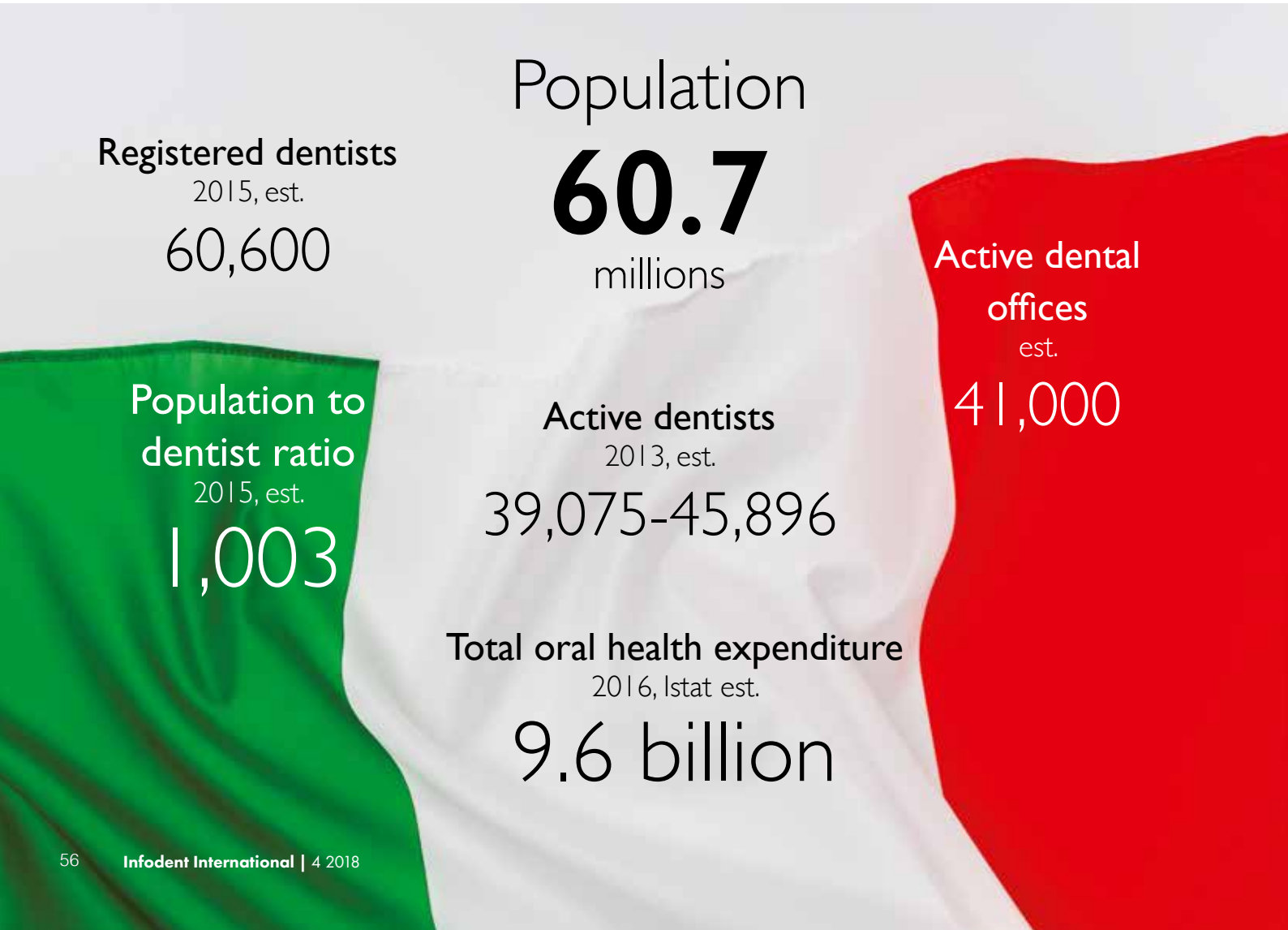


Looking for distributors

A Snapshot on Italian Dentistry, Have Italians Given Up the Dentist?

Author: Silvia Borriello
silvia.borriello@infodent.com

Italian dentistry today is completely different from what it was 25 years ago or even as little as 7 or 8 years ago. But, what kind of a change is it? Is there a crisis and for whom? For private or for public dentistry? For patients or for everyone? For sure, an epochal change has taken place and in such a context Italian dentistry needs to adapt to the new reality and adjust to the emerging market needs.



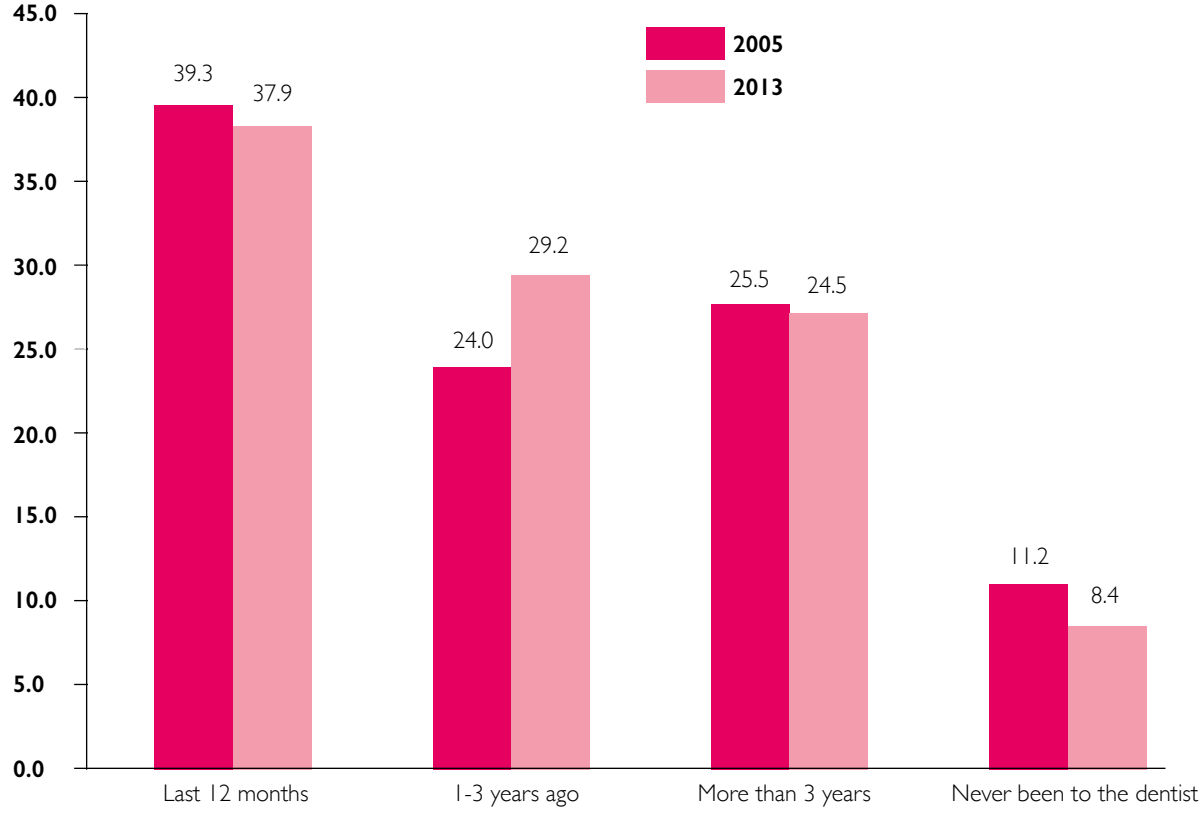
According to the Italian National Institute of Statistics (ISTAT), in 2005, the number of people visiting a dentist in the last 12 months was 39.3%. In 2013 it fell to 37.9%. A 2% fall in eight years is not so much, but dental practices are losing around 40% of turnover. So, what's going on? The answer is simple. **Patients visit a dentist less frequently and the number of patients deferring their visits has increased from 24% in 2005 to 29.2% in 2013.**

It is essential to note that economic reasons account for 85.2% on the total of those who have deferred dental visits. In 2013, 12% of people aged 14 and over had not visited a dentist or had not had a dental treatment, in the previous 12 months, for economic reasons. Dentistry is changed. Dentists are mostly working on performance, not because the population is no longer going to the dentist but simply because it has reduced the number of visits, maybe for many of those treatments that do not have to do with emergency or pain.

A major concern is the diversification of the country, with northern Italy being completely different from the south in terms of oral health. In the South of Italy (Istat data) only 27.7% of the population aged 3 and over resorted to dental treatment compared to the national average of 37.9%. Also, as far as number of visits for prevention in the South, the percentage of people that make them is almost half (16.1%) of that of the North (30.7%), while the number of those who have never been to a dentist is double: 12.1% against 6.2%.
A further paradox is the increasing trend in the use of public or subsidized dental facilities within the country except for southern Italy, which has gone down from 4.4% in 2005 to 4.1% in 2013.
But despite all, the oral health of the total population has improved; in 2005, 37.8% of Italians had 28 natural teeth, rising to 41.4% in 2013. While in 2005, 12% were edentulous patients, falling to 10.8% in 2013.

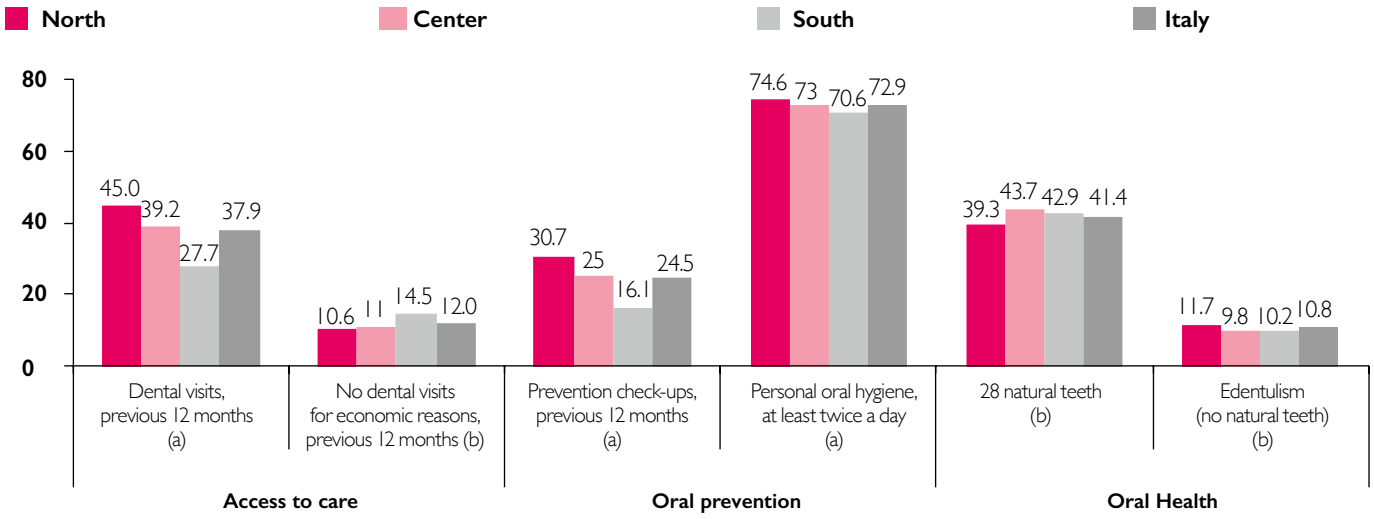
According to a study, made by the Bocconi University (Milan-Italy), on the operating mode of Italian dentistry, 75% of dental practices are made up of individual-independent professionals. So, the financial crisis is not so much for the patient (still going to the dentist, but less frequently and with improved oral health) but more for the mono-professional practice, mostly made up of professionals with an average age of 53 years, operating on average 24 years within their profession. **According to the survey, 77.7% of dentists are over 45 years-old and 69% have been working as dentists for over 20 years.** So, when we talk about a crisis on revenues, we address a population of dentists mainly in this segment which is facing an identity crisis needing to be dealt with, differently from younger dentists that might already have found the countermeasures to react to the change.
According to the study, in 2015 over a third of dental practices have had lower revenues from previous year; among them, 80% are solo practices, many reporting having a lot of competition around them and most of them having few patients (less than 10 per day).

POPULATION 3 YEARS AND OLDER FOR FREQUENCY OF VISITS TO A DENTIST OR ORTHODONTIST
Years 2005 and 2013, standardized rates per 100 people



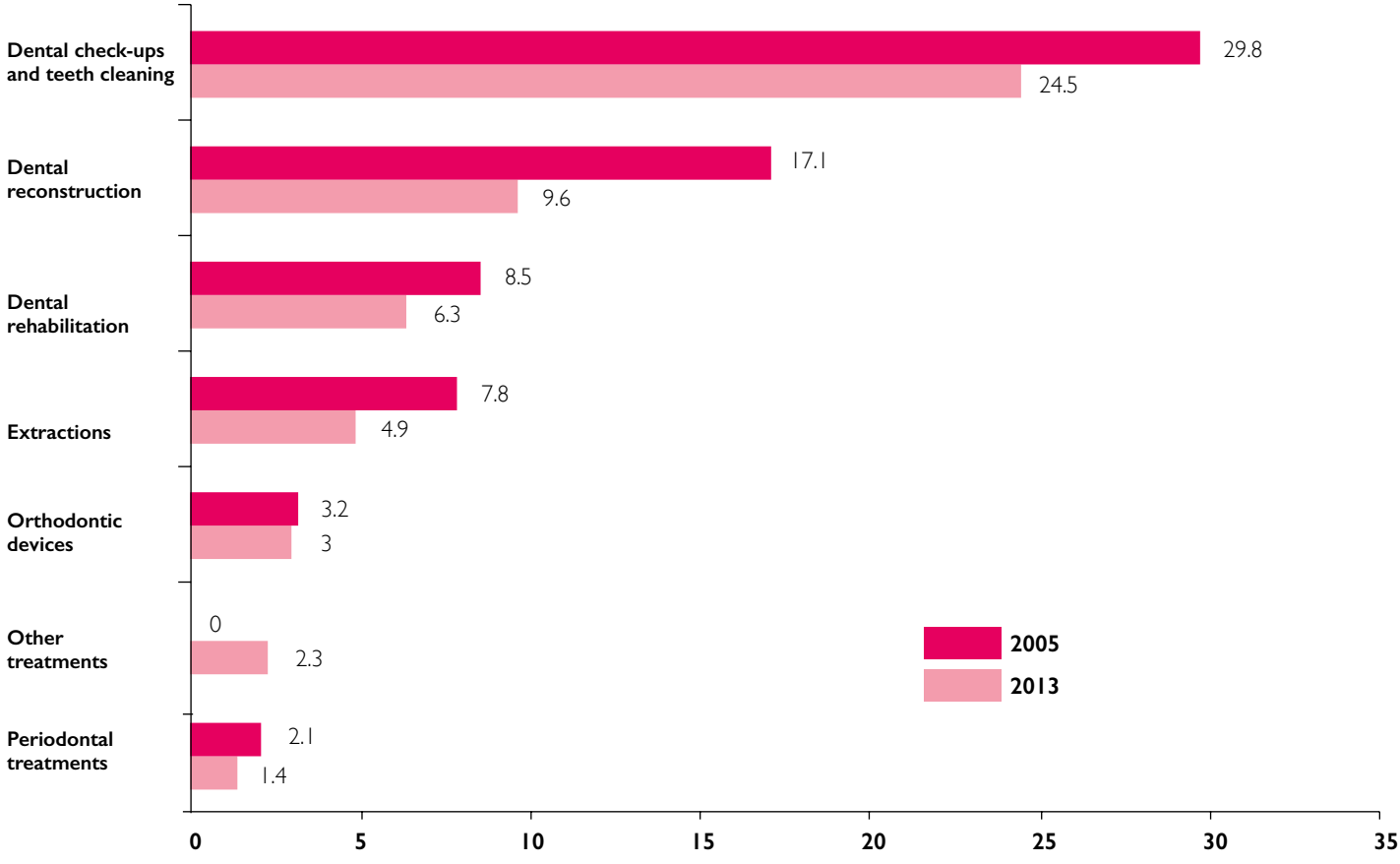
Source: Istat, July 2015

MAIN INDICATORS FOR ACCESS TO DENTAL CARE, PREVENTION AND ORAL HEALTH GEOGRAPHICAL BREAKDOWN. Year 2013, standardized rates per 100 people



Source: Istat, July 2015

POPULATION 3 YEARS AND OLDER FOR TYPE OF TREATMENT IN THE LAST 12 MONTHS. Years 2005 and 2013, standardized rates per 100 people

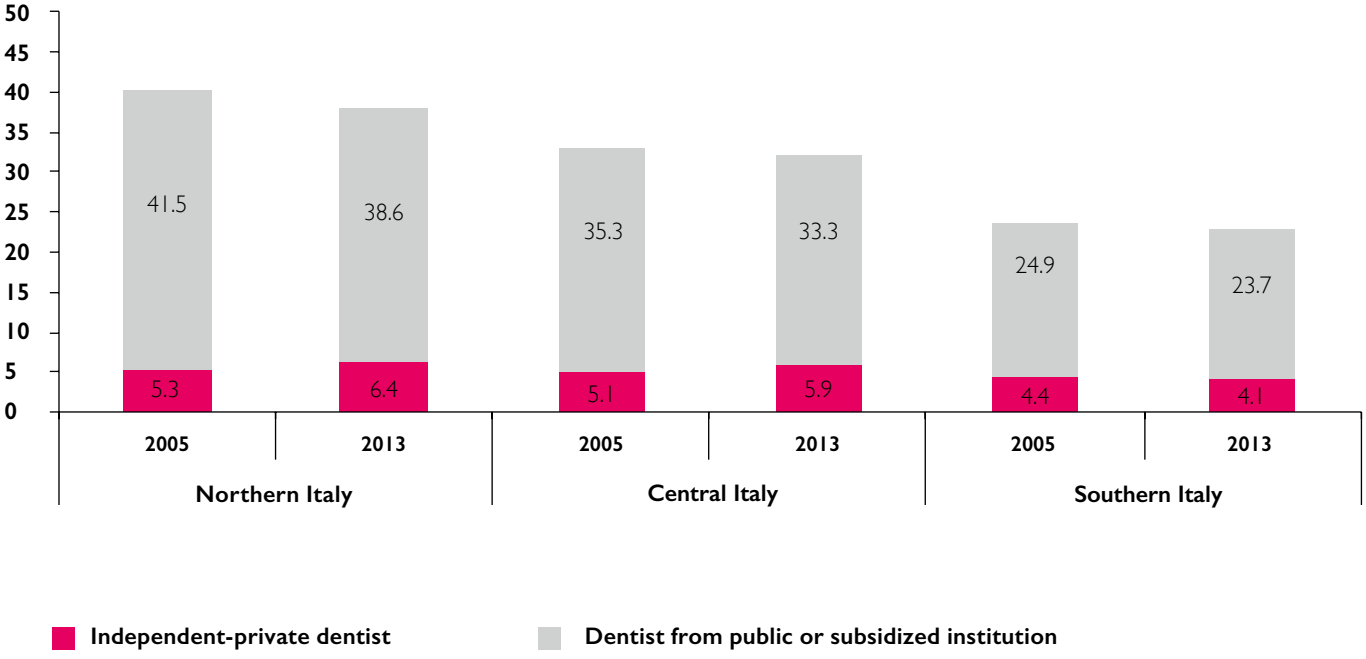


Source: Istat, July 2015

POPULATION 3 YEARS AND OLDER VISITING A DENTIST OR ORTHODONTIST AND GEOGRAPHICAL DISTRIBUTION.
Year 2005 and 2013 per 100 people with the same characteristics

	Last 12 months		Never visited a dentist	
	2005	2013	2005	2013
Northern Italy	47.0	44.5	6.7	6.2
Central Italy	43.4	38.9	8.7	6.7
Southern Italy	29.9	27.7	19.0	12.1

POPULATION 3 YEARS AND OLDER BY TYPE OF PROFESSIONAL TO WHICH THEY HAVE MADE A VISIT IN THE LAST 12 MONTHS AND GEOGRAPHICAL DISTRIBUTION.
Years 2005 and 2013, standardized rates per 100 people.



Source: Istat, July 2015

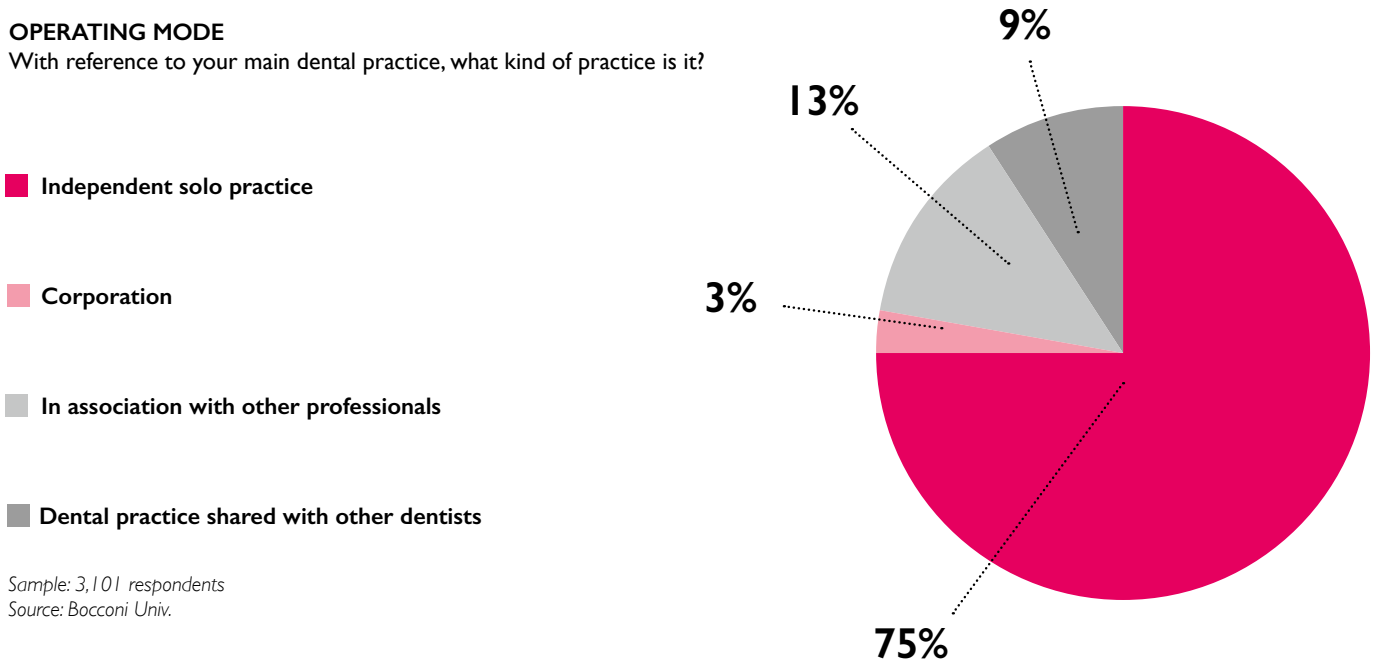
Over half of the professionals (55.8%) expect the economic crisis to continue within the next year or so with 34.9% of dentists believing it will increase even further.

In conclusion, the Bocconi study asked, to a sample of 3,101 dentists, if they had to choose their profession again, would they choose to be a dentist? Among the respondents, 52.2% reported they would probably or surely choose it again (31.1% probably and 21.1% for sure), while 34.1% would probably or surely not choose it with 13.8% not being sure. The most dissatisfied tend to be older dentists in solo-practices.

One last major issue is the fast aging of Italian population with a consequent increase in oral healthcare needs and a welfare state not enough supporting it. With a total population of 60.7 million, people over 65 now represent 22.6% of the population, against an average of 18.9% in Europe. It is the highest figure in Europe. The age group 0-14 years is decreasing (11.7%), as is the fertility rate (1.35 child per woman - European average is 1.58) with an average age of the population at 44.7 years. According to studies, in spite of an increase in oral care needs among the elderly, the percentage of visits to the dentists decreases with increas-

OPERATING MODE

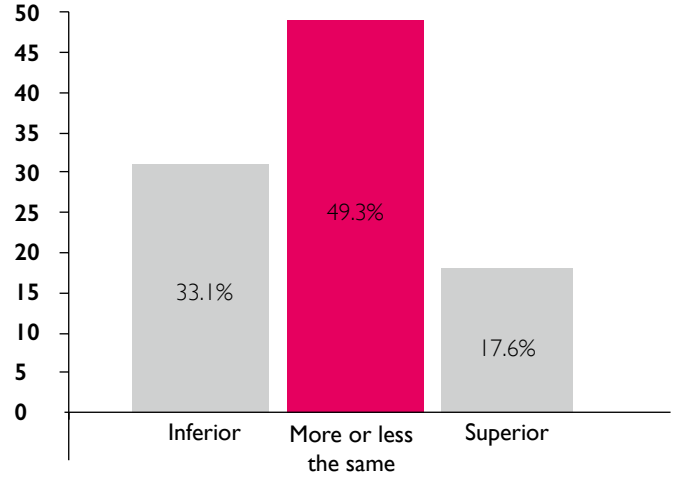
With reference to your main dental practice, what kind of practice is it?



Sample: 3,101 respondents
Source: Bocconi Univ.

REVENUES

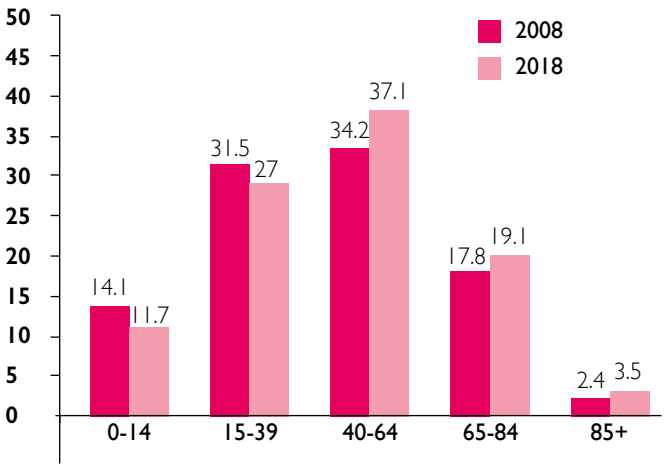
Based on the information you have today, could you indicate whether your practice revenues in 2015, compared to 2014, were roughly:



Question asked to dental practices owner/co-owners
Sample: 2,733 respondents
Source: Bocconi Univ.

RESIDENT POPULATION IN ITALY

(1st January 2008 – 1st January 2018)
(value in percentage)



Source: ISTAT, 2018

ing age, with 36.1% of over 65 years old visiting a dentist while only 29.2% over 75 do.

Only around 5-7% of dental care is provided within the National Health System completely free of charge with the remainder through co-payments and mainly out-of-pocket. The Italian National Institute of Statistics (ISTAT), in 2015, placed the dentist in the first place in the basket of needs for the Italian population. According to an ISTAT report in October 2017, 11.7% of patients 15 years and older used the public service, 86.9% turned to the private sector but over 80% of expenses are out-of-pocket.

Greater focus on prevention is a must within Italian dentistry as ISTAT calculates that on the one hand the percentage of those who take care of their teeth decreases, today there are about 37 Italians every 100 (i.e. 63 Italians give up dental care) and on the other side there are those who still go to the dentist but less frequently.

Source:
Formazione ODG "La salute orale – Il ruolo dei media per una cultura della prevenzione".
Tra i relatori: Dr. Michele Cassetta, giornalista odontoiatra, Docente A.C. Comunicazione Medico-Paziente Università di Bologna, Dr.ssa Antonella Polimeni, Prof. Ordinario alla Sapienza, Dr. Enrico Gherlone, Prof. Ordinario San Raffaele di Milano, Presidente Collegio Docenti di Odontoiatria
Seminar organized by the National Journalist Association, titled "Oral Health – The Role of the Media for a Culture of Prevention". Among the speakers, Dr. Michele Cassetta, dental journalist and A.C. Professor Doctor-Patient Communication, University of Bologna, Dr. Antonella Polimeni, Professor University of Rome "La Sapienza", Dr. Enrico Gherlone, Prof. San Raffaele of Milan, President of the Association of Teachers in Dentistry

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Advocacy for Oral Health and Sustainability at the United Nations – Academy of Dentistry International takes a Unique Role

New York, August 14, 2018 - The Academy of Dentistry International (ADI) was granted Special Consultative Status to the Economic and Social Council of the United Nations (ECOSOC) on 24 July 2018. This consultative status is unique for an oral health-related membership organization and as such, enables a loud and direct voice for global oral health to be heard at the highest levels of the United Nations' member states, the UN Secretariat and Agencies.

As an NGO with Special Consultative Status, the Academy will submit statements and provide advice on matters related to its areas of competence –

• Promotion of oral health as a critical element of general health;
• Role of oral health in the achievement of the UN's Agenda for 2030 – the Sustainable Development Goals; and
• Social responsibility and volunteerism of the dental profession.

This unique status is granted at a pivotal time for oral diseases when over half the world's population have no access to even basic and essential dental care. The 'Global Burden of Disease Studies' funded by The Gates Foundation report that untreated dental decay in permanent teeth is the single most prevalent disease on the planet, severe chronic periodontal (gum and underlying bone) disease the sixth most prevalent and untreated decay in deciduous ('milk') teeth the 12th most prevalent. According to the World Health Organization (WHO) 60% to 90% of children worldwide have dental caries. Unfortunately, oral diseases affect the most vulnerable individuals, children, elderly and members of racial and ethnic minorities. The economic burden of these preventable diseases is severe. The indirect costs, such as time away from school and work, amount to more than US$140 billion per year, ranking the indirect costs of oral diseases among the top 10 causes of death. **The World Oral Health Report (published by WHO) concluded that oral disease is still a major public health problem in high-income countries and the burden of oral diseases is growing in many low- and middle-income countries. Oral diseases are linked to diabetes, heart disease and stroke, and pre-term low birthweight babies among other conditions. Common risk factors for many of these diseases include sugar, tobacco, alcohol, lack of hygiene, unsafe water, and lack of injury prevention. There is a clear social gradient to the inequalities and disparities in oral health, and the social determinants for oral diseases are common to many other Non-Communicable Diseases.**

In the build-up for this unique role the Academy, together with many other civil society organizations, has submitted statements to the forthcoming High-level Meeting on Non-Communicable Diseases to be attended by heads of State and Government during the 73rd session of the UN General Assembly in September 2018.

The Academy's mission is brought to life through the service of its members in volunteer work and oral health projects serving communities in need. The ADI spearheads social responsibility among the oral health community supporting its members and others to design and deliver health programs, and to provide advice on oral health to governments and other NGOs worldwide with focus on the under-privileged and under-served. Through a number of its members, the Academy has close working relationships with the WHO Global Oral Health Programme. The President of ADI, Dr. Gerhard Seeberger, a dentist from Cagliari, Italy, views this new status as a major game-changer for the reductions in oral diseases and their harmful effects on general health and quality of life. "As oral health professionals we need to talk less among ourselves, and truly reach out to Governments and other NGOs within the health sector and beyond, to work together to make health and improved well-being a reality for all peoples. Special Consultative Status brings the call for essential oral health and disease prevention closer toward achievement of the SDGs and the UN's 2030 Agenda - *Transforming our World.*" The designated representative to the UN on behalf of the Academy of Dentistry International is the Academy's Vice President for International Affairs, Dr. David Alexander a specialist in dental public health and the study of oral diseases. In describing the goals for the Academy with ECOSOC, Dr. Alexander added: "We are strong supporters of the Sustainable Development Goals and put significant focus on a broad number of the goals which together will not only help prevent oral diseases but promote health and well-being in general. Currently the Academy is the only voice for oral health within ECOSOC and we hope others will join us and align around common goals for the betterment of mankind. It's time to stop the needless suffering from these preventable diseases."

About the Academy of Dentistry International

The Academy of Dentistry International is a global network of over 3000 oral and other healthcare professionals in more than 80 countries around the globe dedicated to the improvement in the oral health and quality of life for citizens of every nation. As an international honor society, ADI supports and undertakes service projects for the health and welfare of the underprivileged, underserved people of the world and advocates for the 2030 Agenda – Transforming our World: the Sustainable Development Goals, rather than the needs and personal interests of members. See **www.adint.org**

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FDI World Dental Congress 2019 to be held in San Francisco, USA

Interview with FDI President Dr Kathryn Kell

FDI President Dr Kathryn Kell

Tell us a bit about next year's Congress – what makes this event unique?
Next year's FDI World Dental Congress will be a truly collaborative event. In 2019, FDI will work side by side with the American Dental Association (ADA) to host the Congress in San Francisco, California, from 5–8 September. Together, we hope to create a positive and impactful dental meeting for attendees, guests and exhibitors.
Our ambition is to deliver a Congress like no other – we are ready to welcome a diverse global contingent of dentists and other professionals within the oral health community and ensure that each visitor returns home with valuable insights and knowledge to help improve oral healthcare worldwide. We are thrilled to be back in San Francisco next year – FDI first held its annual Congress there 54 years ago, in 1964. San Francisco is a desirable and inclusive destination for local, national and international participants, and we hope that attendees will be able to take full advantage of all that the city has to offer.

As an American dentist yourself, you enjoy a special relationship with the American Dental Association. How do you envision the FDI-ADA partnership?
FDI is proud to partner with the ADA. As the largest dental association in the United States, representing more than 161,000 member dentists, the ADA has successfully supported patients in their quest for quality care since 1859. Next year, we look forward to pooling our strengths to produce an engaging and modern scientific programme and pull off one of the largest industry exhibitions that we've ever seen at an FDI World Dental Congress.

Your term as FDI President will formally conclude at the Congress – what do you hope to achieve in this next phase of your mandate?
Over the years, I've learned that only by working together and having policies of inclusion for all people, countries, and backgrounds, can we achieve our ambition of optimal oral health for all. My goal as FDI president is to collaborate closely with the global oral health community to further our vision as one. Developing a common vision is the only way we will tackle the global burden of oral disease.
This is what I am most excited about in the countdown to the Congress – the chance to narrow our lens and focus our efforts on what matters most to us as a community of dental practitioners.

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The Greater New York Dental Meeting… Be a Part of it!

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Exhibit Dates: Sunday, November 25th – Wednesday, November 28th

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By: Jayme McNiff Spicciatie

The Greater New York Dental Meeting (GNYDM) is the largest Dental Meeting in the United States registering 52,733 attendees from all 50 states and 9,026 international attendees from 151 countries which includes 18,998 dentists, 4,523 dental assistants, 520 dental technicians and 4,102 hygienists.

Dental and Medical professionals are encouraged to roamed over **1,700 exhibit booths** and over **700 companies** for free to learn about the newest equipment and materials available from around the world. The GNYDM offers over 350 seminars, hands-on workshops, and essays including programs in Spanish, French, Chinese, Russian and Korean. There is also a designated workshop room for live Portuguese translation for morning and afternoon sessions. As the GNYDM continues to increase its international population of attendees, it also continues to increase educational programs offered in other languages other than English. The Greater New York Dental Meeting's partnership with the U.S. Department of Commerce International Buyer Program allowed exhibitors a free listing in our Export Interest Directory, the opportunity to meet many worldwide senior level volume buyers, export counseling by government specialists and additional benefits derived from our extensive international marketing efforts. The newest program introduced this year is the 3D Printing and Digital Technology Conference. With 8 programs offered from Sunday – Wednesday of the Meeting, attendees are invited to learn the A to Z on 3D Technology.
The GNYDM included a Free and unique Health Screening Fair for two days of the Meeting, consisting of Oral Cancer, caries, hearing, blood pressure, Diabetes and vision screenings. This year the fair was open to numerous private sectors and to the public who were in need of care.

The World Implant EXPO increased in attendance and welcomes world renowned clinicians to New York City. Implant seminars and hands-on workshops are offered daily at the GNYDM in support with the International Congress of Implantologists, the American Academy of Implant Dentistry, the European Association of Osseointegration and new this year, the INDIAN Implant Symposium. The Pediatric Dentistry Summit offers seminars and workshops from Sunday - Wednesday. The programs are packed with standing room only. The Global Orthodontic Conference offers 6-concentrated Orthodontic Specialty programs; including seminars and hands-on workshops. The "Live" Dentistry arena filled over 550 seats daily with standing room only for all four days. This revolutionary concept takes place right on the show floor with NO tuition costs to attendees. It should not be missed.

As the holiday season is a time for giving and helping others, the Greater New York Dental Meeting once again hosted the "Greater New York Smiles" fun and child-friendly program. Each year the GNYDM invites 1,500 NYC Public School children from all five New York City boroughs. The Smiles Program teaches nutrition and oral hygiene instruction in a fun and child-friendly atmosphere. This program is sponsored by Colgate, UFT and DentaQuest.

2018 Highlights

- 3D Printing and Digital Dentistry Conference
- World Implant EXPO
- Pediatric Dentistry Summit
- Global Orthodontic Conference
- Sleep Apnea Symposium
- Airway Summit
- Specialized New Dentist Program designed for graduates in the last 10 years
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SIDEX 2018
Seoul International Dental Exhibition & Scientific Congress

The 15th SIDEX, Going Global to Move Beyond Korea

SIDEX 2018 ended with great success, setting new records in the event history. SIDEX 2018 was held June 22 to 24 at COEX, with participation of 251 companies with 1,022 booths from 17 nations to present extensive dental equipment exhibition and more than 70 insightful lectures for an international conference with the theme of '4th Wave: Revolution in Dentistry' With more than 15,500 visitors from Korea and overseas, the event ended in great success, with satisfying results both in scale and satisfaction level.

Many of the Presentations Crowded with Audience

The number of registrants for SIDEX 2018 international academic congress was 9,727 in total. Since it is the only ADA certified conference in Korea to give up to 10 points for continuous ADA education, the number of dentists participating from overseas is also increasing.

The conference was crowed, as many of the insightful lectures by high profile speakers were full with the audience from the first day. The lectures covered diverse topics for those running cental clinics in the field from digital dentistry, implant, orthodontic treatment, periodontics and dental insurance and new format of lectures including joint and integrated presentation made the conference even more interesting.

Chang Dong-wook, Scientific Congress Headquarters of SIDEX 2018 said *"It has been a successful event for the two days with more than 70 lectures carefully prepared by the organizing committee"* and added *"It was also impressive that the audience showed interested across all topics from insurance to lectures by foreign speakers, not heavily skewed to certain topics."*

Companies Showed High Satisfaction

SIDEX 2018 exhibition site was busy and crowed all the time. The number of visitors to the exhibition was 15,578 in total and the number of buyers and visitors from overseas was 871, growing more than twice from the previous year.

A source of Company A said "We handled more export contracts than ever during the exhibition period. We almost consumed up the total amount of materials we prepared." while expressing high satisfaction. Company B said *"Buyers said they come and visit SIDEX as it is geographically closer and they can find better quality products here than China. We noticed that the presence of SIDEX is growing every year."* Noh Hyung-Kil, secretary general of SIDEX said *"It seems that the efforts to expand exchange with overseas dental associations and strengthen promotion at overseas exhibitions are now reaping fruits. We will make continuous efforts to seek mutual advancement with the companies growing together with SIDEX."*

Meanwhile, SIDEX organizing committee had a series of meeting with 12 overseas organizations during SIDEX 2018. It was able to expand the scope of exchange to the Middle East and US, as well as Asia and signed an MOU with Dental Association of Los Angeles and Dalian Private Dental Association in China.

Joint Event with APDC Scheduled for Next

This year SIDEX has been building grounds for another leap forward, marking the 15th event. Adding to diverse new initiatives for the conference and exhibition, it held 'SIDEX Development Forum' and many surveys to listen to voices of dentists in the field and the industry.

Choi Dae-Young, Chairman of the organizing committee said "SIDEX will keep working hard to lead the dental medicine and industry of Korea and grow into an exhibition to represent Korea."

Meanwhile, on the last day of SIDEX 2018, an MOU was signed for joint hosting of '2019 the 41st Asia Pacific Dental Congress(APDC), the 54th KDA Congress and the 16th Seoul International Dental Exhibition(SIDEX)'. With the agreement, SIDEX 2019 will be held May next year, jointly with 2019 APDC, organized by Korean Dental Association. Also, as the exhibition site will be expanded to Hall B, adding to the current site of Hall C and D, SIDEX next year is expected to come in largest scale ever.

By Kim Young-Hee/news001@sda.or.kr

CEDE 2018: a breath of fresh air

27TH Central European Dental Exhibition
Poznań, Poland
20–22. 09. 2018

Never before in its history has CEDE put so much emphasis on the importance of integration between the worlds of business and science in the dental industry. Close to 10,000 participants from 47 countries could try out products offered by 200 exhibitors and attended more than 200 educational events.

On Saturday 22 September this year, the 27th Central European Dental Exhibition (CEDE) came to an end. Those who came to Poznan witnessed the next stage in the metamorphosis of this event – from a conventional exhibition into a project that allows visitors to familiarise themselves with the latest technology and acquire world class knowledge.

Nearly 10,000 people attended this year's edition of CEDE from 47 countries. A total of 201 exhibitors presented their products at the exhibition. It is worth pointing out that more than 1000 people took advantage of CEDE's brand new feature – its educational forums: Dentistry 3.0, Dental Club and Business Dental Forum.

This year's exhibition saw the launch of a new social awareness campaign called "Open your Mouth and Say No to Cancer". Several hundred residents of Poznań took advantage of free dental examinations. The project was carried out with the participation of Poznań City Hall, the "A Smile for Life" Foundation, and dental students.

The number of participants attending the 2nd Polish Dentistry Union Congress, CEDE's sister event, can be regarded as an undoubted success. Just under 1200 people came to the lectures and workshops The Congress is thus on its way to becoming the biggest educational event in the dental field. In total more than 100 speakers took part in the project.

- The sheer number of Congress participants this year is proof that we chose our subjects well. We had expected our topics to appeal primarily to non-specialist practising dentists – and such was indeed the case. - explains Professor Marzena Dominiak, chairwoman of the National Scientific Council and President of the Polish Dental Association.

It is no secret that the future of the project, especially in terms of its value as an educational event, is in the opinion of CEDE Organisers, closely tied to that of the recently restructured Polish Dental Association (PTS). Prof. Marzena Dominiak together with her enthusiastic team set themselves the mission of achieving scientific integration, and this mission will be the basis of subsequent editions of CEDE and the Polish Dentistry Union Congress.

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Dental-Expo

44-th Moscow International Dental Forum & Exhibition DENTAL-EXPO 2018 was held 24-27 September in the international exhibition center "Crocus Expo" with support of the dental community and the Ministry of Health of the Russian Federation. 36559 specialists took part in the Forum.

For the first time the exposition of the exhibition was located in four exhibition halls on the area of more than 26 thousand square meters. This year, over 500 companies, 4 national pavilions from Russia, Germany, China, and South Korea were represented at the exhibition. The geography of new exhibitors (73 companies) includes Russia, Belarus, Greece, Malaysia, Germany, China, South Korea, Taiwan, Switzerland. The national pavilions of China and South Korea gained more participants than usual. With support of the state, large companies enter the Russian market.

The exhibition was sponsored by S.T.I.dent, exclusively representing Septanest®, the general information partner of the forum in the Russian Federation was the newspaper Dentistry Today, the general scientific and information partner of the forum in the Russian Federation the Dental Tribune newspaper, the general international information partner of the forum was a media holding "Dental Tribune International". Expansion of the exposition allows companies to represent new products that are being certified and introduced to the dental market of the country. Among the new products at the exhibition there were presented dental materials for therapy and dental laboratories, implants and the latest toolkits for working with them, wireless mini-cameras, 3D scanners and printers, dental lasers, a large number of products for orthopedics, visualization, hygiene, new clothing collections, software. The increased scale of the exhibition area requires more time to prepare for visiting, and dentists do an excellent job using the interactive exhibition tools. On the exhibition website participants can familiarize themselves with the latest changes, select events on the day of the visit, download the list of new products, schedule and print a list of companies to visit, go online registration. Specialists interested in buying or selling a business, as well as in finding or providing work and services, had the opportunity to exchange information on the traditional stand "From teeth to teeth" (hall 7). In fact, the exhibition operated a kind of exchange of information between dentists and clinics. The format of the exhibition, in addition to the exchange of information, provides an opportunity to meet and communicate with potential partners, doctors and employers, sellers and buyers of business.

Within the framework of the Forum a huge number of scientific and educational events were held. For specialists in 10 conference halls and at exhibition stands, the companies organized more than 650 lectures and workshops in conference halls and at exhibitors' stands. On the 23rd of September 2018 in Moscow in the congress center of the hotel "Hilton Moscow – Marina" was held a greatest scientific event of the year in the field of implantology – "IX National festival of implantology". The forum was organized by the Russian Dental Association of and the Russian Association of dental implantology. On September 23, Professor I. M. Makeeva presented a new author's course on endodontics " Personalized endodontics: medical service or medical care?»

On the 24th of September in the international exhibition center "Crocus Expo" a scientific part of the Forum started its traditional lecture of the rector of the Moscow State University of Medicine and Dentistry, professor Oleg Yanushevich for first-year students of dental faculties. On the same day, the conference of cosmetologists, dentists and plastic surgeons "SmART Face 2018" was held for the first time. Synergy of cosmetologists and dentists. Interdisciplinary forum. Related problems». The speakers of the conference were A. Zograbyan (Gingival papillae: stabbing or cutting?), Soikher M. (Botulinum toxin therapy and the oval of the face. Bruxism), A. Akulovich (Teeth whitening: the line between cosmetology and dentistry), busarov. (Injection work in the field of lips, preferably fillers from the point of view of the dentist), Razumovskaya E. (Thread lifting as a stage in the correction of the facial oval), Prokudin S. (Volumization with fillers, lift pads and projection capabilities. Simulation of correction of problems of occlusion). The organizers are grateful to A. Akulovich for the moderation and support of this new, but promising activities. Scientific-practical conference of the strategic partner of the forum - the Dental Association of Russia - "Dentistry of the XXI Century" presented a number of symposiums accredited by the system of continuing medical education.

The next event for dentists - the 45th Moscow International Dental Forum and exhibition "Dental Salon 2019" will be held from 22 – 25 April, 2019 (exhibition center Crocus Expo, Pavilion 2, Halls 5, 7, 8).

Moscow 2019

Dental Salon

April 22-25, 2019

Dental-Expo

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pavilion 2, halls 5, 7, 8

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bdshefsky@bnlbio.com

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T. +886 2 27036465

office@songyoung.com.tw
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E-mail: exhibits@gnydm.com
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27/11-01/12 2018

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Paris - France

Association Dentaire Francaise
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France
Phone: +33 1 58 22 17 10
Fax: +33 1 58 22 17 40
Website: www.adf.asso.fr

Venue: Palais des Congrès
Add: 2 place de la Porte Maillot
75017 Paris - France

www.adfcongres.com/en

29/11-01/12/2018

Implant Expo 2018

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Phone: +49 89 5505209-0
Fax: +49 89 5505209-2
Email: info@youvivo.com

Venue: RMCC RheinMain CongressCenter
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Germany

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December

14-16 12 2018

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Yangon - Myanmar

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Contacts Ms Rosie
Email: rosie.tran@veas.com.vn
Ms Ann
Email: ann.ltb@veas.com.vn
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Venue: Pragati Maidan
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14-16 12 2018
Myanmar 2018

January

30/01-02/02 2019

AADGP 2019 - American Academy of Dental Group Practice - Conference and Exhibition

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AADGP Executive Office
2525 East Arizona Biltmore Circle,
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Phoenix, AZ 85016
USA
Phone: +1 602 381 1185
Email: aadgp@aadgp.org
Website: www.aadgp.org

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Las Vegas, NV
USA

www.aadgp.org/annual-expo

February

05-07 02 2019

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Dubai - United Arab Emirates

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March

03-06 03 2019

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Phone: +86 20 83517101 - 83517102
Email: dental@ste.cn
Venue: Block C, China Import & Export Fair Phazou Complex
Xin Gang Dong Road
Guangzhou
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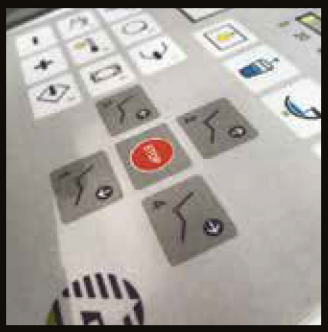

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