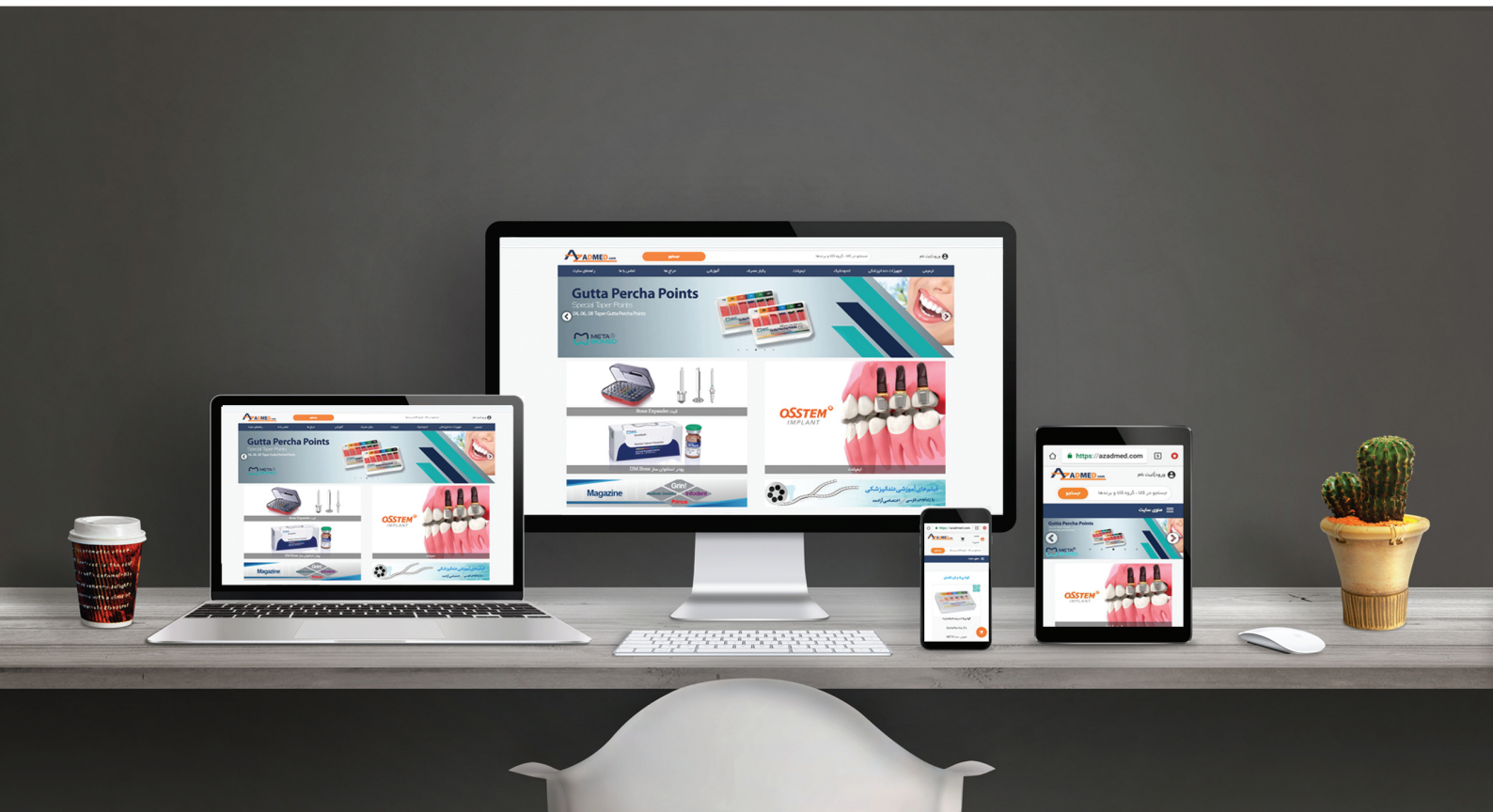




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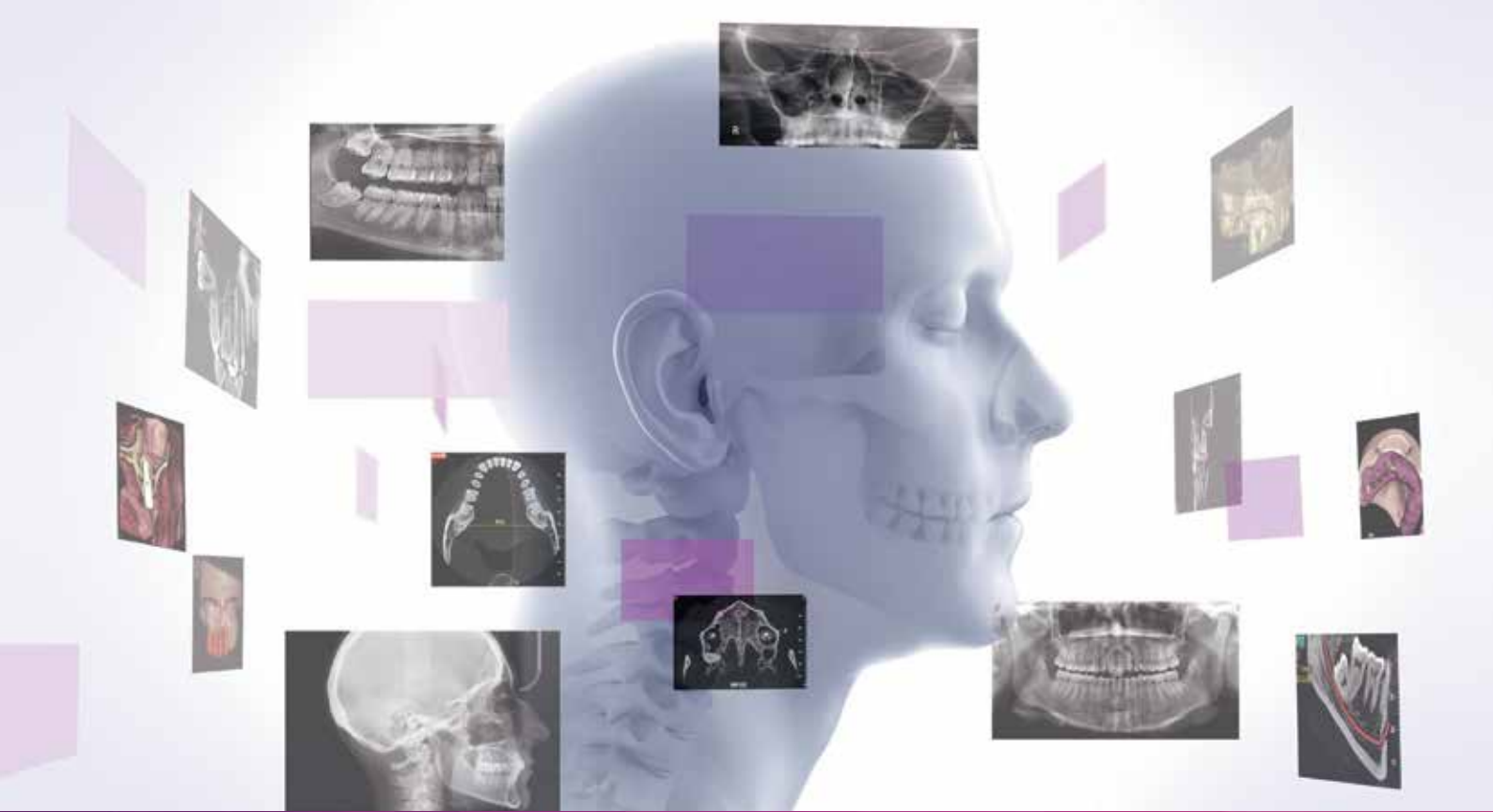
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UNCERTAINTY, THE ENEMY OF BUSINESS



Global economy has had a slow-down, largely due to a widespread sense of uncertainty, the main source of which has recently been the continuing US-Chinese trade war, coming to a partial agreement in these days. The trade disputes between the two has led to a reduction in the investment and consumption levels in both countries as well as among their trading partners, undermining the future of global

economic relations and threatening global economic growth. Firms and markets are struggling to get to grips with uncertainty. This, not tariffs, is the greatest harm from the trade war. But, also, the prospects for economic growth, the high levels of debt, the underestimated levels of risk in financial markets and political developments. Taken together markets express something about both the mood of investors and the temper of the times. The most commonly ascribed signal is complacency. Dangers are often ignored until too late. However, the dominant mood in markets today, as it has been for much of the past decade, is not complacency but anxiety. And it is deepening day by day. America's decade-long expansion is the oldest on record, its GDP growth rates have been relatively good so far so, whatever economists say, a downturn feels overdue. Meanwhile, China is experiencing an economic slowdown that the authorities are trying to counteract through monetary, credit and fiscal measures. Their success would renew the confidence of market participants but, it could also prove insufficient to maintain a relatively high GDP growth rate. In Europe, the economy of the whole Eurozone is also slowing down, which is the result of domestic factors, such as the political developments in France, Italy and Germany, as well as regional and global factors. One alarming vulnerability on a global scale is the high levels of both public and private debt. Indebtedness has especially increased in recent years. According to the IMF, the global debt-to-GDP ratio has reached 250%, which is about 30 percentage points more than on the eve of the financial crisis in 2008. The level of uncertainty in the global economy is also increased by political developments. In 2020 presidential election will be held in the United States. Their result will determine the possible scenarios for the future economic policies in the world's largest

economy. In Europe, the main source of uncertainty is United Kingdom's exit from the European Union. A so-called hard Brexit would undoubtedly have a negative impact on the confidence of entrepreneurs and investors in the United Kingdom and across the European Union. Meantime, Europe is also behind other countries in terms of innovation and the implementation of new digital technologies. Digital technologies themselves are also contributing to increasing global uncertainty. The extent to which digital platforms could influence political processes is still unclear. Digital technologies are also driving new and powerful economic trends that are and will be visible especially in the labor markets and in growing income inequality, which can already be observed in developed economies. The entire global economy is undergoing a significant transition also due to the development of emerging markets, especially in Asia. The locations of target markets and the configurations of supply chains are constantly changing. As diverse economic and political trends may lead to another global crisis, or at least prolong the current period of uncertainty, caution may seem like the best choice under these circumstances. Central banks are anxious, too, and easing policy as a result. Last July the Federal Reserve lowered interest rates for the first time in a decade as insurance against a downturn. Central banks in Brazil, India, New Zealand, Peru, the Philippines and Thailand have all reduced their benchmark interest rates since. However, caution also has its costs as companies and countries that do not invest enough, for example, in the new digital technologies, may end up losing out. At the same time, if the rules and institutions governing the world economy remain uncertain, we should be expecting weaker economic performance in the future. In such a context, anxiety could turn to alarm, and sluggish growth descend into recession. Yet a recession is so far only a fear, not a reality. The world economy is still growing, albeit at a less healthy pace than in 2018. From our side, Infodent International keeps its readers up to date, focusing on specific markets of interest, their economies and politics. Our duty is to understand who and what might be drawn in next, in the global economy, to create unrest. We firmly believe that big investments are hard to reverse, and firms are disinclined to press ahead with them unless they have the pulse of where they will be making business.

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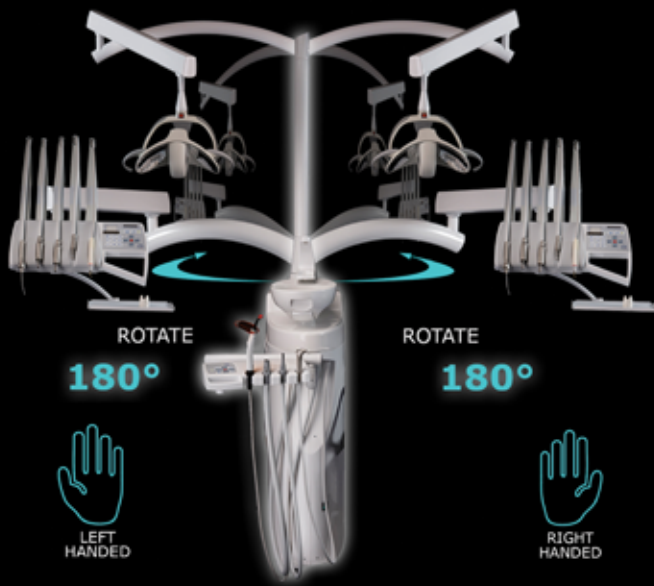
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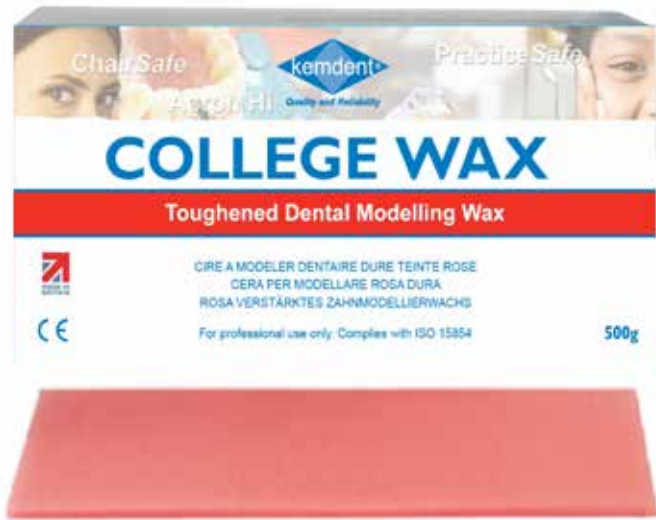
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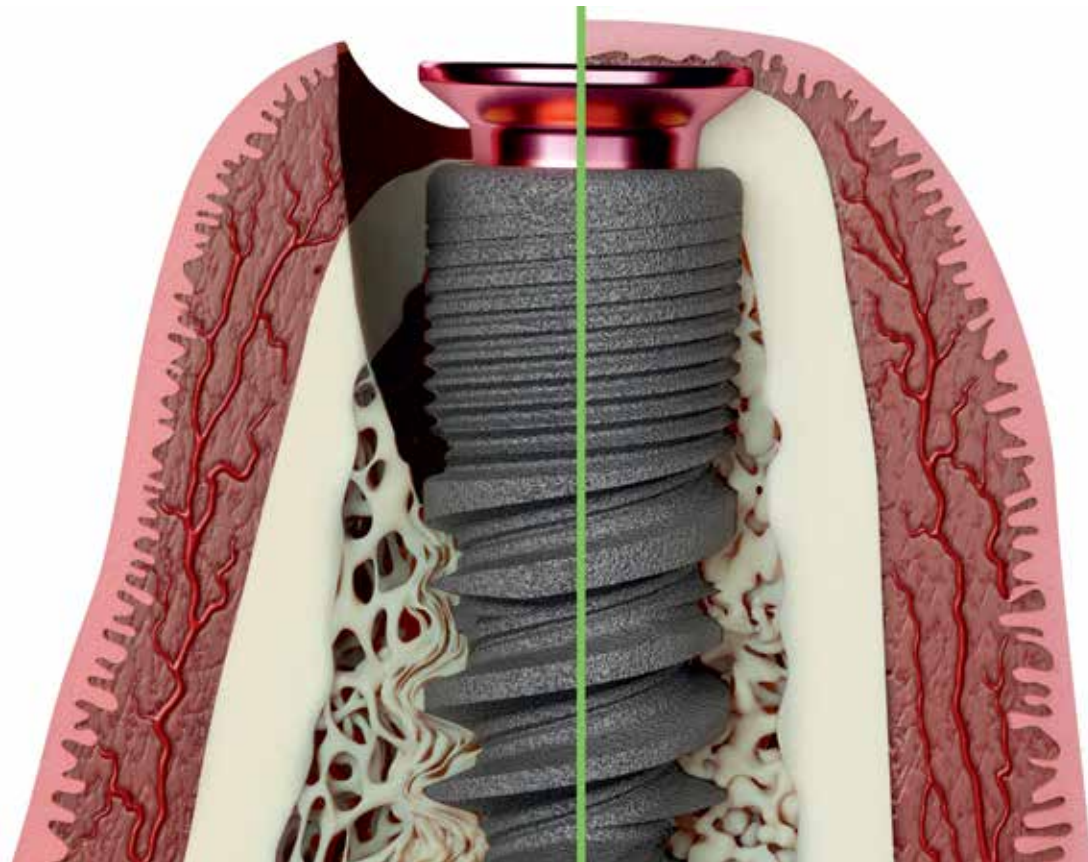
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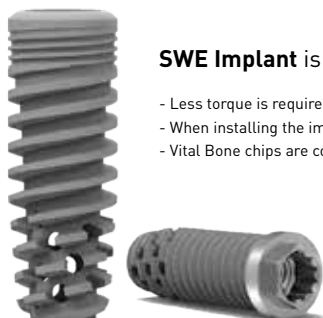
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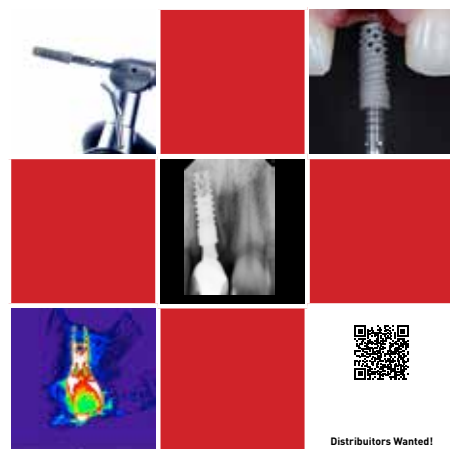


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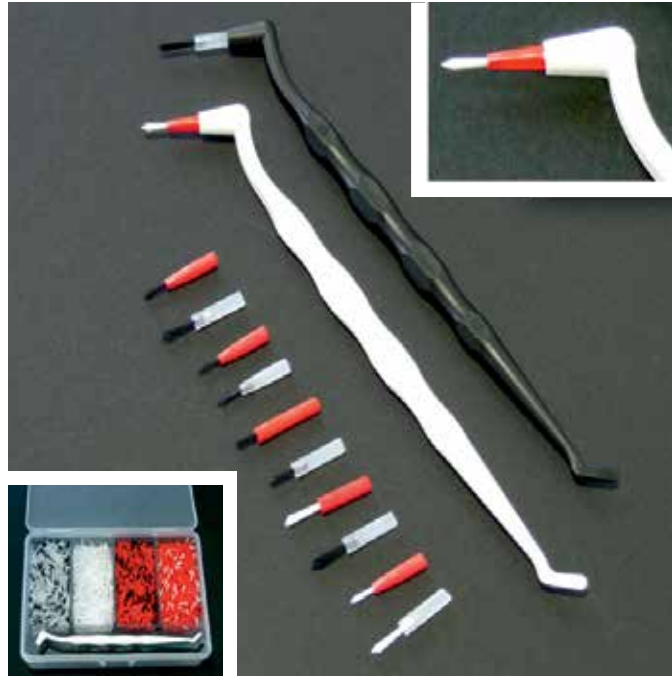
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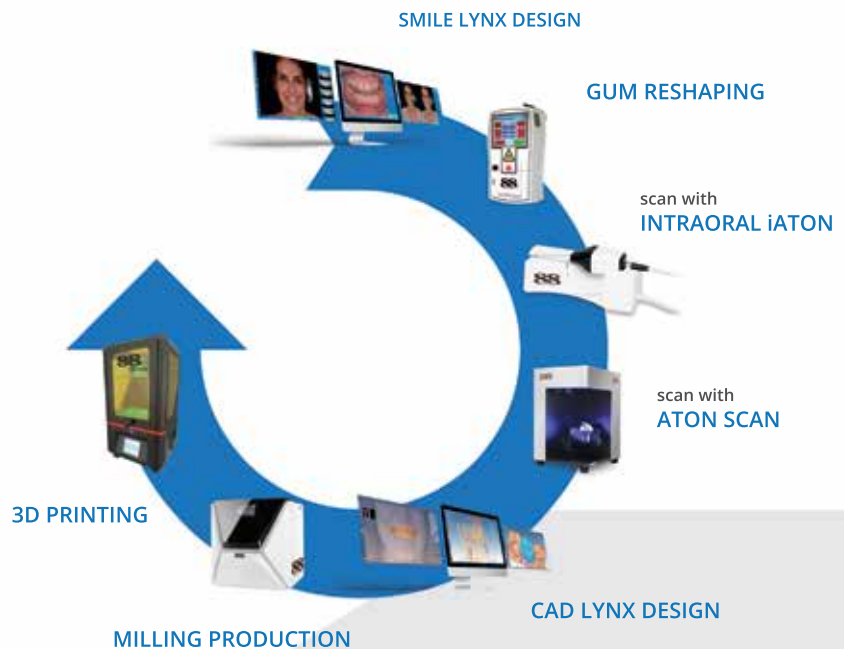
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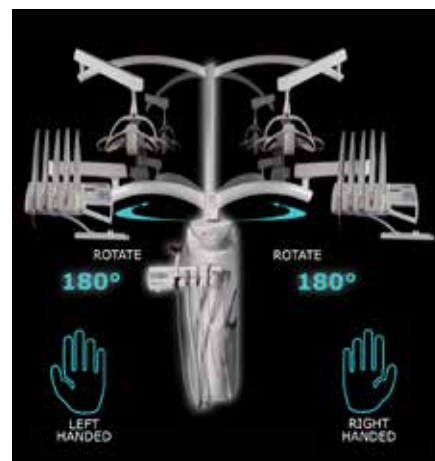
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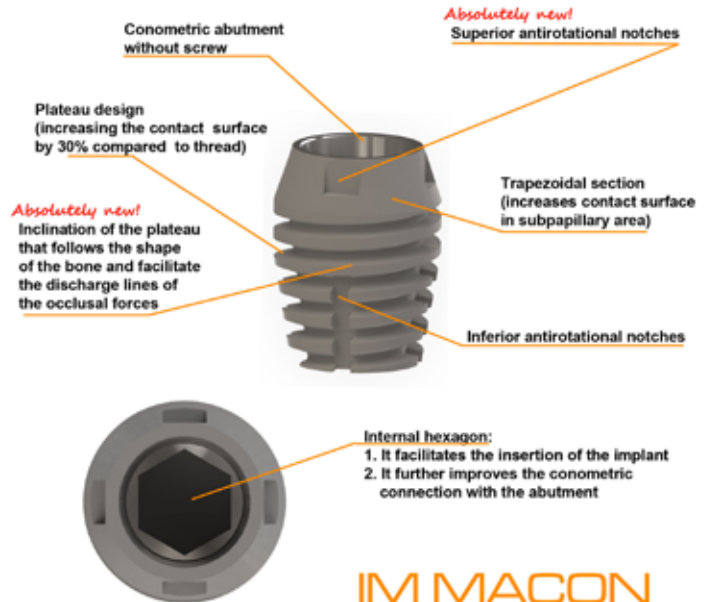
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The platelet growth factors have extremely high efficiency in every biological process, in which it is necessary to stimulate tissue repair, growth and modulation of cell life and self-control of the immune system. The technique of platelet concentrates moves plasma rich in growth factors from the blood to the treatment area, speeding and tracking the natural processes of healing. Concentrated Growth Factors (CGF), developed by Sacco in 2006, is a special type of platelet preparation with great potential for clinical application.

At the base of the regenerative process, three factors are particularly important: the scaffold (organic, natural or synthetic), growth factors and autologous cells. All these elements are present in the CGF which is obtained by a "one-step" centrifugation process of the blood samples, using a special centrifuge (Medi-

fuge Mf 200, Silfradent srl, Forli, Italy), without the addition of exogenous substances. Its main characteristic lies in its consistency; in fact CGF is an organic matrix rich in fibrin, thus more dense than other platelet concentrates, able to "trap" a large amount of platelets, leukocytes and growth factors, (Rodella et al. 2011) showing regenerative properties and versatility.

These features, together with the simple and standardized centrifugation protocol MEDIFUGE, make the CGF a superior autologous product which can be used in different areas of regenerative surgery; for example in dentistry, maxillofacial surgery, cosmetic surgery and orthopedics.

Its clinical efficacy, has so far been demonstrated in various situations ranging from filling of extraction sockets (Tadić et al., 2014), to the filling of the cavities after cystectomy (Mirković et al., 2015), to interventions of sinus lift and augmentation of the crestal profile (Kim et al., 2014; Del Fabbro et al., 2013; Sohn et al., 2011). In addition, CGF features, make it suitable to be used both alone and with bone particulate or autologous biomaterials (Gheno et al., 2014). In conclusion, if it is true that the blood is the "source of life" for the organism, platelets in it play an important role in the body's regenerative processes.

The research, however, does not stop and Silfradent has still in progress studies at several universities in Italy (University of Bari, University of Brescia), Europe (ACTA Amsterdam University, Dental School-Medical University Vienna; University of Warwick - UK) and also outside Europe (IPK center Hospital Havana-Cuba; Almejiera center Hospital Havana-Cuba).



CGF biological membrane



Bio-Poncho with CGF



Fibrin clots



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(2017, IMF)

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Currency Rial (IR);
IR10 = 1 toman.

(Although all government statistics are given in rials, in conversation Iranians refer to tomans.)
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Iran is experiencing a youth bulge; roughly 30% of the people are aged 19 or under, 60% are aged 20 to 59 and 10% of over 60

80% Iranians receive secondary education and the literacy rate is more than 98%, according to the UN.

Iranians are also highly educated; with 44% of the population having majored in the STEM fields (science, technology, engineering and mathematics)

Indicator of Economic Freedom - Score:
50,5/100

Reintroduction of sanctions by the U.S. government, coupled with the fall of oil prices in the second half of 2018, has brought Iranian economy into recession again, with a rebound expected in 2020





Iran's Developing Healthcare

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Despite the difficulties of Western-imposed sanctions Iran's healthcare system is far more modern than many would expect. Its Primary Health Network has shown its ability to provide quality healthcare in all areas and overall improvements have been achieved. Nonetheless, the present challenging economic conditions of the country, combined with rapid advances in medical and information technology, individuals' expectations and the young demographic of the population will undoubtedly challenge the sustainability of past improving trends.



In line with the Constitution of the Islamic Republic of Iran, Iranians are entitled to basic healthcare, with the government subsidizing some services, such as prescription drugs, prenatal care and vaccinations. **Its public-governmental system is based on Public Health Insurance, with almost 90% of Iranians having some form of health insurance. The government's focus on expanding healthcare in recent years has made public facilities the main provider for healthcare for primary, secondary, and tertiary health services, especially in rural areas. Although waiting times are often long, public hospitals provide an acceptable standard of service and are considerably cheaper than in Western countries.** Also, the quality of hospitals varies according to location, but in the bigger cities such as Tehran, hospitals meet international standards with well-trained medical staff. Separately, the private sector covers secondary and tertiary health services, mostly in urban areas. Additionally, there are other parallel organizations such as Medical Services Insurance Organizations that act as a relief foundation as well as an insurance firm. Some hospitals, such as Mahak for children's cancer, are also run by charitable foundations. Lastly, many Non-Governmental Organizations offer care for more specialized issues, such as diabetes or childhood cancer.

As a result of Iran's young population boosting growth rate, and together with the increase of noncommunicable diseases, there is a lot of pressure on the public healthcare system as the country faces the common problem of other young demographic nations in the region, which is keeping pace with growth of an already huge demand for various public health infrastructures and services.

Most public hospital facilities are operated by the Ministry of Health and Medical Education (MOHME). The MOHME integrates healthcare and medical education into one organization and system. The MOHME is also in charge of the supervision and regulation of the whole healthcare system in the country, policymaking, production and distribution of pharmaceuticals and research and development. This approach began in 1985 in order to

Also, the quality of hospitals varies according to location, but in the bigger cities such as Tehran, hospitals meet international standards with well-trained medical staff.

improve coordination of medical care and education. Although some support this integration saying it has increased medical education's focus on objective based learning, critics say it has politicized medical education, negatively affecting independent training for medical students.

National Public Healthcare System - The public healthcare system in Iran is composed of a healthcare network called "Health and Treatment Network" (HTN) covering most of the urban and rural areas in the country. One of the most important parts of Iran's healthcare system is the Primary Health Care program. **The Constitution of the Islamic Republic of Iran, established following the 1979 Revolution, includes a constitutional mandate to provide universal access to basic health services in Article 29. Subsequently, to address the vast divergence of healthcare access between rural and urban areas, the Primary Health Care (PHC) program was created in the 1980's.** Prior to the establishment of this program, Iran's rural population faced a severe lack of healthcare infrastructure and was forced to travel large distances to receive basic care. Iran has a four-level public healthcare network system. **The primary access point for rural residents to obtain health services is through health houses (level I-a), small medical facility that provides basic health services to the surrounding rural community.**

Most facilities include at least two medical personnel, common pharmaceuticals and basic medical equipment. There are over 17,000 health houses in rural areas of Iran, or approximately one for every 1,200 residents, who constitute 26% of the total population. Behvarz, or trained medical workers, are individuals with associate degree trained to provide primary care for the residents in the area before they are given the responsibility. **Typically, Behvarz handle vaccinations, family planning services, maternal healthcare and child healthcare. Oral health evaluation and oral hygiene instructions are also among the services provided by the Behvarz.** Behvarz are trained at the district level, with tuition covered by the government in return for at least four years of service at their respective health house. More complex health issues are referred to *rural health centers* (Level II-a), independent medical units covering multiple villages with the population of about 10,000 individuals in remote areas, which are staffed by physicians, dentists, health technicians and administrators. The oral healthcare personnel, including dentists and other healthcare providers working in the Health Centers are supervised by a Family Physician.

In urban areas, there is a similar structure with approximately 2,783 *health posts* (Level I-b) providing preliminary and basic healthcare and *health centers* (Level II-b) handling more complex health issues. **Oral healthcare is provided at all Health Posts as one of the elements of integrated health services.**

Health concerns too complex for the rural and urban health centers are referred to the *district health centers* (Level III). Along with the *district general hospitals* (Level III), the district health centers are managed by the district health network. Furthermore, each province has a university of medical studies which have specialized schools and teaching hospitals (Level IV). There are 58 public medical universities with numerous specialized schools and teaching hospitals. Even if the government has worked to eliminate the disparities in coverage between urban and rural areas, urban areas still have better health resources and they necessarily have a higher density of healthcare personnel; this is also because nearly 75% of Iranians



live in urban areas. The 954 hospitals in Iran are located primarily in cities, making access to specialized health issues easier for urban residents even if public hospitals are often too crowded and appointment date is too long for specialist visits. Moreover, the private sector is nearly completely focused in urban areas, so urban residents have the advantage of choosing between public and private facilities. Wealthier Iranians opt to use private clinics and hospitals which offer higher standard of care, better facilities and speedier service. Even if more expensive, private healthcare in Iran is still quite cheap compared to other neighboring countries.

While urban areas still see improved healthcare access for more serious or complicated health matters, the disparity between urban and rural healthcare for basic healthcare has dramatically declined over the past 40 years thanks to the health house model.

Health indicators have improved every year since the PHC program was established, even if access and availability of healthcare continues to be somewhat limited in lesser developed provinces and noticeable health inequalities still exist within provinces in life expectancy and for almost all indicators excluding the vaccine coverage and access to primary healthcare which are above 90% nationwide. **In the two decades since 1990, Iran's life expectancy increased approximately eight years. By 2008, more than 90% of the rural population had access to primary health services. Over 90% of the population has access to clean drinking water and over 80% has access to sanitary facilities.** The infant mortality rate has also dropped to 13 per 1,000 live births in 2016, down from nearly 80 in the early 1980's.



Even if the government has worked to eliminate the disparities in coverage between urban and rural areas, urban areas still have better health resources and they necessarily have a higher density of healthcare personnel

Public Health System - Iran has four main public health insurance options. The Social Security Organization is the most common, responsible for insuring employed citizens in urban areas and their dependents, as well as self-employed persons who voluntarily join. It also insures retired people. People insured under this program are quite well covered and hospital care related to this organization is totally free. The Medical Service Insurance Organization covers government employees, students with

at least one parent covered under this insurance and most inhabitants of rural areas, including freelance workers. Almost all health service providers accept this insurance. The *Emdade-Emam Committee* provides health insurance for the uninsured low-income population, while the *Military Personnel Insurance Organization* provides health insurance to members of the armed forces. Beyond these schemes, there are several private and semi-public insurance programs that cover the more affluent members of society.

In general, health insurance covers 70% of the cost of drugs on the insurers' coverage list and 90% of public hospital costs, with extra provision for those with rare diseases or in remote areas. Out-patient services are subject to co-payments. Emergency care is however not covered unless you have insurance. **While approximately 10 – 15% of the Iranian population remains uninsured, this number has fallen significantly, from as high as 60% in the 1990's. Also, costs for those covered by government health insurance dropped significantly from an average of 37% of total treatment costs to as low as 6%.**

Still, due to the high government cost of the plan, some critics question whether it is sustainable in the long run. Additionally, many doctors and nurses are growing frustrated with increasing responsibilities yet stagnant salaries. In 2015, there were 1.1 physicians per 1000 population according to the World Bank (11.4 per 10,000 according to WHO), 46% of which are women. Even if the number of health professionals has increased dramatically in the past three decades, meeting the country's needs, the challenge of their sustainability in remote under-developed areas is still prominent. The burden of this problem has become less for nurses, midwives and general physicians in recent years with the policy of indigenous participation of students in these disciplines. While the problem is growing for specialist physicians as many of them want to live in larger cities.

As the amount of public budget devoted to health is limited, the health-care system is usually faced with shortage of financial resources for its programs. Total health spending in 2017 was equivalent to 6% of its

GDP, of which 39% came from public resources. System inefficiency, high administrative costs and lack of specifically trained managers represent a further challenge.

Iran is the only country with a legal organ trade. The government-sponsored system brings together donors and patients and facilitates the payment of donors. Regardless, many criticize the potential for exploitation of the lower classes in need of money as well as the use of money illegally. Thanks to the program however, the waiting list for kidney transplants was completely eliminated by 1999 and today, a majority of transplants performed are from living non-related donations.

Iran also boasts a well-developed pharmaceutical production capability (mainly generic drugs) even if the

Medical companies must resort to paying intermediaries exorbitant sums to secure needed supplies, including imported medicines and medical instruments which have more than tripled in value during Iran's rapidly dropping currency.

country still relies on imports for raw materials and many specialized drugs. Sanctions have in fact enabled Iran to build a self-sufficient and large drug production infrastructure, meeting 96% of domestic demand. While most drug facilities do not meet international good manufacturing standards, the Iranian government has pushed out a few initiatives to address these issues. R&D focuses mainly on new generic drugs, al-

though investment in novel products is increasing. In order to establish itself as a biotechnology hub, Iran is also building a government funded USD 2 billion "Industrial Pharmaceutical City" near Tehran. It will house incubators and startups under the same roof as research labs and biotech producers. To add further attractiveness for international investors, foreign companies will be exempted from taxes. **There are about 100 companies in Iran that are active in the pharmaceutical industry. As of 2010, 50% of raw materials and chemicals used in the drug manufacturing sector are imported.** Although over 85% of the population use an insurance system to reimburse their drug expenses, the government heavily subsidizes pharmaceutical production/importation in order to increase affordability of medicines, which tends also to increase over-consumption, over-prescription and misuse of drugs.

Though most of Iran's medicines are domestically manufactured, much of the primary materials, many of them imported, are in short supply. And even if the state provides universal healthcare, some of the treatments needed for critical cases cannot be covered by state insurance. Lack of vital drugs results in corruption and black market. Naserkhosro, in south Tehran, is an example of a famous street where most unavailable drugs can be purchased, though at higher prices. In recent years, sanctions are also causing shortages for chronic diseases drugs such as Multiple Sclerosis or Alzheimer. Officially, the sanctions exempt humanitarian goods, such as food, medicine and medical equipment but in the reality, according to CNN reporting, shortages in essential goods have affected households across the country. **Because of U.S. sanctions, Iran's health sector is in fact struggling to keep up with soaring prices of medications and medical instruments and it is not uncommon to see long lines of people outside facilities waiting to obtain state-funded medications.** Medical companies must resort to paying intermediaries exorbitant sums to secure needed supplies, including imported medicines and medical instruments which have more than tripled in value during Iran's rapidly dropping currency. Patients and their families are

doubly affected by plummeting purchasing power across the country and even when families can afford medical equipment they often join long waiting lists, health professionals tell CNN.

The MOHME is also responsible for supervising imports of medical equipment, but the import and distribution of such equipment is mostly handled by the private sector. Iran has undergone the primary stages of development in terms of industrialization and a rather strong indigenous manufacturing capability exists in the country. **Therefore, one can expect to find a handful of local producers for basic medical equipment, making it very hard for similar imported products to penetrate the Iranian market.** There are over 100 Iranian companies representing international suppliers in this market, handling both promotion and the after-sales service of the products. Iran is a mature market when it comes to medical equipment. Most of the major international players in this sector are present in the Iranian market.

Oral Healthcare

Despite progress, Iran's healthcare insurance system has experienced piecemeal development over the years and is characterized by a complexity of revenue-collection schemes, fragmented insurance pools and passive purchasing of dental services. Dental services are therefore provided by both the public and private sectors in Iran. **In cities, where over 70% of the population resides, about 80% of dental services are provided by private practices, while in rural areas well over 70% of oral health services are delivered by the governmental sector. On this regard, the integration of oral health in the Primary Health Care (PHC) system was implemented over 20 years ago (1996), with the aim of oral health promotion at the community level.** Since 1972, major health improvements have been achieved and the prevention of common oral diseases is the main evidence-based strategy currently used by the Ministry of Health and Medical Education (MOHME) in Iran. Two target groups have been selected to provide regular preventive services, primarily in the Health Houses, Health

Dentist-population ratio 1997-2017		
Year	Dentists	I Dentist
1997	10,000	6,000
2007	20,000	3,500
2017	between 25,000-30,000	2,667

Source: www.jocms.org/index.php/jcms/article/view/460
 Figures refer to dentists and dental specialists

Posts and Health Centers: (i) pregnant women and lactating mothers as well as (ii) children under age 14. Furthermore, the integration of oral health was revisited and further improved in the "2015-Oral Healthcare Reform". **Children under the age of 14 years and pregnant or lactating mothers, making up the target groups, are entitled to receiving subsidized basic oral healthcare in public dental clinics. Those aged 14 years and over meet all costs for oral healthcare out-of-pocket according to a fixed fee schedule which is determined by the MOHME.** The cost of services in public clinics for the target population is about 80 to 90% less than the cost of the same service in private clinics without insurance and for all others outside the target groups it is 50% less than in the private sector. There is a four-level dental healthcare network in Iran; the first level is of primary prevention at 'health houses' through Behvarz, or trained medical workers, at the next level (level II), oral hygienists and dentists in health centers perform basic oral healthcare services such as fillings, scaling and extractions. At the third level, dentists manage and treat oral diseases in urban health centers, while the last level (IV level) is for advanced treatment by specialists in university health centers in the big cities. Except for those covered by special institutions (that offer supplemental coverage to their insured members) and some groups that can afford commercial supplementary insurance, for the rest (at least half) of the population the dental benefit package is limited to the approved basic package, which does not meet people's needs. **Resource scarcity has been the driving factor to replacing many services, which were once included, resulting in in-**

adequate dental insurance coverage. The inclusion of tooth extraction but not tooth restoration for adults may be an example and may well result in the loss of teeth that could be perfectly saved. Among the dental services in the basic package that must be covered by all funds are: dental examinations, radiography (periapical/bitewing), extraction of untreatable primary and permanent teeth, supragingival scaling and oral hygiene instruction, subgingival scaling (only for those older than 14 years), tooth polishing, restoration of first molar teeth for 6- to 14-year-old children. These services are also included as a component of a national plan called the "Family Physician plan" that provides full medical coverage to populations living in the remote and underserved areas of the country. Therefore, anyone with rural insurance coverage can obtain all covered dental services free of charge in the rural areas. Similarly, urban citizens can benefit all covered services by paying 30% co-payment. **The 2015 reform is mainly focused on all three levels of preventive care, the primary, secondary and tertiary prevention. However, due to resource limitation, the permanent dentition of the over 7 million primary school children has been the initial target population of the National Oral Healthcare Reform at the time being.** The major objective is the prevention and early diagnosis of dental caries, periodontal diseases and provision of early treatment for any existing conditions by referral to dentist. In 2015, through a formal ceremony in one of the primary schools in Tehran, a memorandum of understanding was signed between the Minister of Health and the Minister of Education to facilitate the initiation of free preventive oral

healthcare in all primary schools nationwide. Based on this reform plan, all students will be checked two times a year for receiving intraoral examination, oral health education, oral hygiene instruction, fluoride varnish application, as well as referral to dentist if sealant therapy or other treatments are needed.

In accordance with new policies of the 2015 Oral Healthcare Reform, level I preventive dental services are mainly provided during the morning shifts in order to comply with new regulations and level II or therapeutic services are provided during the afternoon shifts. Dentists can use the public facilities in order to provide dental treatments with no limitation of services in the afternoon shifts, as long as dental materials and dental assistants are provided by the dentist. The government-established fee schedules are used at these facilities and from each payment 20% is deducted by the government and the rest is considered provider's income. For the morning shift contract, there are additional fee incentives based on remoteness of assigned location and deprivation category of the geographical area. Using these payment models, the combination of income from morning and afternoon shifts have been well accepted and considered satisfactory by most recruited dentists. **These assignments are usually given to new dental graduates who need to fulfil 2 years of duty service for government in return for free dental education (before being able to have a private practice).** The MOHME is responsible for distributing these young dentists according to its priorities. Along with dentists completing the mandatory practice stage, there are dentists who are employed by the government, permanently, and work in urban public dental clinics. Both groups earn a monthly salary which is less than the amount earned by the dentists in private sector, and they provide simple care services. **Regardless of the high number of dentists in the private sector, their contribution to the insurance scheme is minor, as such dentists/clinics are in short supply in the public sector.**

With its developing healthcare system and treatment-oriented insurance schemes Iran experiences a higher utilization of services when patients have trouble with their teeth or gums. The

DMFT Index among Iranians (INOHS-2012)					
Age Group	DMFT	Urban	Rural	Caries-free	Periodontal Diseases
5-6	5.16	4.94	5.78	12.7%	9.7%
12	2.09	2.02	2.29	35%	26.9%
15	3.29	3.26	3.42	0.4%	33.8%
35-44	13.20	12.99	13.98	-	55.5%
65-74	25.71	25.29	27.25	-	60.9%

DMFT= Decayed, Missing or Filled Teeth
Source: www.jocms.org/index.php/jcms/article/view/460

policies of either public or commercial insurance include no obligation to attend regular dental check-ups, representing only around 16% of visits to the dentists. Data from surveys in the past two decades show a marked decline in dental caries from DMFT (Decayed, Missing or Filled Teeth) of 4 to 2.09 in 12-year-old children while periodontal diseases and tooth loss are increasing compared with previous data. Caries-free status is sharply declining from 12 to 15 years old and number of edentulous people is exceeding 50% in 65-74-year-old age groups. **The general level of oral health is not satisfactory, indicating the urgent need for proper interventions in all age groups, especially in children.** The percentage of caries-free children among 5-6-year-olds is 12% and over 60% of 12-year-old children have caries experience, with the decayed component being the greatest component. **The declaration of "2015-Oral Healthcare Reform" has paved the way for oral health promotion in children under age 14 at the national level. The target is to halt the progression of oral diseases and maximize the promotion of oral health and quality of life by the year 2025 for the target population.** The behavior of visiting a dentist regularly for check-ups has its origins in one's childhood to continue into adulthood.

Over the past 60 years, the number of dental schools training dental specialists, dentists as well as other dental health technicians has increased from five

schools to 66 dental schools that are currently fully functional. The number of local graduates is about 1,500 annually. Additionally, about 500 foreign graduates begin practicing in Iran each year. The workforce is developing rather fast and the total number of graduates is expected to increase by 8-10% annually. **The role of the dental hygienists and oral health technician are the keys to success of the National Oral Healthcare Reform. The initiative for training hundreds of such mid-level personnel is currently underway, to provide level-I preventive services in local communities, focusing on target population groups.**

Public health dentists, dental hygienists and oral health technicians, responsible to visit the local primary schools and provide preventive oral healthcare in urban areas, are not enough to cover all primary school children and dental students are helping to provide such preventive care. **As the provision of preventive care expands, more manpower is obviously needed. Ideally, it would be best if private dental practitioners would be involved. About 90% (27,000) of the dentists in Iran are in the private sector and mostly into solo practice.** Through public-private-partnership more primary school children can receive early dental restorations (level I preventive care) if proper policy were in place. There is still very low interest among the private dentists to sign a contract with insurance companies. The main problem for such

With its developing healthcare system and treatment-oriented insurance schemes Iran experiences a higher utilization of services when patients have trouble with their teeth or gums.

outlook is the low rate of insurance reimbursement and delay in payments for services provided by dental practitioners. Two main dental insurance systems are available: public and commercial. **The public insurance system is overseen by the Ministry of Welfare and Social Security, since all companies under**

% Tooth Loss and Dental Prosthesis		
Age group	Tooth Loss	Complete Edentulous
35-44	40%	4%
65-74	84%	52.2%

Source: www.jocms.org/index.php/jcms/article/view/460

Treatment Needs By Age And Place Of Residence (INOHS-2012)			
Age group	Total	Urban	Rural
5-6	84.3%	81.9%	88.2%
12	75.1%	72.3%	79.6%
15	76.0%	73%	81.2%
35-44	86.1%	84.4%	88.9%
65-74	45.9%	43.7%	49.4%

Source: www.jocms.org/index.php/jcms/article/view/460



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the Labor Law must insure their employees. About 80% of the insured people in Iran have this kind of insurance, but it covers only basic oral healthcare services. The employees' compulsory premium is deducted from their wages or incomes, to contribute to health and social services.

Commercial insurance is also playing an increasing role in healthcare financing (around 17% of Iranians are covered by commercial health insurance). **Since the 1990s firms and factories can buy health insurance for their staff from the same commercial insurance companies which insure their goods and services.** For health insurance, the employers pay the total premiums for the employees and their families (employer-sponsored) as a fringe benefit. This amount of money which is paid by employers as the premium will be subtracted from the taxes that the company must pay. Oral healthcare services are provided by a contract between commercial insurance companies and dentists practicing in private dental clinics. Recently, following the privatization policy, several commercial insurance companies have been established with a variety of oral healthcare benefits.

The High Council for Health Insurance

is responsible for making changes to the social insurance provisions of each scheme and sets the fee according to its own fixed tariff schedule. The fee for oral healthcare services in insurance schemes is obviously lower than that in the private sector (approximately 50% lesser). All health insurance schemes use the same fee schedule. Public health insurance benefits continue after retirement. For commercially insured people this benefit will be stopped at their retirement. It seems however that there is a need for better administration, mainly to improve equity in premium contributions within and between social funds. **Meanwhile, according to data, in two major funds (MSIF and SSO) covering about 80% of total population, the dental share was about 1% of their total health expenditure. Such low share of dental expenditures in these major funds is consistent with the high out-of-pocket payments for dental care by Iranian households.** The escalating cost of treatment will greatly impact low income individuals and communities. There is strong evidence that the cost of preventive care is much less than the treatment, for both individuals and governments. On this regard, the declaration of the National Oral Healthcare reform, as a fully

integrated program in PHC, has greatly facilitated better public access to preventive oral care.

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-"MYTH vs. FACT: Iran's Health Care", by: AIC Research Associate Carrie O'Foran

The American Iranian Council was founded in 1990 with the goal of furthering dialogue and understanding between the United States and Iran. It is incorporated as a [501 C (3)] nonprofit and nonpartisan educational organization to provide research, policy analysis, public education, and community mobilization. The AIC seeks to help policymakers and citizens improve their understanding of those two great countries and their long, sometimes difficult, relationship. In order for the AIC to be a positive catalyst for a change, it must have relevant programs. For full report: www.us-iran.org/resources/2018/8/27/myth-vs-fact-irans-health-care

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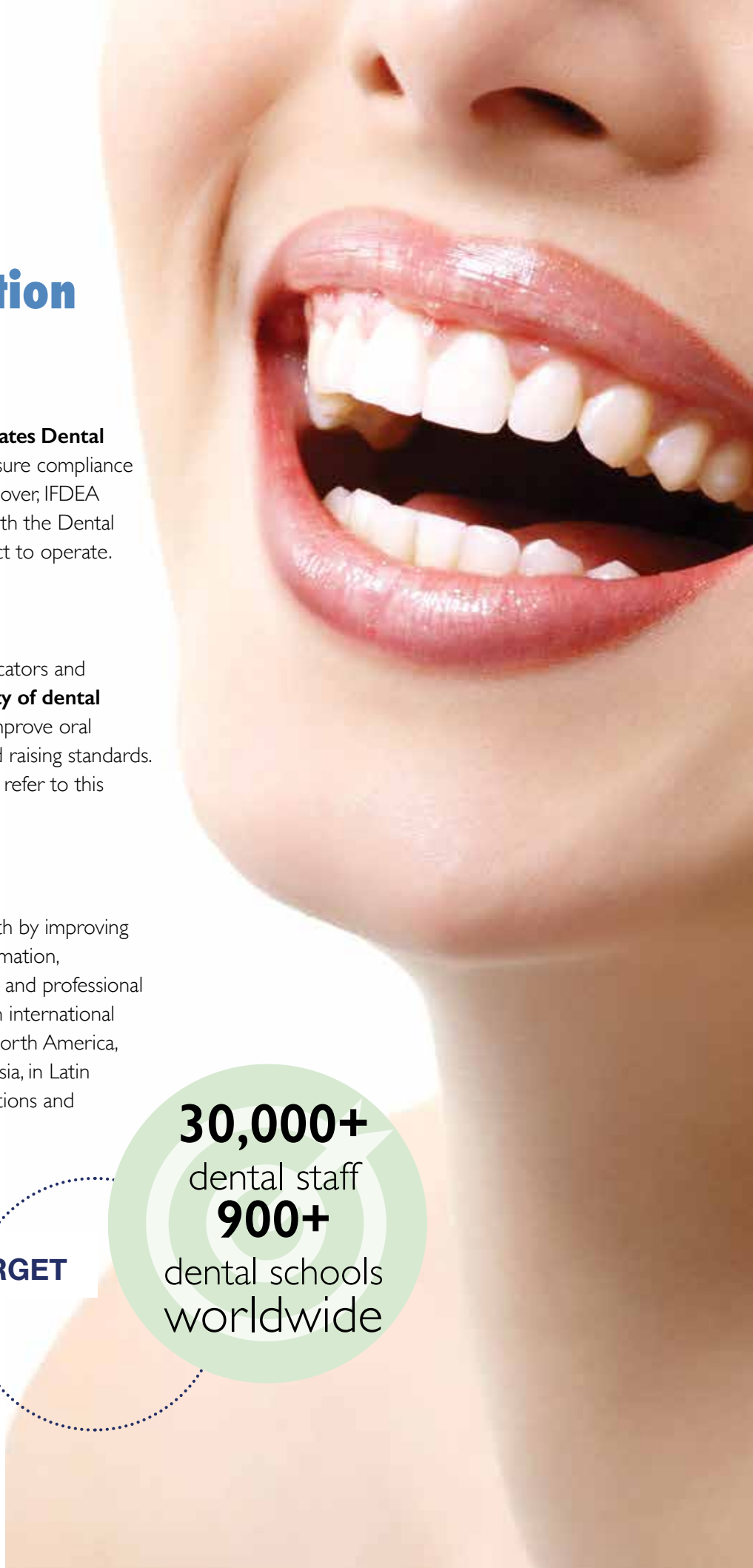
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Total health expenditure per capita ranges on average between **US\$ 988 - 1,079**, well below the EU average of US\$ 3,379

GDP per capita
(current USD, 2018 World Bank):
12,301

Over 90% of oral healthcare in Romania is funded privately – some public support is available for children

Poverty rate in Romania is the second highest in the EU and the country has the fifth highest score for income inequality in the EU

On the other hand, over 80% of total health expenditure is publicly funded, which is just above the EU average of 76%.

Share of total health expenditure spent on outpatient care is among the lowest in Europe, according to OECD data.

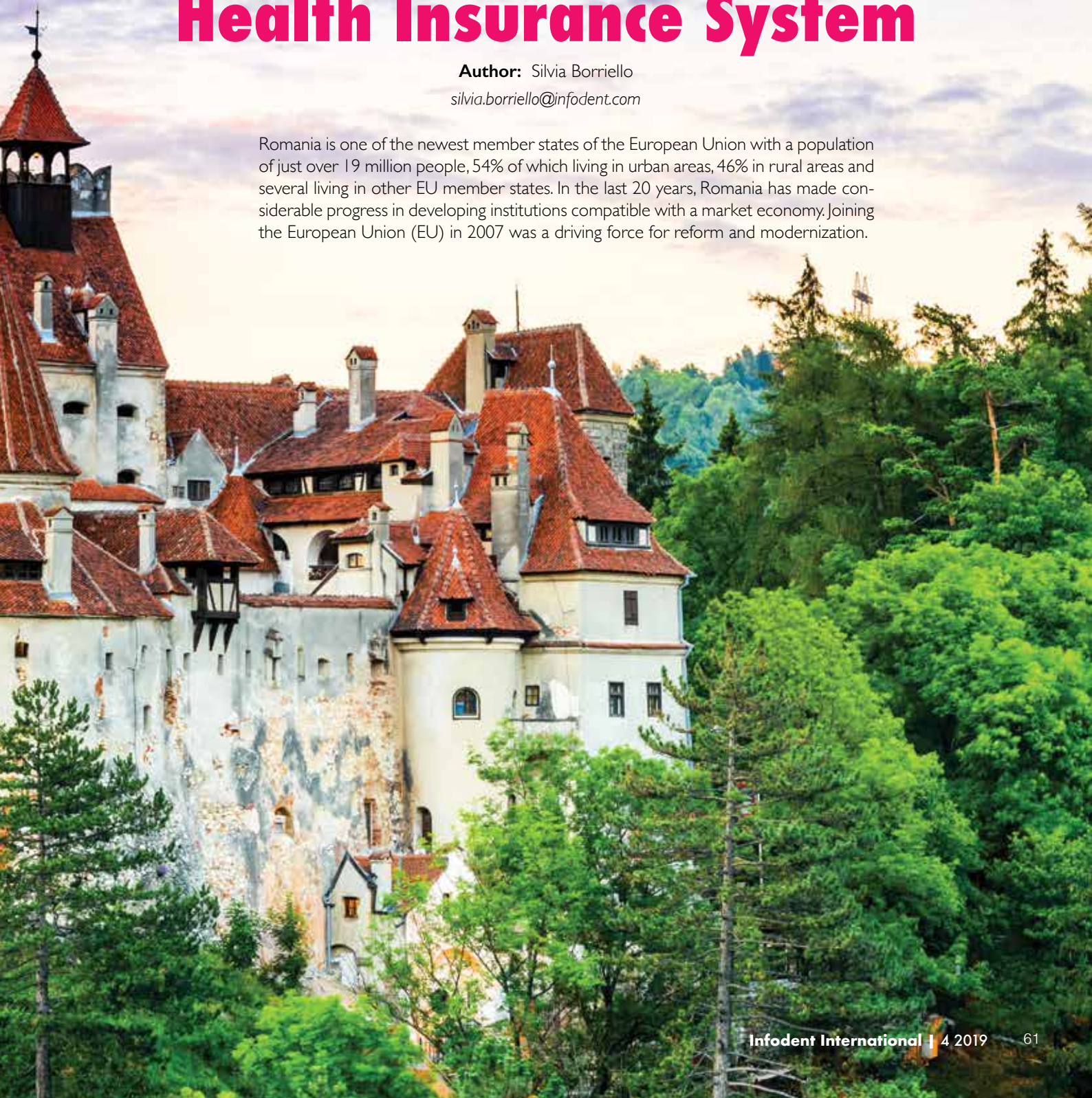
Lowest health expenditures as a share of GDP among EU Member States. Healthcare expenditure has been decreasing steadily since 2010, ranging from 5.8% of GDP to 5.6%



Romania, A Bismarkian Model Health Insurance System

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Romania is one of the newest member states of the European Union with a population of just over 19 million people, 54% of which living in urban areas, 46% in rural areas and several living in other EU member states. In the last 20 years, Romania has made considerable progress in developing institutions compatible with a market economy. Joining the European Union (EU) in 2007 was a driving force for reform and modernization.



Challenges to accelerate growth in the country include uncertainty in the Euro zone and export markets, political developments and availability of EU funds. **The key challenges for Romania have been and are to achieve steady economic growth and improve living standards while meeting fiscal targets and to continue structural reforms and the modernization of public administration, health and education.**

The provision of health services is the responsibility of the Government through the Ministry of Public Health. General and oral healthcare depends on the compulsory membership of each insured citizen in the Social Health Insurance System. The system of public health insurance provides a legally prescribed standard package of general and oral healthcare while financial resources coming from general taxation (provided under the national budget) only cover general prevention programs, managed by the Ministry of Health and Family.

The current health insurance system was founded in 1998 and it is administered centrally by the National Social Health Insurance House (NSHIH), which is divided into 42 district houses of health insurance (County Social Health Insurance Houses), corresponding to the 41 Romanian counties and the city of Bucharest. The whole population contributes a monthly fixed amount of their salaries to the County Social Health Insurance house (CSHIH), situated in the county where they live. While social health insurance is in principle compulsory, in practice it covers only around 86% of the Romanian population, the main uninsured groups being people working in agriculture or those not officially employed in the private sector; the self-employed or unemployed who are not registered for unemployment or social security benefits as well as Rom people who do not have identity cards. **Insured individuals are entitled to a comprehensive benefits package while the uninsured are entitled to a minimum benefits package, which covers life-threatening emergencies, epidemic-prone/infectious diseases and care during pregnancy.**

The NSHIH budget is directly proportional to the level of the salaries of the

The NSHIH budget is directly proportional to the level of the salaries of the population as the system establishes a principal in which citizens contribute according to their income.

population as the system establishes a principal in which citizens contribute according to their income. Thus, every year, the NSHIH budget is estimated according to the previous year's budget, adjusted for inflation. The NSHIH funds are met by a 12.5% levy on salaries, of which the employers contribute 7% and employees 5.5% (2017 data). The allocation of money and resources is managed by the NSHIH and CSHIH, which are the legal financing institutions. The NSHIH and CSHIH main functions are to pay the providers of medical and dental services and to control the quantity and quality of the services. **On the whole healthcare financing is somewhat progressive, with health insurance contributions being the main source of healthcare financing and vulnerable population categories (young people, disabled, unemployed, war veterans etc.) exempted from the contribution payment and from cost sharing (co-payments).** The administration of the NSHIH establishes at every year-end, by negotiating with the Romanian Collegiums of Dental Physicians (RCDP), the expenditure for the different medical specialties (hospitals, family medicine, specialties, emergencies, drugs and dentistry). At the end of 2002 the Government ended the right of the RCDP to be a negotiating organization and established that the Ministry of Health and Family together with NSHIH undertook all the activities of social health insurance system.

There are approximately 16,400 dentists and 4,500 dental technicians provid-

ing oral healthcare in Romania. In 2017 there were 12 Dental Medicine Faculties, 5 traditional ones, namely Bucharest, Cluj-Napoca, Târgu Mureș, Timișoara, Iași, as well as 7 newly created faculties (Bucharest, Craiova, Constanta, Sibiu, Oradea, Arad, Galati).

The shift from a communist system to a democratic or capitalist one and the lack of public funds during post-communist years has contributed to a dependency on private oral healthcare rather than on government financed public provision.

Affordability and social awareness have together established a mixed economy for oral healthcare costs and oral healthcare is growing slowly compared to other developed EU member states.

Consequently, since 1989, almost 90% of all dentists have become private practitioners; they have fiscal codes and have obtained all kinds of legal permits for liberal (private) practice.

60% of dentists are owners of their dental office, 30% are not owners but work in old buildings offered temporarily by the government, for an annual fee of around €50. Since 1994, when the healthcare reform began, there have been many proposals by the government to sell their medical and dental offices to their occupants, but these have never been finalized - maybe for political and social reasons. 10% of dentists work as employees in primary schools and dental faculties. A real free dental market was established between 1990 to 1998, with prices regulated by the principles of market economy. Only around 20% of Romanian dentists, owners or non-owners of their dental offices, work under the CSHIH. The other 80% of the dentists work in a completely liberal (private) system, with direct payments from patients only. The number of CSHIH dentists is limited by the Social Health Insurance Houses at county level. **Less than 1% of the medical funds of the CSHIH are spent on dental treatments – most of the funds are spent in hospitals (75%), for general (family) practitioners (10%), etc. It is estimated that patients directly pay at least 90% of the costs of dental treatments.**

At the same time, there has been over-



production of new dentists in Romania, recording the highest relative increase within the EU (up 33% between 2011 and 2016). This has led to under-employment and emigration of dentists to other EU member states. **Relative to the total number of inhabitants, Romania recorded 10.4 graduates per 100,000 inhabitants, the highest number of dentistry graduates within the EU in 2016.** More than 40% of dentists are younger than 40 years.

Dental care is provided through a network of 14,118 ambulatory facilities, most of them (86%) private (12,127), which are organized as private dental practices (11,931) or medical dentists' civil societies (a form of professional organization for liberal professions in Romania) (196). Out of 1,991 public dental practices, 432 are dental practices at schools and 31 are dental practices at universities. Dental practices at schools and universities are financed from the state budget. The NSHIH pays dental services for dentists who accept

the terms offered to them. Some work is completely paid, whilst other work is paid at only 40-60% of the cost. For children and categories under special laws the work is completely paid for but only out of the value of what the RCDP considers an insufficient maximum price (about €400). The number of dentists who work only in the public service is not exactly known, because they also work in their own dental offices. The main sector is public schools, but the number is decreasing every year. Children do not pay for their treatment; general prevention programs of Ministry of Health and Family support the costs. Hospital dentists work in maxillo-facial surgery in hospitals, as employees of the hospitals, owned and run by regional government. They can work part-time in private practices. Academic dentists are normally salaried employees of the Faculty of Stomatology. They are allowed a combination of part-time teaching employment and private practice (with the permission of the faculty).

Due to limited funds, the NSHIH covers only a small number of dental healthcare services. In 2014, dental care accounted for only 0.2% of the total NSHIH expenditure on healthcare services. Most dental care services are paid for directly. **The basic benefits package includes a very limited range of dental services, which are free of charge for children**

The number of dentists who work only in the public service is not exactly known, because they also work in their own dental offices. The main sector is public schools, but the number is decreasing every year.

Ora Health Personnel (2016)

Number of dentists	16,285-16,400
Qualified overseas	450
Percentage female	68%
Ratio dentist/population	82.7 /100 000
Dental technicians (2013)	4,500
Hygienists (2008)	100
Denturists (2013)	8
Assistants (2013 estimates)	2,000

Figures are approximate and estimated, from different sources
Source: CED, Manual of Dental Practice 2015 and Eurostat Statistics Explained

Graduate Dentists

Year	2006	2011	2016
No. of graduates	1,018	1,263	2,042
Ratio per 100 000 inhabitants	4.7	5.9	10.4

Source: Eurostat Statistics Explained



and people under 18 years and for specific population groups such as war veterans, fighters in the 1989 revolution, etc. For patients aged over 18 years the NSHIH will cover services for between 60% and 100% of the tariffs. More specifically, following proposals of the Romanian Dental Association of Private Practitioners (RDAPP) to improve the dental social health insurances, which had been invited by the Ministry of Health to a “Partnership for Health”, since the beginning of 2004 in *Norms of Application of the Frame Contract* between dentists and NSHIH, the following treatments are supported by the social health insurance:

- Preventive care for children and adolescents – 100%
- Dental treatments of children and adolescents (up to 18 years) – 100%
- Pain relief and emergency treatments – 60%
- Basic surgical care (with emergency treatments) – 60%
- Risk-diagnostics and preventive consultation – 100%
- Mobile social acrylic dentures for adults – 100%

Uninsured persons have access to a minimum benefits package that only covers medical emergencies. There are currently no reform plans in the area of dental care and there is no precise data available on the quality of the dental services. There are also major differences in access to dental care between rural and urban areas as in rural areas only around 25% of the population has access to dental treatment, in urban areas, 75% of the population do. There is also shortage of dentists working in the inner-city areas and within some specific social groups (children, farmers, retired persons) who have trouble accessing dental care in rural areas. **Among the problems related to access to dental services are public insurance covering only very few therapeutic treatments, the reduced number of private practices under contract with the health insurance house (around 20%), people’s low income, especially in rural areas, in addition to lack of informa-**

Almost 1,000 new companies offering dental services entered the market within the last few years.

tion regarding oral hygiene and the importance of risk factors (nutrition, smoking, alcohol, other habits). These together, inevitably, lead to a high number of caries, periodontitis and oral mucosa diseases among the population. Also, the lack of regular dispensary checks, especially of children, leads to an increase in the incidence of oral pathology. Currently, a national oral health prevention program for children is being implemented. A coherent program to simplify the access of disabled persons to dental services should also be introduced, considering the specific features of their treatment and anesthesia. Health policies should be unitary, they should address mainly patients in the rural areas, emphasize prevention, and, also, properly fund dental treatments, increasing the payment per treatment to the dentist, and stop limiting the monthly amount that the state insurance covers for dental care.

To become a dental student, a Romanian citizen must have a high school diploma and pass an entry examination. There is no need for a vocational entry. Dental schools were known as Faculties of Stomatology and, until 2003, were part of a University of Medicine and Pharmacy (with title of “Physician Stomatologist” once graduated). Since the 2003-2004 academic year, they have become Faculties of Dental Medicine (with title of “Dentist” once graduated). In publicly funded schools: Bucharest, Cluj-Napoca, Iași, Timișoara, Târgu-Mureș, Craiova, Constanța, Sibiu, Oradea, Galați, students pay no tuition fee, but they must pay the full cost for privately funded schools: București, Iași, Arad. As for all medical studies in Romania, the tuition fee for dental schools varies with the minimum being €2,000 (for Romanian nationals) and the maximum €5,000 a year (for non-nationals) (data from 2013). Every state-funded faculty also has the right to manage a limited number of tuition paying places for students each year, for both bud-

geted and fee-paying students. The Ministry of Education monitors the quality of the training process and the Faculty Board is directly responsible. Diplomas from other EU countries are recognized without the need for any vocational training. The Romanian Collegiums of Dental Physicians (RCDP) registers all Dental Physicians and all specialists. It is mandatory to know Romanian to be registered with the RCDP. Continuing education is compulsory for all dentists otherwise the RCDP has the legal obligation to terminate the right of the dentist to practice. **The migration of skilled labor, and especially dentists, to other EU member states, due to higher incomes, is seen as a problem given the expenses incurred by Romania to train dentists.**

A solution would be to increase the number of dental treatments reimbursed by the Health Insurance House, to increase the price per treatment, while also multiplying the number of treatments affordable to a larger share of the population. Any dentist can undertake specialist training but the Ministry of Health limits the number of specialists. Specialist training is undertaken in the Dental Faculties and the Board of the Faculties monitors and are responsible for the quality assurance of the training. The trainees are paid during their training by a fixed budgetary salary supported by the Ministry of Health. During this time, it is forbidden to work in private dental practice. Six dental specialties are recognized in Romania:

- Orthodontics: 3 years training (in 2008 there were 234 registered orthodontists)
- Oral-maxillofacial surgery: 5 years training (234 in 2008)
- Dento-alveolar surgery: 3 years training (157 in 2008)
- Endodontics: 3 years training
- Periodontology: 3 years training
- Prosthetics: 3 years training

There is a limited number of clinical dental auxiliaries in Romania. Dental technicians are trained in dental technician colleges, organized in frame of the dental faculties. The training is for 3 years, with a final examination and a diploma. Since 2007 they have had to register with the Order of Romanian Dental Technicians. Dental technicians

normally work in separate dental laboratories and invoice the dentist (or directly the patient) for completed prosthetic work. A small number of technicians are employees of dental offices and are paid with a percentage of the fees for the prosthetics work. There is some illegal dental practice by non-specialized technicians, without a higher degree qualification, but the RCDP and RDAPP fight against these and the number of cases is decreasing every year. Dental assistants train in secondary medical schools, with 3 years of study and a final examination and diploma. They must be registered in the Order of Romanian Medical Assistants. The duties of dental assistants are limited to assisting dentists, maintaining records, sterilization, infection control and office work. Despite the difficulties, the dental services market in Romania keeps growing, even if at a slow pace, reaching RON 1 billion (EUR 220 million). Almost 1,000 new companies offering dental services entered the market within the last few years. **In total, more**

than 4,300 companies are active in the market, employing almost 10,000 people. In Bucharest, there are over 1,300 companies providing dental services, with almost 300 new firms having entered the market in the last few years. The dental clinics in Bucharest recorded a turnover of over RON 380 million (EUR 83.5 million) in 2016 and a profit of almost EUR 15.4 million, according to Creditinfo Romania. The most developed dental market outside of Bucharest is in Timis county, Western Romania, where more than 180 dental companies are active with a turnover exceeding RON 53 million (EUR 11.6 million), a profit of over EUR 2.6 million and over 400 employees.

Main International Trade Fair

DENTA, Fall Edition, 5-7 December, 2019
Organized by: Romexpo SA
www.denta.ro/en

Among main sources:

-Extracts from: Regional European Organisation

of the FDI, National Report, Romanian Society of Stomatology. For full report: file:///C:/Users/Silvia/Downloads/assets_meetings_new-group-2018-04-13-salzburg-2018_reports_Romania-RSS-National-Report-2017-EN%20(1).pdf
- Eurostat Statistics Explained (<https://ec.europa.eu/eurostat/statisticsexplained/>), data extracted July 2018
-Extracts from: Vlădescu C, Scîntee SG, Olsavszky V, Hernández-Quevedo C, Sagan A. Romania: Health system review. Health Systems in Transition, 2016; 18(4):1–170.
HiTs and HiT summaries are available on the Observatory's website (www.healthobservatory.eu)
-Extracts from: Council of European Dentists, Manual of Dental Practice 2015 (Edition 5.1). Authors: Dr. Anthony S Kravits OBE, Professor Alison Bullock, Professor Jon Cowpe with Ms. Emma Barnes. Cardiff University, Wales, United Kingdom
-“Dental services market in Romania, up by a third”, by Romania-Insider.com - <https://www.romania-insider.com/dental-services-market-romania-third>
-“The Healthcare system and the provision of oral healthcare in European Union member states: Part. 5: Romania” - British Dental Journal, www.nature.com/articles/sj.bdj.2016.265

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CEDE 2019: Poles change the nature of trade exhibition



CEDE is one of the longest held dental exhibitions in Europe. Over 10 000 participants of this year's edition witnessed a significant metamorphosis of the project.

Since 2017, the creators of CEDE (Poznań, Poland) have consistently emphasized that their undertaking has changed the formula from a classic exhibition into a many element event. The foundation of CEDE are exhibition and the Polish Dentistry Union Congress, whereas the value of the event is increased by initiatives carried out alone or with industry partners.

At the stands

193 companies participated in CEDE 2019 exhibition. The area of stands took exactly 4 750 sq m. The exhibition was visited by 10 616 people. In addition to Poles, the most numerous nations participating were: Germans, Irish, Italians, Ukrainians and Norwegians. Of course, the largest professional group who came were dentists, of whom the vast majority without dental specialization. It is worth noting that about 500 dental hygienists took part.

In the lecture hall

In 2019, the Polish Dentistry Union Congress confirmed the status of one of the largest educational events in the dental industry in Poland. 1 049 people took part in 81 lectures, 2 discussion panels, 22 workshops and 4 seminars. The most numerous group of attendees were general practitioners without specialization. Next came general specialists, preventive dentists, prosthodontists and periodontists. The presence of dr Gerhard Seeberger, the president of the FDI World Dental Federation, among the lecturers is worth emphasizing.

On the red carpet

It's the third time that CEDE was accompanied by an online plebiscite for the most popular dental products, in which Internet users vote. The winners were: Planmeca Creo™ C5 (KOL-DENTAL) in the Equipment category, Omnichroma composite (Marrodent A Henry Schein Company) in the Materials category, Oral-B Genius X electric toothbrush (Oral-B) in the Prevention category and HappyDental Academy (HappyDental) in the Education / IT category. 3 142 people nominated their favorites casting 4 826 votes.

Special projects

This year their number was record-breaking, let's just mention the most important ones. Once again, the organizers joined the celebration of the European Head and Neck Cancer Awareness Week with screening tests for the inhabitants of Poznań ("Open your mouth. Say NO to cancer!"). Even more people, about 100, took part in the "Hygienist the best investment of a dentist?" debate. Experts, including representatives of the Supreme Medical Council, discussed various aspects of cooperation between hygienists and doctors and the future of the profession. This year, the Dentoexpress field game was implemented in Poznań for the first time. 1 333 people took part in it, half were dentists.

Next edition: 29th Central European Dental

Exhibition will take place on September 24-26, 2020.

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26th Moscow International Dental Forum & Exhibition DENTAL-EXPO 2019



26th Moscow International Dental Forum & Exhibition DENTAL-EXPO 2019 was held 23-26 September.

The exhibition "Dental-Expo 2019" represented the largest exposition of all the history of the event. Four exhibition halls accommodated more than 500 exhibitors from 35 countries and more than 1000 dental brands. A distinctive feature of the autumn exhibition is the ever-growing number of foreign exhibitors. For the first time, 79 companies from Russia, Germany, China, Korea, Turkey, the USA, and Lithuania took part at Dental Expo 2019. Total attendance is 36709. During the Forum were held more than 700 training and presentation events for dentists. Most of the lectures and workshops were free for visitors to the exhibition. The topics of training events were as follows: Implantology - 97, Surgery 34, Endodontics - 68, Orthodontics - 47, Orthopedics - 115, ZTL - 120, CAD / CAM - 92, Gnatology - 12, Pediatric Dentistry - 18, Periodontology - 18, Therapy - 80, Aesthetic dentistry - 63, X-ray medicine - 7, Management - 52, Laser dentistry - 4, Anesthesia - 16, Hygiene - 16, Prevention - 11, Functional diagnostics - 3, Interdisciplinary dentistry - 9, Infectious control - 9, etc. The main events of the past 46th Moscow International Dental Forum:

- Meeting of the Specialist commission of the Ministry of Health of the Russian Federation on dentistry
- Meeting of the Specialist Commission of the Ministry of Health of the Russian Federation on maxillofacial surgery
- Council meeting of the Russian Dental Association
- Conference of the Dental Association of Russia "Dentistry of the XXI century" (2000 participants)
- VII Russian-European Congress on Pediatric Dentistry - REPDC (with the support of EAPD, 500 participants)
- Brazilian Aesthetic Congress
- International Symposium of Orthodontic Technicians "Orthodontics without borders"
- Festival of Implantology
- Original course of Dr. Yoshi Terauchi (Japan) on broken files removal and retreatment
- (300 участников)
- Original course of Dr. Pierpaolo Sandro Cortellini (Italy) on periosurgery update (200 participants)

See you in 2020!



Stomatology St. Petersburg



The largest in South-West of Russia exhibition in the field of dentistry - spring exhibition "Stomatology St. Petersburg 2019" was held 14-16 of May 2019 in Saint Petersburg.

74 companies from Russia, Armenia and China participated in the exhibition. They presented dental equipment, dental units, instruments and materials for dental practice, as well as furniture, clothing, medical optics for dental equipment, and much more. Among the exhibitors were present such companies as N.Sella, "Coral" Distribution Center, GVM Transit, Olympus Dental, SIRONA DENTAL SYSTEMS, Techno-Dent Group, North Carolina, Euro-Med Neva, VERTEX / ASEPTA, GlaxoSmithKline Helsker, Amrita, Raudentall, Trate, Farmadental, Dentalstom, Arkom, Profix Plus, Microworld and many others. For the first time, in the exhibition participated such companies as Asteria, Symphony Materialoff, TRI DENTAL IMPLANTS, Kvale, Ivoklar Vivadent, "Dentservice" Dental Laboratory, Sealing Materials Plant, Antogyr, Nearmedic, TRIHAWK, Center for Postgraduate Education of Medical Specialists. The exhibition was visited by 3,399 specialists, most of the visitors were private and public dental clinics, companies selling wholesale and retail products for dentistry, dental laboratories, and pharmacies. As part of the event program of the exhibition, more than 25 events took place: conferences (including those accredited in the system of continuous medical education), seminars and workshops for specialists. International scientific and practical conferences "Northern Capital Dentistry. Science and practice", "Dentistry of the Northern Capital. Integrative Periodontology", XXIV International Conference of Oral and Maxillofacial Surgeons and Dentists "New Technologies in Dentistry", as well as the XV Russian Scientific and Practical Conference "Dentistry of childhood and prevention of dental diseases" were held 14-15 of May. More than 500 dentists of various specialties took part in the conferences.

The organizers of the exhibition "Stomatology St. Petersburg" are the company MVK, St. Petersburg office, and VK "DENTALEXPO". Among all common projects the organizers also hold the international exhibition "Dental-Expo St. Petersburg", which will be held on October 29-31, 2019 in the ECC "EXPOFORUM".

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FDI reports high attendance and packed exhibition space at ADA FDI World Dental Congress in San Francisco



FDI World Dental Federation and the American Dental Association welcomed over 31,000 participants from 137 countries at the ADA FDI World Dental Congress at the Moscone Center in San Francisco, USA.

The Congress had 678 exhibitors in 121,500 square feet (11,288 square meters) of exhibition space, occupying 98% of the total space that was available. 598 of the industry exhibitors were from the United States, 80 of them came from abroad.

The ADA FDI World Dental Congress was one of FDI's largest and most-attended joint dental meetings in recent history. FDI was proud to collaborate with the ADA, build its presence in the United States, and celebrate being part of a rich worldwide network of dentistry.

FDI welcomed three new members

- **Two Regular members:** *The Association of Dentists in Republic of Srpska* (Bosnia and Herzegovina); the *RS Chamber of Doctors in Dentistry* (Bosnia and Herzegovina). Both associations will form a National Committee with an existing FDI member, the *Dental Association of Bosnia and Herzegovina*.
- **One Supporting member:** *Fondazione Andi Onlus* (Italy)

FDI General Assembly adopts eight policy statements

FDI policy statements, which detail FDI's position on issues of interest within the oral health community, are put together through consultation, discussion and consensus among leading dental experts from around the world.

This year, the GA adopted eight policy statements:

- Access to Oral Healthcare Among Vulnerable and Underserved Populations
- Antibiotic Stewardship in Dentistry
- Carious Lesions and First Restorative Treatment
- Continuing Education via eLearning
- Ethical International Recruitment of Oral Health Professionals
- Infection Prevention and Control in Dental Practice
- Malocclusion in Orthodontics and Oral Health
- Repair of Restorations

The newly adopted policy statements will be available for consultation on the FDI website.

What's next?

The 2020 FDI World Dental Congress, hosted together with the Chinese Stomatological Association, will take place in Shanghai, China, from 1-4 September 2020.



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Calendar

Here our trade shows selection. Discover all worldwide dental exhibitions at www.infodent.com/calendars/tradeshows

December

01-04 12 2019

Greater New York Dental Meeting 2019 (GNYDM) - 95th Annual Session
Infodent Booth: 1039

New York City - USA

Greater New York Dental Meeting
 200 W. 41st Street, Suite 800
 New York, NY 10036
 Tel: +1 212 398 6922
 E-mail: info@gnydm.com
 Website: www.gnydm.com
 Referent: Dr. Robert R. Edwab (Executive Director)
 E-mail: execdirector@gnydm.com
 Exhibits Manager: Ms. Carla M. Borg
 E-mail: exhibits@gnydm.com
 Exhibition venue:
 Jacob K. Javits Convention Center
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 New York, NY 10001 - USA

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February

04-06 02 2020

AEEDC 2020
Infodent Booth: 317, Hall No. 3

Dubai - United Arab Emirates

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 Sina Building Block B, Office 203.
 P.O. Box: 13636, Dubai - UAE
 Phone: +971 4 3624717
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- The 25th Dental South
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E-mail: dental@ste.cn
Website: www.dentalsouthchina.com
- Exhibiting Contact: Cherry Wu, Christine Su, Hui Li
Phone: +86 20 8354 9150 - 8356 1174 - 8355 8271
Venue: Block C, China Import & Export Fair Panzhou Complex
Xin Gang Dong Road
Guangzhou - P.R.China

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12-14 03 2020

Expodental 2020

Madrid - Spain

Promoted by: FENIN (Federacion Espanola de Empresas de Tecnologia Sanitaria)
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Venue: IFEMA - Feria de Madrid
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Madrid
Spain

www.ifema.es/en/expodental



April

24-26 04 2020

**IDEM Singapore 2020
- International Dental
Exhibition and Meeting
Infodent Booth: Level 4
B22**

Singapore - Singapore

Organised by: Koelnmesse Pte Ltd
152 Beach Road
#25-05 Gateway East
Singapore 189721

Contact
Aaron Ann (Project Manager)
Phone: +65 6500 6700
Email: aaron.ann@koelnmesse.com.sg

Venue: Suntec Singapore Convention & Exhibition Centre
Add: 1 Raffles Boulevard, Suntec City,
Singapore 039593

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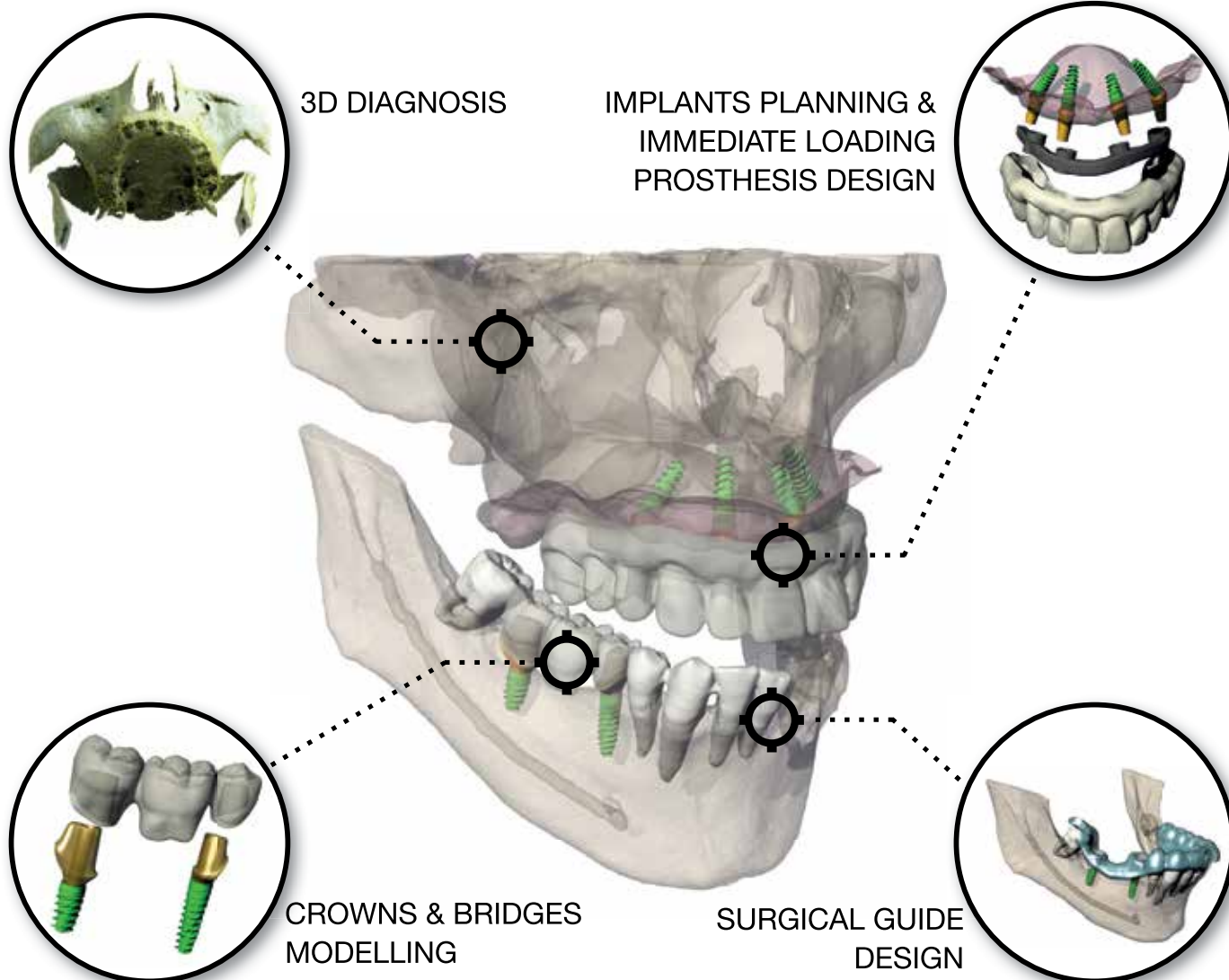


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