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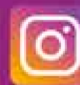

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WHAT ABOUT DIGITAL?

For years, we have been engaged in the print vs digital debate and the never-ending question of "which is better?"

But what if we tell you that these two methods aren't enemies, but allies? There are a lot of opinions regarding print and digital means, as well as whether this argument has any validity at all. Some say print is dying. We say it gained a partner to expand its business. Let's look at the facts. In 2018, a U.S. printing company, Freeport Press, conducted a survey where they received feedback from 1,226 magazine readers on their preferred format for publications. Their findings may surprise you!

Approximately 41% of readers read 1-2 print magazines a month, 33% read 3 or more while only 28% read 1-2 digital magazines a month. 55% of respondents had not read a digital magazine in the past month.

You may think that print is the winner, right? Wrong. This is the assumption that has led many publications to miss out on key opportunities to grow–or even save–their business. Think about it. When you calculate 28% of 1,226 people, that's almost 343 people. That's 343 potential readers print magazines are missing out on.

So, what if print publications tapped into this resource? They could deliver digital versions of their magazine to subscribers with a click of a button.

While the internet is a great resource and many people use it to quickly read up on the news and various niche stories, print magazines are viewed as more leisurely formats. Many readers classify sitting down and reading a physical magazine as a form of relaxation, taking their time to focus on it. It gives them a break from the screen they spend a good portion of their day staring at while at work.

Yet where it excels, it also lacks. Digital magazines have many advantages, one of the primary ones being convenience. They are easy to access, and whether you are on the computer or scrolling through the mobile phone, you won't have trouble reading a digital magazine if it's designed correctly.

Digital magazines have unique advantages over their print counterparts. Just like a physical magazine has its own feel and smell, digital magazines carry an advantage unique to its platform: interactive features.

You can view videos while you are reading, you can share it with your friends and family, and you can track analytics based on how your readership interacts with an issue.

The more you consider it, the more it seems ridiculous to choose one or the other when print and digital mediums work together so well.
Isn't it time to start seeing their synergy? Both print and digital mediums have their place. Let them work hand-in-hand with you to grow your readership. With unique advantages to each, you can build your publication strategy around the pros that work best for your target audience.

But serious times call for serious journalism, something editors are paid to conjure up; that is what Infodent International Press Office is doing and working on. We believe to have found the right balance between physical and digital content. We believe in quality.

A big change is taking place in the market. There's now too much writing online, and in an era of fake news, where you get your analysis from has never been more important.

> **Digital magazines have many advantages, one of the primary ones being convenience. They are easy to access, and whether you are on the computer or scrolling through the mobile phone, you won't have trouble reading a digital magazine if it's designed correctly.**

We have, for this, created a digital platform as container of extraordinary amount of news and press releases from all over the world and from which we can draw on for dental world news, to double check the sources and to publish in both the digital and printed formats.

We will turn general-interest daily news into an almost universally available commodity in the internet, so that it can be quickly shared, and readers can move on to the next morsel. On the contrary, specialist-focused journalism – which is still a service people value and think they can't get elsewhere - will remain our milestone on the Infodent international printed version.

In this same context, a new digital interactive section will help distributors find new global business through our "Distributors Wall" on-line.

As newspapers and magazines are finding out, if you can publish writing that is consistently and significantly better than what can be found online, you'll gain loyalty from readers.

Stop by our booth at the ADA and FDI Annual World Dental Congress to leave us material for our digital platform: scientific and trade news, press releases and classifieds for the "Distributors Wall" for all of us to share!

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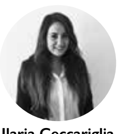

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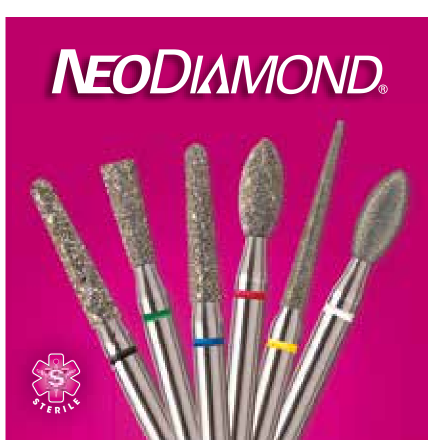

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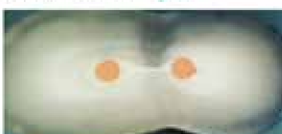

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FDA-Approved Goccles® Early Oral Cancer Screening Device by Pierrel Pharma S.r.l. Announced as Winner of 2019 Edison Best New Product Silver Award™

Capua, Italy, April 9, 2019 – Pierrel Pharma S.r.l. received recognition from the Edison Awards™, a prestigious organization known for acknowledging innovation, creativity, and ingenuity in the global economy, for its advanced, early oral cancer screening device: Goccles®. The FDA-approved medical device is used in combination with traditional examination to help identify early signs of oral cancer. The eyewear utilizes a patented optical filter with a standard curing light, exposing the fluorescence of healthy mucosa and potentially suspicious pre-cancerous and cancerous lesions. With Goccles, there is no need to purchase additional consumables for use and its price point is relatively low in comparison to similar devices. Goccles is supported by clinical studies and has received an excellent clinical evaluation from Dental Advisor.

Pierrel Pharma's chief executive officer, Fabio Velotti (Capua, Italy) attributes the Best New Product Silver Award™ win to the company's dedication to research and development, as well as its overall mission to create better dental healthcare experiences for professionals and patients. He said, "I am so proud of Goccles and how it is transforming the oral cancer screening process on the dental side. As time passes, I believe we will see a major shift in dental professionals' attitudes towards their role in early detection of oral cancer." He continued, "Pierrel Pharma is known for developing Orabloc®, a leading anesthetic product for dental procedures, which since marketed is now used by 1 out of every 4 US dentists. I look forward to the day Goccles becomes a 'household name' in its own right among dental professionals." Goccles was launched in the US in 2018, and is available through all major distributors, including Patterson Dental, Henry Schein, Benco Dental, and Darby Dental.

About the Edison Awards™

The Edison Awards honor global leaders in innovation across different disciplines, presenting awards in different categories. Winners of Edison Awards represent the best of the best technologies that have the power to impact the world and change lives. In a press announcement, Edison Awards' executive director, Frank Bonafilia, said in a statement, "After 32 years, it never ceases to amaze us how innovations that we could only dream about become our reality. Once again, the winners created innovations that are revolutionizing industries and becoming indispensable." The Edison Awards was originally established in 1987 by the American Marketing Association, and since 2008 has been an independent organization.

About Pierrel Pharma S.r.l.

Pierrel Pharma is the parent company of Pierrel Group which manages new drug product development, registration, marketing, and commercialization of Pierrel branded dental anesthetics. Pierrel has more than 30 years' experience in the development and manufacturing of dental anesthetics for the international market. Following a 2008 reorganization of Pierrel Group business development and marketing strategies, Pierrel has introduced a full range of state-of-the-art dental anesthetics in Italy. Today, Pierrel is in rapid expansion throughout the world. For more information about Goccles by Pierrel Pharma, please visit **www.goccles.com/en.com.**

Visit us at: ADA and FDI 2019, Booth 5381

MORE THAN 21.000 VISITORS AT EXPODENTAL MEETING 2019
Another successfull edition confirms that the Rimini trade-show is the most relevant dental event in Italy

The last edition of Expodental Meeting, the dental trade-show organized by UNIDI – the Italian Dental Industries Association, confirms the positive trend of the Italian market: 21.600 among distributors, buyers, dentists, dental technicians, hygienists and dental assistants visited the trade-show, with an 8% increase over the 2018 edition.

The Exhibiting Companies

About 350 dental Companies from all over the world showed their latest innovations at Rimini Fiera, with a large commitment in terms of wonderful booths, strong promotion of the event, organization of workshops, hands on and leisure activities. The International Buyers Programme, thanks to the cooperation between UNIDI and ICE/ITA (Italian Trade Agency), brought in Rimini 85 highly qualified dealers from 24 Countries to meet the Italian Companies in more than 1.400 targeted B2B meetings, with an increase of 10% over the last edition. Italian Companies and foreign dealers are more and more interested and involved in this project, and this means that Expodental Meeting is an important hub for internationalization.

Science and Innovation

Bringing together a wide range of professional associations, scientific organizations and universities in a single cultural program, Expodental Meeting represented a unique opportunity of scientific updating for the Italian oral care professionals: 12 training rooms with 40 clinical and extra-clinical events, ECM courses, more than 120 high-level international speakers and more than 25 workshops by the Exhibitors. With the EXPO3D project, a particular attention was payed to the latest innovations of digital dentistry: the EXPO3D area, at the entrance of the venue, was dedicated to scientific lectures focused on the digital workflow realized in partnership with dental associations and academic experts, and a programme of table clinics and hands on, realized with the cooperation of the Industry and a pool of young speakers.

Not only business

Besides the extra-business initiatives organized by the Exhibitors – contests, happy hours, parties, etc. – UNIDI celebrated its 50th anniversary on Friday night with an happy hour by offering to the Exhibitors and Visitors before the closing time, accompanied by an acrobatic performance inspired by Fellini's circus. Even though the bad weather stopped the complete development of the show, it was a nice opportunity for UNIDI to celebrate with the exhibitors and Visitors of Expodental its very important birthday: form 1969 the Association represents the Italian Dental Industry – one of the world leaders, among the first for volume of business, technological innovation and exports – and gives an important contribution to this sector with the organization of Expodental.

See you at Expodental Meeting 2020, in Rimini from May 14th to 16th.

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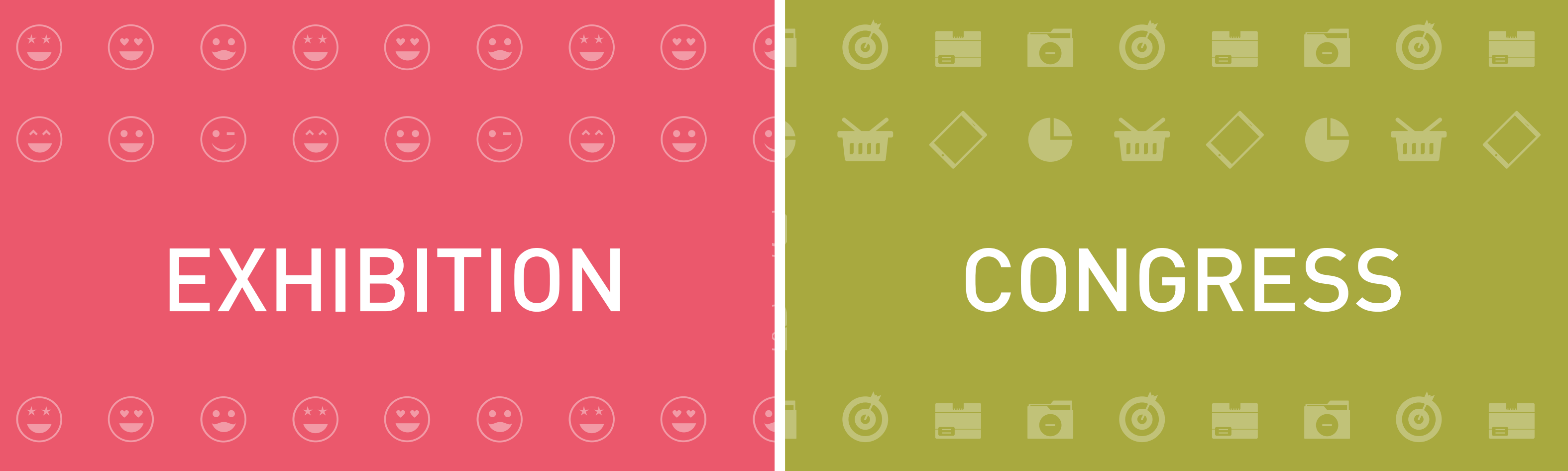

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Save the date!

	USA	CANADA
Total Population, 2019	329.1 million	37.2 million
GDP per capita, current US$ (2018 World Bank)	62,641	46,124
Total Health Expenditure as % of GDP (average est.)	17.9%	11.1%
Health Expenditure per capita, US$	9,536	4,508
Total expenditures on dental services, US$	124.4 billion	13.6 billion
Total per capita spending on oral healthcare, US$, est.	378.60	351
Dentists	196,441	21,109
Population/dentist ratio	1,000 / 0.6	1,622 / 1

Oral Health at a Glance, Canada & USA

Author: Silvia Borriello
silvia.borriello@infodent.com

Canada

"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."

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.** 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.

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.

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	USA
19.1%	22.6%

Source: World Health Statistics (WHO), 2018

Almost all essential basic care is publicly covered, including primary care physicians, specialists and hospital services. **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. 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 around 67% of Canadians buy it to cover for noncovered benefits (e.g. private rooms in hospitals, pharmaceuticals, dental care, optometry etc.). 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%).

Private insurance in Canada is therefore complementary and around 67% of Canadians buy it to cover for noncovered benefits (e.g. private rooms in hospitals, pharmaceuticals, dental care, optometry etc.).

Oral Health - 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 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 maintenance services and root canals, periodontal cleaning and scal-ing. It may also extend to major restorative procedures, such as crowns, bridges, dentures, braces 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.

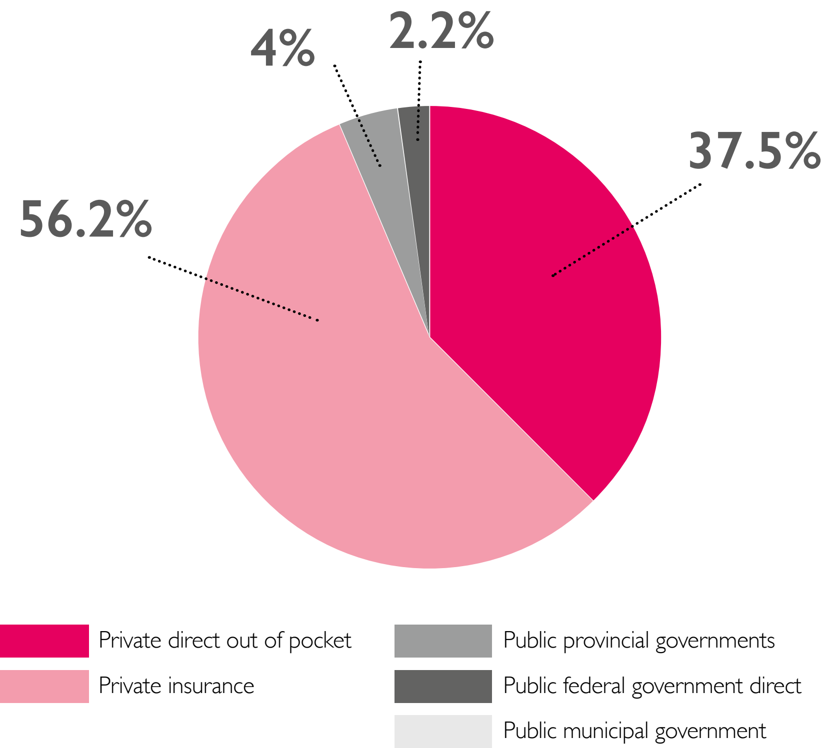
PERCENTAGE OF POPULATION VISITING DENTIST IN PAST YEAR

	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.



Private direct out of pocket
Private insurance
Public provincial governments
Public federal government direct
Public municipal government

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/)*

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.

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.

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*

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. **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%).

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/

COMPARATIVE HEALTH INDICATORS, 2016

	CANADA	USA
Life expectancy at birth (years)	82.8	78.5
Healthy life expectancy at birth (years)	73.2	68.5
Prevalence of obesity (BMI>30)	26 % (2014)	38 % (2014)
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%

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

USA

"Thus, the United States has a unique healthcare system unlike any other in the world. While most developed countries have healthcare systems that offer coverage as a right of citizenship, not all Americans are automatically covered by health insurance"

The U.S. has a federal system of government, with substantial authority delegated to its regional governments – the 50 states – and a historical reluctance regarding central planning or control either at federal or state level. Its healthcare system reflects this wider context, having developed largely through the private sector, and combining high levels of funding with a distinctively low level of government involvement.

Private sector stakeholders play a stronger role in the US healthcare system than in other high-income countries; the private sector led the development of the health insurance system in the early 1930s, with the major federal government health insurance programs, Medicare and Medicaid, only arriving in the mid-1960s. **Medicare provides coverage for seniors and some of the disabled and Medicaid covers healthcare services for some of the poor and near-poor. There is also a combined federal and state funded Children's Health Insurance Program (CHIP), which offers coverage to children in low-income families.** Both public and private payers purchase healthcare services from providers subject to regulations imposed by federal, state and local governments as well as by private regulatory organizations. **Thus, one main feature in the U.S. healthcare system is its fragmentation as different people obtain healthcare through different means.**

International comparison shows a varied picture with respect to health quality and outcomes, though, with very good indicators for some diseases (e.g. certain cancers) and poor ones for others (e.g. asthma). As to health behaviors, the picture is again varied; the United States has been notably effective in reducing smoking rates but equally ineffective in grappling with nutritional health and obesity.

As to health behaviors, the picture is again varied; the United States has been notably effective in reducing smoking rates but equally ineffective in grappling with nutritional health and obesity.

Most Americans (around 60%) still receive their coverage from private health insurance. Public programs cover just over 30% of residents; unusual for high-income countries is the high number of people completely lacking health insurance, although this is expected to be gradually reduced thanks to the implementation of the Affordable Care Act (ACA) in 2014.

Prior to the enactment of the ACA there had been several unsuccessful efforts to provide universal health coverage and the Patient Protection and Affordable Care Act, although controversial, constitutes the most significant health reform in the United States since Medicare. Improving coverage is a central aim, with the ACA introducing a requirement for nearly all individuals to have some form of health insurance. Improved coverage is envisaged through both the public and private sectors. Among the measures, subsidies are provided for the uninsured to purchase private insurance (there is no government-provided healthcare delivery option) and in some states, more low-income people will obtain coverage through expanded eligibility for Medicaid. The ACA also addresses underinsurance, providing greater protection for insured persons from their insurance being too limited in scope, inadequate in coverage or even being cancelled once they become ill.

SOME ACA RESULTS SINCE IMPLEMENTATION

• A 2018 government report saw 11.8 million Americans re-enrol in Obamacare plans, and 27% were new users. It was around 400,000 fewer people than in 2017.

• Average premiums have nearly doubled since 2014.

• A Gallup poll earlier this year found 55% of Americans worry "a great deal" about accessing and affording medical care - the fifth year in a row that healthcare has topped the issues list.

• Gallup also reported the adult uninsured rate had dropped to a record low of 10.9% in 2016, but has since risen to 12.3% post-Trump.

WHAT DOES THE EXISTING LAW DO?

The Patient Protection and Affordable Care Act, known as Obamacare or the ACA, was the largest overhaul of the US healthcare system since the 1960s.
It aimed to eventually slow the growth of US healthcare spending, which is the highest in the world.
Obamacare intended to extend health insurance coverage to the estimated 15% of Americans who lacked it and were not covered by other health programs for the poor and elderly.
The law created state-run marketplaces - with websites akin to online shopping sites - where individuals can compare prices as they shop for coverage.
Some of the more popular provisions include:

• Children can stay on their parent's healthcare plan until age 26
• No one who is sick or has a medical condition can be denied insurance
• Companies can no longer charge women more than men
• Businesses with more than 50 full-time employees must offer health insurance

Extract from: BBC News, for full article, visit: https://www.bbc.com/news/world-us-canada-24370967

Public financing sources constitute around 48% of healthcare expenditures in the U.S., private third-party payer sources 40%, with the remaining 12% being paid by individuals out-of-pocket. **Even though the proportion of public and private spending on healthcare is roughly comparable, only a minority (30%) of the United States population is covered by the public financing system – mainly through Medicare and Medicaid.** Medicare is financed through a combination of payroll taxes, premiums and federal general revenues. Medicaid is a tax-funded, joint federal-state health insurance program administered by the states, within broad federal guidelines. Even among those with coverage, high out-of-pocket costs can be a barrier to receiving timely care and medications; Out-of-pocket (OOP) payments (e.g. direct payment by consumers for health services, coinsurance, co-payments, and deductible amounts) per capita have increased substantially in real terms in recent years. The average national health expenditure as percent of GDP is around 17.9%. According to estimates it is expected to rise to $4.5 trillion by end 2019, comprising 19.3% of GDP.

• In 2016, % of all persons 2 years of age and over with a dental visit in the past year was 68.7

• Dental services expenditure: 62 billion USD (2000) - 124.4 billion USD (2016)

• 57 accredited dental schools in the United States.

• U.S. spends far more money on healthcare per head than any other country – 53% more than the second-highest country, Norway.

• The U.S. ranks near the top in out-of-pocket spending among high-income countries

• Medical costs are responsible for over 60% of personal bankruptcies in the country

Oral Health - Overall, dental insurance coverage is less prevalent than medical insurance in the US. Nearly 60% of adults age 21-64 have private dental coverage, 5% public dental coverage and more than 35% have no dental coverage. Among elderly Americans, traditional Medicare is not a source of dental insurance, therefore almost 70% of Americans aged 65 and older do not have dental coverage. Among adults with low incomes, Medicaid is the primary vehicle for oral healthcare, but while Medicaid programs cover comprehensive dental services for children, states have flexibility to determine what dental benefits are provided to adults. Consequently, there is a wide variation among states in the types of dental services and the degree of coverage offered to adult enrollees.

Medicare only pays for a small fraction of dental care because it only covers dental care when it is linked to the treatment of a medical problem. The remaining 94% of dental care financing is from private sources, 53% of which is from dental insurance and the rest from OOP payments. Americans may receive dental care in private settings, for which they must have dental insurance or pay for out-of-pocket, or in community settings, where they pay a sliding scale fee for the service. Community-based clinics form the dental safety-net for those with limited incomes. Thus, oral healthcare services are predominantly funded by the private sector. The largest source of financing is through private health insurance (48.6% of total oral healthcare expenditure), followed by out-of-pocket payments (41.6%). **The proportion of total healthcare expenditure allocated to oral healthcare is roughly around 4.0%, amounting to approximately US$ 351 per capita.**

In 2016 there were 196,441 professionally active dentists, 90% of which private practitioners, and around 127,033 dental offices. The dentist/population ratio is 0.6/1000 population. The final authority on dentists' licensure requirements is the individual state. Though requirements vary from state to state, all applicants for dental licensure must meet an education requirement, a written examination requirement and a clinical examination requirement. The US also recognizes dental hygienists, dental assistants, denturists and dental laboratory technicians.

Overall, dental insurance coverage is less prevalent than medical insurance in the US. Nearly 60% of adults age 21-64 have private dental coverage, 5% public dental coverage and more than 35% have no dental coverage.

Group practices (including dental chains) and dental practice management companies (DPMCs-large companies providing services for multiple dental offices, lowering operational costs) are on an increasing trend while single-owner practices are declining. In just two years the number of large dental group practices rose 25 %. In 2008 solo dentist practices accounted for 92 % of all dental practices (very large group practices with 20 or more dentists made up only 3 %). In 2010, 69 % of dentists were solo practitioners and the trend is continuing. Such decline is due to a slow-down in revenues due to high operating costs. Corporate practices have competitive prices, the ability to provide care to walk-in patients (populations in traditionally underserved and working-class areas often do not have steady sources of income and find it difficult to set up appointments weeks ahead of time) and accept government insurance (financing fixed costs and reimbursement).

Also, the practice patterns of new dentists have changed; driven by efficiency and increased competition. Fewer than 20% of graduates are seeking practice ownership.

In 2016, 68.7% of Americans over the age of 2 years received dental care at least once in the past year. However, when broken down by age group, an increase in utilization occurred in children under 18 years and in adults older than 64 years, but a decrease occurred in adults aged 18–64 years. The dental health of older adults, which in the past was poor, has improved over the past 50 years. Access to dental care varies by age, income, insurance status, race, ethnicity, socioeconomic status, geographical location and special needs. In particular, Medicaid beneficiaries, the uninsured, the "working poor" and underserved minorities are more likely to have access problems. In a 2010 national household survey 13.3% reported that they had neglected dental care in the last 12 months due to costs (Centers for Disease Control and Prevention, 2011a). The percentage was higher (18–20%) among working adults. Among those below the poverty line who were uninsured up to or over 12 months, it was 34% and 44% respectively. Safety-net clinics provide much of the care for underinsured or uninsured individuals but these clinics "have limited resources and only modest capacity to provide dental services".

ORAL HEALTH PERSONNEL DENSITY PER 1000 POPULATION (2010)

Dentists	0.6
Dental hygienists	0.46
Dental assistants	0.97

Waiting times are long. The clinics provide less than 5% of total dental care. Public insurance, such as Medicaid and the CHIP, removes some of the financial barriers to dental care for a portion of the population. Medicaid coverage of dental services for adults varies by state, but under federal law, Medicaid must cover dental services for children. CHIP programs receiving expansion funds from Medicaid must also cover these services. However, private dentists may refuse to provide care to these beneficiaries due to low payments and other reasons, and safety-net clinics are over capacity. Despite these difficulties, a child with one of these forms of public insurance is more likely to see a dentist than one who is uninsured. Access to dental care through the safety-net clinics does not guarantee that all needed services will be provided. Often, the clinics cannot provide specialized services and referrals to specialists outside the clinic are difficult to make. Again, this appears to be due to private dentists' unwillingness to treat lower income patients.

MAIN U.S. DENTAL EQUIPMENT & SUPPLIES EXPORTS (USD)

PARTNER	YEAR 2016	YEAR 2017
WORLD	**1,193,687**	**1,154,318**
Canada	185,524	202,833
Japan	179,396	158,026
Germany	121,479	128,923
China	106,496	91,505
Korea	84,588	83,977
Mexico	50,599	52,508
Taiwan	50,838	39,947
Hong Kong	53,578	35,411
Australia	34,379	33,502
Russia	21,944	29,012
Switzerland	23,797	24,744
United Kingdom	29,116	23,920
Singapore	25,686	19,509
France	17,004	18,679
Spain	12,372	18,075
Netherlands	13,639	15,564
Italy	12,198	11,224
Colombia	6,732	7,391
India	6,389	7,322
Brazil	5,681	6,789
Israel	6,720	5,824
Costa Rica	3,112	4,531
Czech Republic	3,350	3,810
Argentina	2,650	2,575
Iran	1,759	2,346

Source: U.S. Department of Commerce

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/

All figures are estimates, taken and/or compared from different sources.They only have the aim to give a general and comparative outlook on health and/or dental care.

Among Main Sources:

*Extracts from "A comparative analysis of oral health care systems in the United States, United Kingdom, France, Canada, and Brazil", Daniela Garbin Neumann*1 and Carlos Quiñonez2*
Garbin Neumann NCOHR Working Papers Series 2014, 1:2. For full report: http://ncohr-rcrsb.ca/knowledge-sharing/working-paper-series/content/garbinneumann.pdf
-Extracts from: Rice T, Rosenau P, Unruh LY, Barnes AJ, Saltman RB, van Ginneken E., United States of America: Health system review. Health Systems in Transition, 2013; 15(3): 1– 431.
https://www.statista.com/statistics/186273/number-of-active-dentists-in-the-us-since-1993/
-Extracts from "The Canadian Health Care System", The Commonwealth Fund - https://international.commonwealthfund.org/countries/canada/
-The Government of Canada, for details on health-care: 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 Canada", Canadian Dental Association, https://www.cda-adc.ca/stateoforalhealth/
https://www.cda-adc.ca/stateoforalhealth/snap/
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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/PIIS0140-6736(18)30181-8/fulltext

Oral Health At A Glance, United Kingdom

Population (million)	66.02
GDP per capita (USD)	38,886
Health expenditure as % of GDP (average)	9.9%
Share of dental expenditure on total health expenditure (average)	6%

Based on developments that took place during the Second World War, particularly the Beveridge Report, which called for comprehensive healthcare as part of a postwar government plan, the Labour Government established the UK's National Health System (NHS) in 1946. **The NHS provides preventive medicine, primary care and hospital services largely free at the point of use to all those "ordinarily resident". Some healthcare is however funded privately, through private insurance, by user charges for NHS services and by out-of-pocket payments for items such as over-the-counter drugs and medical appliances.** Approximately 12.3% of the UK population has private insurance and the dominant form is supplementary but, private insurance coverage is, in general, narrower in scope than the comprehensive coverage offered by the NHS.

- **The National Health System (NHS), largest employer in the United Kingdom**
- **Historically, the U.K. has employed health workers from Commonwealth countries and the EU and there has been intensive international recruitment**
- **The U.K government allocates money for healthcare in England directly, and allocates block grants to Scotland, Wales and Northern Ireland which in turn decide their own policy for healthcare**

Oral Healthcare
Dentistry was included in the NHS at its inception, to assure that the whole population would be entitled to oral healthcare. **However, because of the huge amount of unmet need, it became rapidly apparent that the dental service was a threat to the affordability of the NHS and patient charges were introduced in 1951, although hospital and community oral health services remain free at point of use.** Oral healthcare in the UK is in fact delivered in three ways: ambulatory services (general dental services), to meet most oral health needs, are delivered in independent practices; secondary and tertiary dental services, for difficult problems, are delivered in acute hospitals (and some single-specialty hospitals); and community dental services, such as screening of schoolchildren, oral health promotion and dental services for patients with special needs are provided in community settings, the patient's own home and nursing homes.

- **Share of dental expenditure on total health expenditure (average), 6%**
- **% of Oral Health expenditure private (average), 54%**

Access to a NHS general dental practitioner (GDP) is, in principle, available to all. NHS charges are about half or less of that which is paid privately. In many parts of the UK however, access to NHS dental care is difficult, therefore "Access Centres" staffed by salaried GDPs and Public Health Dentists (PHDs) offering clinical services at NHS charges are available.
Individuals are entitled to immediate access to urgent oral healthcare when required and also have the right – subject to a set of co-payments – to all clinically necessary treatments. **Treatment considered necessary to dental health can include: dentures, root canal treatment, crowns and bridges, preventive treatment, white fillings, and orthodontic care (for under-18s). Individuals are entitled to these under the NHS but may choose to receive them in both private and NHS settings.** Local commissioning groups must ensure that NHS dental care is available within the geographic area for which they are responsible. Dentists may subcontract their work, which results in some dentists being providers (they contract with the NHS), providing performers (they contract with the NHS and deliver services) and performers (they deliver services but do not contract with the NHS). Most GDPs treat patients both within the NHS and privately.
Thus, patients may choose to receive a mix of private and NHS treatment within the same episode of dental care (known as "mixing"). Often, basic treatment is carried out within the NHS and more advanced treatment, involving the use of more expensive materials, privately. **The effect of an increased expenditure by patients in the private sector and the high proportion paid by them as dental charges when obtaining treatment in the NHS, means that patients in the UK are funding 54% of all spending on oral healthcare, with 46% being publicly funded.** About 75% of private oral healthcare expenditure is made up by out-of-pocket payments and 25% by private dental insurance. Children under 18 years old, pregnant and nursing mothers, individuals on welfare benefits, individuals under 19 years old in full time education are entitled to free oral care within the NHS. The remainder of the population receives subsidized care where prices are regulated within a national framework of patient charges with three charging bands: band 1 – includes examination, diagnosis, preventive care and urgent care; band 2 – includes all treatment covered under band 1 plus additional treatment such as fillings, root canal or extractions; and band 3 – includes all necessary treatment covered under band 2 plus more complex procedures such as crowns, dentures or bridges. Per capita public spending on oral healthcare in the UK has grown over the last twenty years, reaching US$141.23.

All dentists who wish to practice in the UK must be registered with the Gen-

- **Mixture of publicly and privately funded oral healthcare**
- **Publicly funded either in relatively small number of public service clinics or in private clinics where owners contract with the state**
- **Free of charge to all under 18 years of age and "special groups"**
- **Widespread and increasing use of team dentistry**
- **Growing numbers of dental hygienists, dental therapists, dental nurses. Also, clinical dental technicians and orthodontic nurses all are registered**

Individuals are entitled to immediate access to urgent oral healthcare when required and also have the right – subject to a set of co-payments – to all clinically necessary treatments.

Number of registered dentists (2015)	39,258 (Percentage female 45%)
Active Dentists (estimated)	Between 33,000 – 34,638
Active dental offices (2015)	11,800
Population to (active) dentist ratio (2015)	1,630
Membership of the British Dental Association (BDA)	57% (active dentists)
Technicians	7,656
dental labs (dentists' & commercial labs, 2015)	2,080
Dental hygienists (2010)	5,545
Dental assistants (2010)	42,700
Dental therapists (2010)	1,393
Denturists (2010)	120
No. of dental dealers (2015)	60
No. of Dental schools	16

** All figures are approximate, varying year by year, taken and/or compared from different sources.*

eral Dental Council (GDC). In 2015, there were 39,258 registered dentists and almost 90% of them were carrying out NHS activity in primary care settings. Dental auxiliaries or Dental Care Professionals (DCPs) also must be registered with the GDC. There are seven types of recognized dental auxiliaries: dental nurses (dental assistants), dental hygienists, dental therapists, orthodontic therapists, dental technicians, clinical dental technicians (denturists) and oral health educators. In the UK, dental hygienists may only work under the direction of a dentist, who must prepare a treatment plan, but need not be on the premises during treatment.

On average, about 60% of adults and 70% of children (0-18 years) see GDPs for continuing care annually. According to an oral health survey on 12-year-old children conducted during the school year 2008/9, 33.4% of children were found to have experienced caries. Across the whole of the population examined the average number of DMFT per child was 0.74 but it is important to consider that the mean DMFT among those children who were found to have disease (i.e. DMFT > 0) was 2.21. As regards adult oral health, the 2009 Adult Dental Health Survey showed that only 6% of the adult population (16 years and older) were edentate in the UK. At the same time, 31% of dentate adults had tooth decay and 85% had at least one filled tooth. In terms of access to and utilization of oral health services, 64% of the population had visited a dentist less than one year ago. Also, the survey showed that of those adults who had tried to make an NHS appointment in the previous three years before the survey, the vast majority successfully received and attended an appointment. The NHS remains the dominant provider of oral health services, however, there has been a gradual increase in the number of people receiving private dental care, partly because the NHS contract, introduced in 2006, reduced the number of dentists providing NHS services.

While dental health has improved considerably over the last fifty years, there is still a social class difference in oral health. Around 10% of the population receives fluoridated water in England, but the Department of Health is providing extra funding to increase coverage. Fluoridation is not provided elsewhere in the United Kingdom, although there is one area in Scotland where it occurs naturally.

Among Main Sources:

*- Extracts from "A comparative analysis of oral health care systems in the United States, United Kingdom, France, Canada, and Brazil", Daniela Garbin Neumann*1 and Carlos Quiñonez2*
-Extracts from the "EU Manual of Dental Practice". For full and detailed report: http://www.cedentists.eu/library/eu-manual.html
-Cylus J, Richardson E, Findley L, Longley M, O'Neill C, Steel D. United Kingdom: Health system review. Health Systems in Transition, 2015; 17(5): 1–125.

See you at the ADA FDI World Dental Congress in San Francisco this 4-8 September 2019!

It's been more than 20 years since FDI World Dental Federation has met in conjunction with the American Dental Association (ADA) Annual Meeting. That all changes in 2019.

Make plans now to attend the ADA FDI World Dental Congress 2019 at the Moscone Center in San Francisco, California, this September. We look forward to seeing you there!

This year, the ADA FDI World Dental Congress will strengthen ties and foster collaboration within the global oral health community. Held under the theme Be part of something extraordinary, the 2019 Congress offers a unique opportunity to meet with leaders within the oral health profession from around the globe. Combined, FDI and the ADA represent over one million oral health professionals in 130 countries. This year's historic joint meeting brings together these two organizations that influence health policy, affecting billions of patients worldwide. The Opening Ceremony and General Session will spotlight how we all succeed by working together toward achieving optimal health for every human being.

To advance the art and science of dentistry, this annual event delivers a cutting-edge scientific programme and interactive forums. Here's a snapshot of what you can expect at our Congress:

The World Oral Health Forum on Saturday, 7 September from 8:30-11:00. The subject will be Universal Health Coverage: The Good, the Bad and the Necessary for Oral Health. A set of international speakers will debate the evidence, strategies, and solutions that are essential to stop governments from neglecting and marginalizing oral health and provide a roadmap for making optimal oral health a global aspiration and an essential component of universal and primary health packages.

Don't miss our Hot-Topic Sessions:

- **COURSE 5169 Hot Topic Session:** Latest Clinical Approaches on Pediatrics: Focused on the global epidemic of early childhood caries (ECC) and innovative ways to prevent ECC and promote children's oral health.

- **COURSE 6170 Hot Topic Session:** Using High Technology Tools and Materials in our Daily Practice: Will delve into the advantages and disadvantages of using high technology tools and materials in the daily dental practice.

The Congress also offers a dental exhibition attended by the most prominent figures in the dental industry.

The dental profession and the dental industry are essential partners in delivering oral health to populations around the world.

Bridging the gap between the two is even more important today, as new materials and technology are developed to accommodate the latest treatment philosophies.

As they tour the exhibition hall, attendees are also encouraged to visit the FDI booth.

Here, visitors are welcome to learn more about FDI's oral health advocacy activities and browse FDI's recently released publications, which cover topics from improving access to endodontic care around the world to establishing a long-term care plan for partially dentate patients.

Every element is in place to deliver an event that serves to strengthen ties between oral health professionals, industry innovators and committed stakeholders to raise the voice of the oral health community and advance the practice of dentistry worldwide.

Remember, the Congress will held in San Francisco, California, at the Moscone Center from 4—8 September 2019. The meetings will take place in all three buildings at Moscone Center – North, South and West.

The address of the center is 747 Howard Street, San Francisco, CA 94103.

Don't delay – register today!

4–8 September 2019 Moscone Convention Center

3 DAYS OF EXHIBITION	**SCIENTIFIC PROGRAMME**
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MORE THAN 1,300 STANDS	200 WORLDWIDE SPEAKERS
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Early-bird registration deadline	**30 April 2019**

www.world-dental-congress.org

FDI Experts Publish Guidance On Antibiotic Stewardship In Dentistry

27 June 2019 Antimicrobial resistance - FDI experts Dr Susie Sanderson OBE and Professor David Williams recently authored a piece on the need for global guidance on antibiotic stewardship in dentistry. The article is published in AMR Control, the leading annual review on antimicrobial resistance (AMR).
Dr Sanderson is FDI speaker and immediate past president of the British Dental Association; Prof. Williams is co-chair of the FDI Vision 2020 Think Tank and the FDI Vision 2030 Working Group, as well as professor of global oral health at Queen Mary University in London.

The authors assert that dentists should be involved in the development and implementation of national action plans to counter antibiotic resistance, as they prescribe almost 10% of all antibiotics.

They say that to optimize the use of antibiotics in dentistry, there needs to be global attention on stewardship policies that are achievable and consistently disseminated.

What is antimicrobial resistance?
AMR is a major threat to human health and security. Some countries have reported that more than 42% of infections are resistant to common antimicrobial therapies. Moreover, these microbes do not recognize borders between countries or sectors. One of the major drivers of AMR is misuse and overuse of antimicrobials.

Thus, prudent prescribing of antimicrobials by healthcare providers is critical to slow the emergence of resistant infections. In addition to antimicrobial stewardship, the Global Action Plan on AMR calls for strengthening in four other strategic areas, including awareness and understanding, surveillance, infection prevention and control, and sustainable research and development. Fulfilment of these objectives is paramount for preventing transition into a post-antibiotic era.

What can dentists do in the fight against antimicrobial resistance?
Dentists have a role to play in this battle, particularly by reducing and improving the way to prescribe antibiotics. They are too often prescribed without real indications, sometimes under the pressures of patients. Dentists have a responsibility to educate patients about the spread and consequences of AMR.

For full ADA FDI Congress Schedule: www.eventscribe.com/2019/ADA/agenda.asp?pfp=FullSchedule

LEARN MORE

FDI is organizing a special session on AMR at the ADA FDI World Dental Congress in San Francisco in September. If you are attending, make sure you register for the session.

"The Role of Dentists and Dental Teams in Mitigating Antibiotic Resistance"

Friday 6 September • 13:30-14:00

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Henry Schein® Orthodontics™ presents 5th Annual European Carriere® Symposium in Barcelona

The Event Will Demonstrate the Sagittal First Philosophy and the Latest Innovations to Help Orthodontists Achieve New Levels of Patient Care and Practices Efficiencies and Effectiveness, Featuring Keynote Speaker, Dr. Luis Carrière

Henry Schein Orthodontics™, the orthodontics business of Henry Schein, Inc., is pleased to announce its 5th Annual European Carriere Symposium that will take place from 19 to 21 September 2019 in Barcelona, Spain, at the W Barcelona hotel.

The Symposium will focus on the evidence-based Sagittal First™ Philosophy powered by the Carriere® Motion 3DTM Appliance, feature the latest tools and technologies to help operate a more efficient and productive orthodontic practice, and raise awareness about solutions that can help make a total-health difference in patients' lives. Renowned speakers will share proven strategies that have shown to increase clinical efficiency, shorten treatment time, and help achieve extraordinary long-term results and happier patients.

Keynote speaker will be Dr. Luis Carrière, the inventor of the Sagittal First Philosophy. He will be supported by the programme chairman, Dr. Dave Paquette, who is also Henry Schein Orthodontics' lead clinical advisor.

Additional speakers include amongst others:

- Dr. Ana-María Cantor
- Dr. Peri Colino
- Dr. Christy Fortney
- Dr. Francesco Garino
- Dr. John Graham
- Dr. Alvaro Larriu
- Dr. Jep Paschal

Attendees will leave this event with a comprehensive set of new tools to differentiate their practice, exceed patient expectations, and achieve new levels of exceptional clinical results.
In addition, networking will be available to allow participants the opportunity to share their experiences with other peer professionals from around the world.

As in prior years, the event is expected to sell-out, bringing together leading orthodontic speakers and forward-thinking attendees in a powerful learning environment.

To register, visit **www.CarriereSymposium.com**, email **CE@HenryScheinOrtho.com**, or call +1 760 448 8712.

About Henry Schein Orthodontics
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International VIP at the opening cerimony of the 10th International Congress of Italian Dental Associations

Improving the accessibility to the professional's office and to dental care as a whole; collaborating in order to find ways to make dental care affordable by everyone; teaching prevention techniques. These are the 3 goals to enhance dentistry set out by the main National and International dental associations, as in Italy as worldwide.

The opening cerimony to the 10th International Congress of Italian Dental Associations in Chia had the pleasure to welcome Kathryn Kell, President of the International Dental Federation (IDF) (as well as over a thousand subscribers from 100 different countries), Anna Lella, previous president of ERO, the European Regional Organization of IDF, Cheryl Watson Lowry, President of the Chicago Dental Society, Alice Boghosyan, President of the Illinois Dental Society, Raffaele Iandolo, President of the National Commission of the Dental Order, Roberto di Lenarda, president of the Italian Dental Dean, Luca Barzagli, Vicepresident of ANDI, Vladimir Sadovskij, the President of the Russian Dentistry Association, Gerhard Seeberger, President of the International Academy of Dentistry, and Fausto Fiorile, the President of AIO.

Even the main representatives from the Dentistry Federations of Bulgary, of Georgia, of Hungary and of Romania chimed in for a greeting. Seeberger, voted as the next president of IDF, highlighted how appropriate dental care is often out of the reach of anyone beloging to low-income households and how according to the World Health Association "each family should invest at least 10% of its income to provide for the health of its members".

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Henry Schein Sponsors 13th Annual Senior Dental Leaders Programme At Harvard University

Conference Forges Global Network of Senior Oral Health Leaders to Advance the Mission of a Cavity-Free World for Children

MELVILLE, N.Y., April 8, 2019 /PRNewswire/ -- Henry Schein, Inc. (Nasdaq: HSIC) demonstrated its commitment to expanding access to health care and developing high-level capabilities in oral health leaders from around the world by sponsoring the Senior Dental Leaders Programme for a 13th year. The six-day conference took place at The Westin Copley Place in Boston and included representatives from 10 countries who benefitted from leadership development training they can use to address oral health challenges in their communities.

First conceived in 2007 at King's College London by Professor Raman Bedi, DDS, the programme is attended by a diverse cohort from within the international dental community working collaboratively toward a cavity-free world for children, including dental policymakers, national Chief Dental Officers, representatives from non-governmental organizations, members of the clinical and academic communities, and other stakeholders.

During the conference, participants exchanged knowledge and research, shared best practices, and discussed strategies to meet oral health challenges facing people and communities in need. They also gained greater insight into effective team leadership and change management, scenario planning and public health innovation, and how the oral health landscape may change in the next decade.

During the conference, participants exchanged knowledge and research, shared best practices, and discussed strategies to meet oral health challenges facing people and communities in need.

Speakers included Dr. Bedi; Dr. Bruce Donoff, Dean of the Harvard School of Dental Medicine; Professor Jennifer Gallagher, King's College London; Dr. Marsha Butler, Vice President of Oral Health and Professional Relations, Colgate-Palmolive; and Dr. Conrado Barzaga, CEO of the Center for Oral Health.

The programme is organized by the Global Child Dental Fund, the King's College London Dental Institute, and this year's host, the Harvard School of Dental Medicine. Together with co-sponsor Colgate-Palmolive, Henry Schein has supported the event since its inception through Henry Schein Cares, the Company's global corporate social responsibility program.

This year, Henry Schein supported 12 delegates representing Australia, China, Colombia, Ethiopia, New Zealand, the Philippines, Portugal, Tanzania, the United Kingdom, and the U.S. Since 2007, nearly 200 oral health professionals have attended the programme, each of whom has returned to his or her community better

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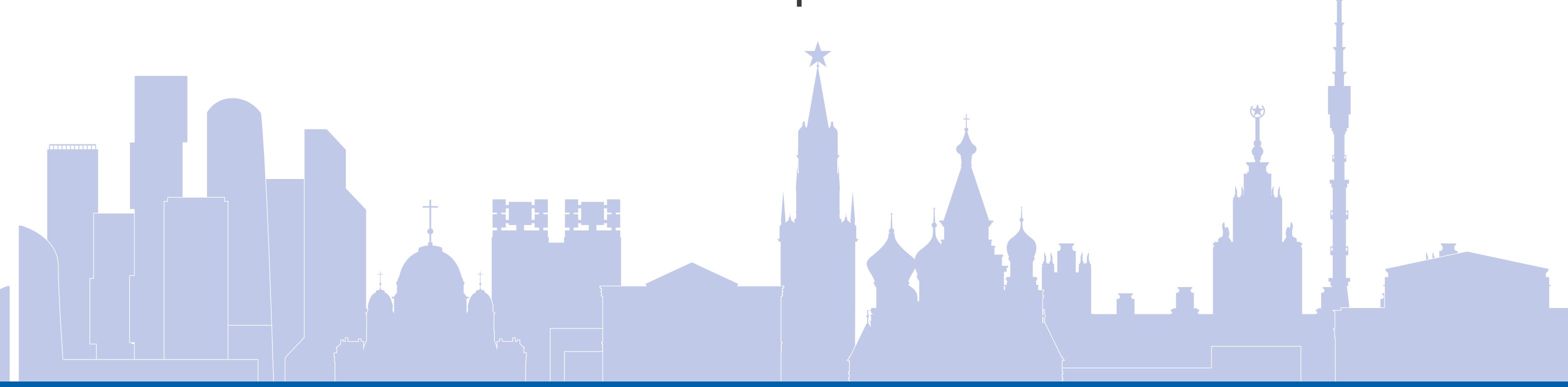

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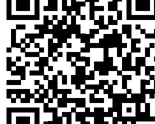

equipped to build partnerships and manage the change necessary to positively impact public health.

"Overcoming the oral health challenges facing our global community requires the commitment and resources of every segment of the dental community, and the Senior Dental Leaders Programme was created to foster the conversations, debate, and motivation needed to enact real change," said Stanley M. Bergman, Chairman of the Board and Chief Executive Officer of Henry Schein, Inc. "I am struck by the progress we have made during the past 13 years, and look forward to our future accomplishments. By working together and forging partnerships across borders, we are taking real steps to improve the oral health, and overall health, of children around the world."

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"Helping Health Happen Blog" is a platform for health care professionals to share their volunteer experiences delivering assistance to those in need globally.

To read more about how Henry Schein Cares is making a difference, please visit our blog: **www.helpinghealthhappen.org.**

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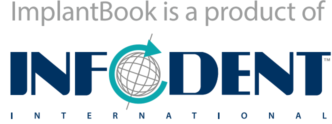

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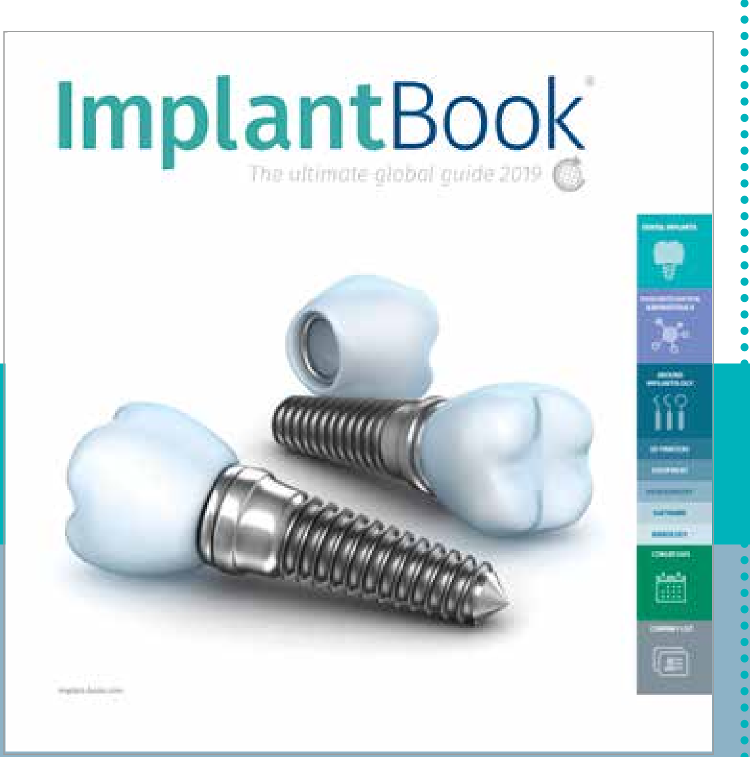

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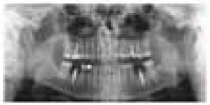

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Pre-endodontic restoration: a predicatble way to success

Long term success in endodontics is the result of various factors among which rubber dam isolation, predictable techniques of root canal cleaning, shaping and tridimensional sealing of the endodontic space.

Dr Daniele Natalini

Dr Daniele Natalini is a freelance dentist and in his dental office in Ancona - Italy - he deals with conservative dentistry, prosthesis and in particular endodontics. Since 2001 he is active member of SIE (Italian Endodontic Society) and for the biennium 2005-2009 he was SME President (SIE Regional Section of the Marches, Italy). Dr Natalini is speaker at numerous conferences and courses.

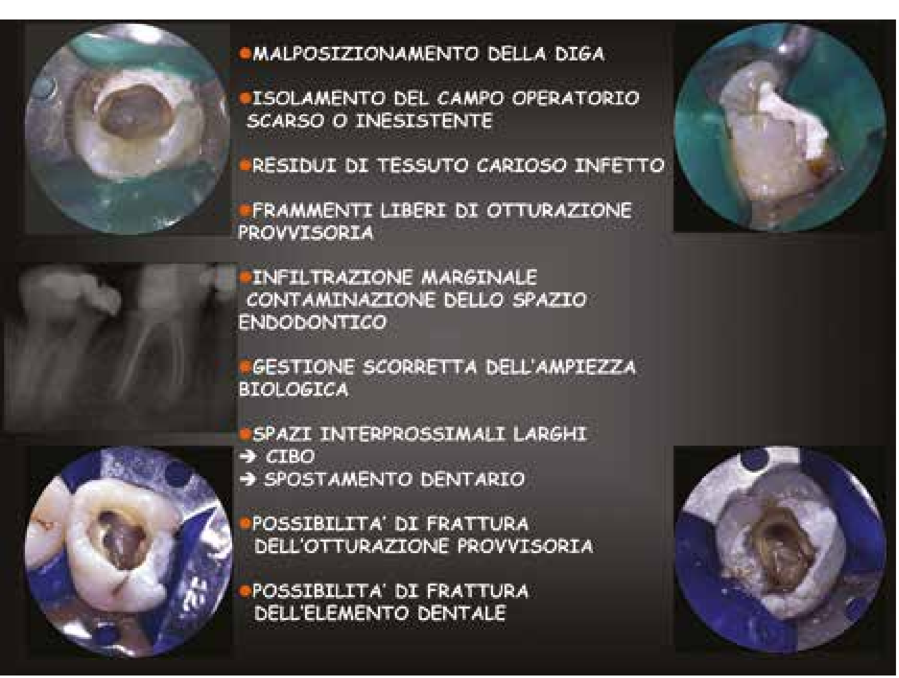

Fig. 1 This image translation and explanation are in the text.

Long term success in endodontics is the result of various factors among which rubber dam isolation, predictable techniques of root canal cleaning, shaping and tridimensional sealing of the endodontic space. Anyway, sometimes it seems endodontists forget that restoration of endodontically treated teeth is another determinant factor of this success. First because a faultless final restoration is the best way to prevent a bacterial micro leakage of the endodontic space and then because post endodontics restoration is a part of a whole rehabilitation of tooth for anatomy, function and periodontal tissues respect.

Furthermore, we well know that endodontic micro leakage could start since first steps of our endodontic treatments, reason why we should never start our intervention if we can't ensure a perfect isolation of our operating field. In my experience I never had problem to place rubber dam but sometimes, it can be hard to create perfect isolation in case of loss of a remarkable part of the tooth for caries or in case of complete or extended fracture. What makes difference is not only impossibility of a whole isolation at moment of treatment, but specially later, when endodontic system could be exposed to the bacterial activity if not well protected (for example with temporary restorative materials); in case of inadequate restoration protracted for a long period, we could also have critical issues for periodontal tissues, chewing function and mechanical strength of the element, including fracture of some other parts of the tooth not well sup-

ported by right materials like composite. All this issues could frustrate our efforts waiting for final conservative or prosthetic rehabilitation and create contamination of the endodontic space previously sealed. We should never allow that overflowing, not retentive and not sealing restorations violate periodontal space, cause bacterial leakage and food accumulation, expose the tooth to possibility of fractures and undermine masticatory function, especially if following appointments are scheduled at a long distance of time. (fig.1)

Considering all elements above and the importance of operating times and ergonomic in my private practice, I developed in years a systematic methodic to easily handle most of endodontic cases, from simple to complicated.

The ratio of this method is to achieve, from first visit, three goals: one, as mentioned, a fast and whole recovery of tooth; second, a firm and accurate endodontic working cavity, for visibility, straight access of instruments and to maximize irrigant solutions ability (fig. 2); third, saving time for final restorations, having already built a part of it. This is possible because of adhesion techniques with light curing (or in some case dual curing) composites that represent the state of art of modern conservative dentistry, thanks to their aesthetics and mechanical properties.
In this article we see two typical situations in which pre endodontic composite restoration can help endodontist to have a predictable way for success.

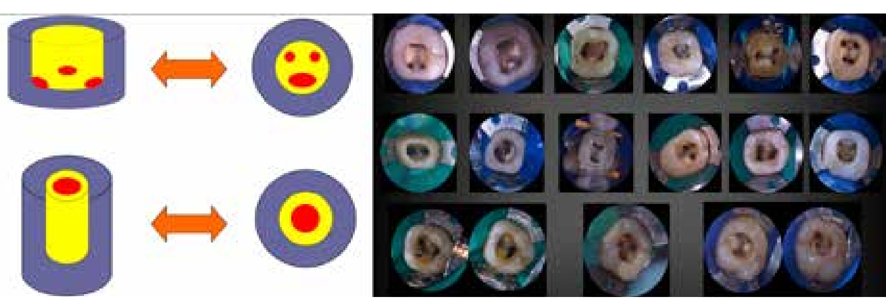

Fig. 2

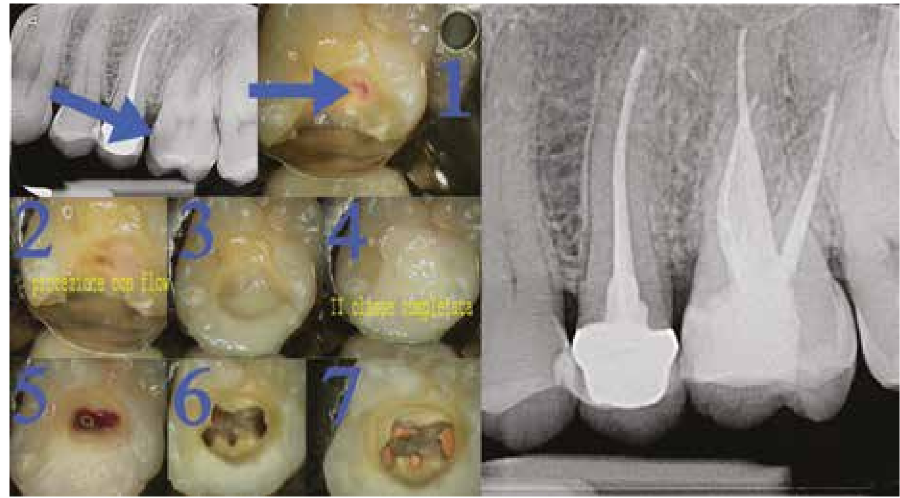

Fig. 3

Case A) (fig. 3) Very often, deep interproximal caries are not predictable to become a conservative or an endodontic treatment. My approach, even when radiographic exams can easily tell us a pulp involvement, is always to program a second class restoration. If, after complete carious tissue removal, there's no pulp chamber opening, we proceed with final composite restoration of II class.
If, at the opposite, there's a pulp opening and we decide that it becomes an endodontic treatment, we can immediately and temporary seal this opening with a piece of guttapercha, a flowable composite or other cement, to prevent blood contamination that would make our adhesion technique hard to reach, complete our second class restoration and then easily and quickly go inside the pulp chamber with a simple occlusal cavity of first class.

As opened this cavity, with maximum visibility, we can remove guttapercha, flow or cement previously placed, and go straight to canal access to make our endodontic treatment. If there's no time to proceed with endodontic treatment, it should be sufficient to open the cavity, remove pulp or a part of it, use a medication (very often not necessary), put a small cotton inside and close again with composite.

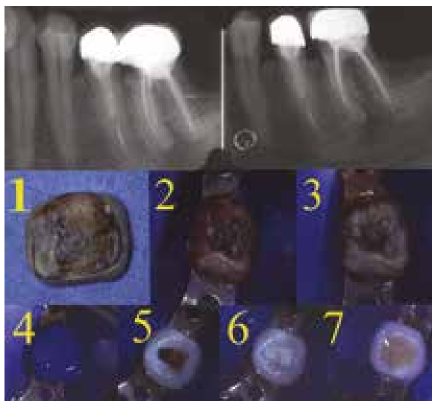

Fig. 4

All these procedures above mentioned would take exactly the same time of the second class we have planned and the advantages are well definite; patient can go with a "new tooth", ready to chewing function, no periodontal impairment and no pain because of pulpotomy; in second visit we can finish our endodontics with a simple first class access.

Case B) (figg. 3,4,5,6) Remarkable or whole loss of tooth structure (fracture, caries, very small cores under old crowns…).

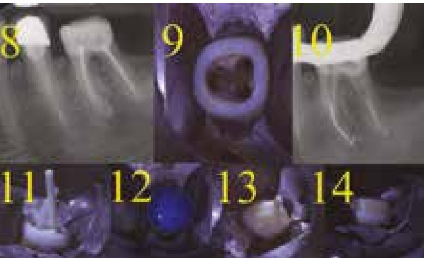

Fig. 5

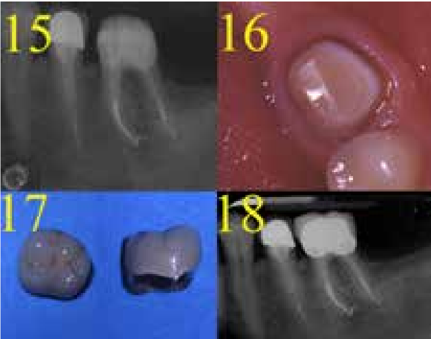

Fig. 6

In these cases, rubber dam isolation could be arduous and inefficient and even using "tricks" and expedients like liquid dam, just for time of our endodontic treatment, then problems of chewing function, of periodontal impairment and coronal micro leakage and aesthetics, in short and long-term temporization, remain.

Moreover, in teeth previously treated, we often find sclerotic or contaminated dentin that impose us a strict attitude towards adhesion techniques for our restoration. As in case shown, a valid alternative is to completely build, under rubber dam isolation, a new core or a "new tooth" in light-cure composite following adhesion protocol based on etching, primer and bonding steps; this model called "donut technique" aims to create a composite/tooth core exactly like a donut, with its "hole in the middle" ready for every endodontic procedures under visibility, straight access to the canal of our instruments and a wide and deep cavity for our irrigants.

The clinical case shown in pictures was very complex from the beginning, not only for periapical lesion but, above all, for complete destruction of coronal substance due to secondary caries under previous prosthetic crown, for residual sclerotic dentine and a small bone defect in the mesial part of the tooth testifying a periodontal suffering. By the way, after first isolation with rubber dam, thanks to a 9T clamp for incisors, very useful in molar prosthetic cores with conical shape, I easily had the way to realize my "composite donut" rigorously applying bonding protocol (etching, primer, bonding) followed by lite cure composite resin.

This permitted a second visit endodontic treatment, Nickel-Titanium instrumentation (Race FKG) finalized with complete tridimensional canal sealing, three glass fiber posts and dual curing composite core build up, inside and over the previous pre endodontic light curing composite restoration. Then, a final metal ceramic crown, fully prepared with intra-crevicular margins. As we can observe (fig. 7), follow up at 8 years proves complete healing of periapical lesion, prosthetic crown and core restoration stability and no impairment of periodontal health around the tooth. On the other hand, element 3.5 has been extracted because of root fracture and waiting for implant.

Fig. 7

CONCLUSION

Canal cleansing, shaping and tridimensional sealing, although basic steps of our endodontic treatment, must not be considered an end in itself; endodontist may first create proper conditions in order to make this procedures effective (visibility, aseptic, straight access for endodontic instruments), and pre endodontic restoration is a powerful methodic to obtain it. Furthermore, an accurate and meticulous pre endodontic restoration is a quick and safe way to restore periodontal health, aesthetics and chewing function; finally, is an ergonomically advantageous procedure that can make us save time for final prosthetic core or conservative restoration. Every endodontist shall consider this option and always have a 360 degrees vision of dental recovery procedures. "Think about everything, not only canals!".

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Prevention as the real well-being therapy: advanced technologies and tailor-made approach from concordance to compliance

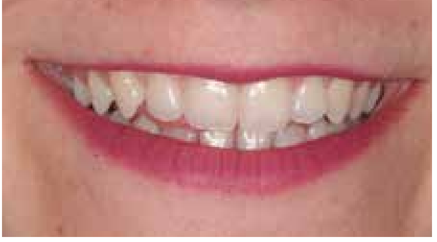
by Prof. Gianna Maria Nardi
Assistant professor MED 50
Scienze Odontostomatologiche e Maxillo Facciali Department - Università Sapienza di Roma
Qualification for full associate professor, academic area MED 50

Periodontal disease is a deceitful pathology because its progression often leads patient to underestimate symptoms like inflammation and bleeding of the gums. The blood-loss leads patients to ineffective dental plaque control, makes periodontium healthy status worse and alters oral microbioma.

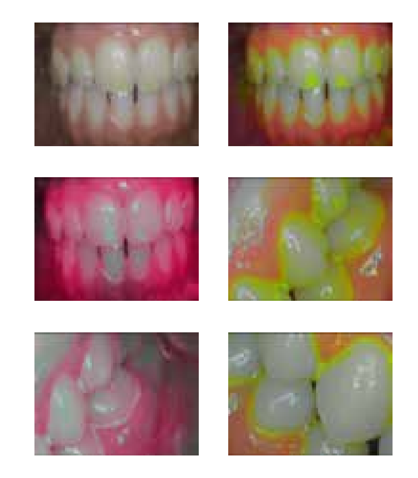
Patients go through check up when they are unable to treat themselves either because of spontaneous blood loss, dental mobility, or, in few occasions, of perceived halitosis because of lack of kindness (Gaurilcikaite et al., 2017).

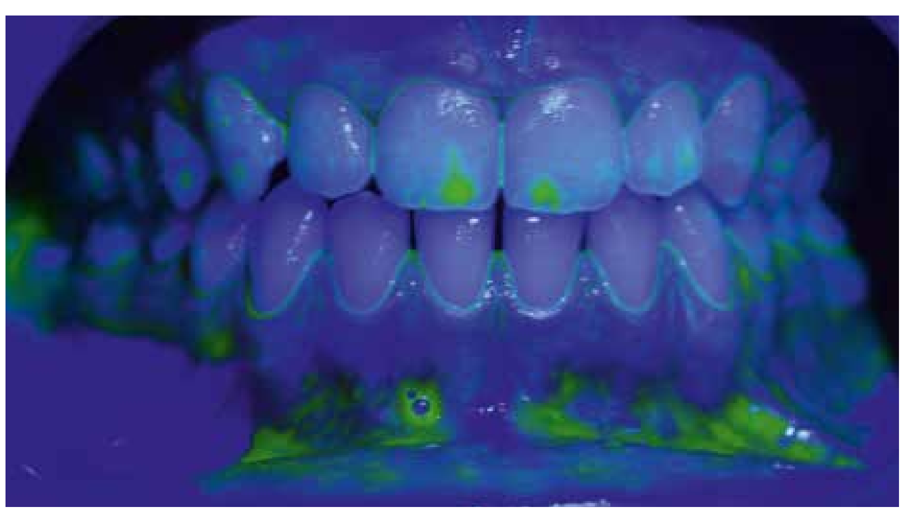
Prevention as **"true well-being therapy"** should be the first reason for professionals to urge their patients to face follow-up, with customised protocols, based also on the systemic conditions. The prevention culture needs to consider the lifestyle risks which are defined as dangerous by scientific evidence. In addition, the professional clinician must adapt prevention therapies to the concordance approach, due to the dynamism of periodontal disease. The concordance approach is based on an exchange of information that respects the autonomy of individuals in taking decisions about their own lives. This produces the sharing of power in the professional-patient interaction. It is expected from this approach to lead to an effective compliance and, therefore, adherence to the treatment.

The important role of research is to validate the advanced technologies through which it is possible to suggest effective operational and least invasive protocols, however also the clinical evidence, and also recent technologies need to be considered. The main goal of the **tailor-made** approach is selecting the most suitable technology for every clinical condition: this helps the professionals in the non-surgical periodontal disease treatment field in carefully observing anatomical and tissue characteristics, potential pathologies, and any other characteristic of the surface to be treated, allowing, therefore, efficient and least invasive activities that can be presented to the patients in order to assist their choices.



Lastly, the oral cavity pathologies which have a higher epidemiological relevance (cavities, gingivitis, periodontitis) are caused by the bacterial biofilm. Its mechanical re-



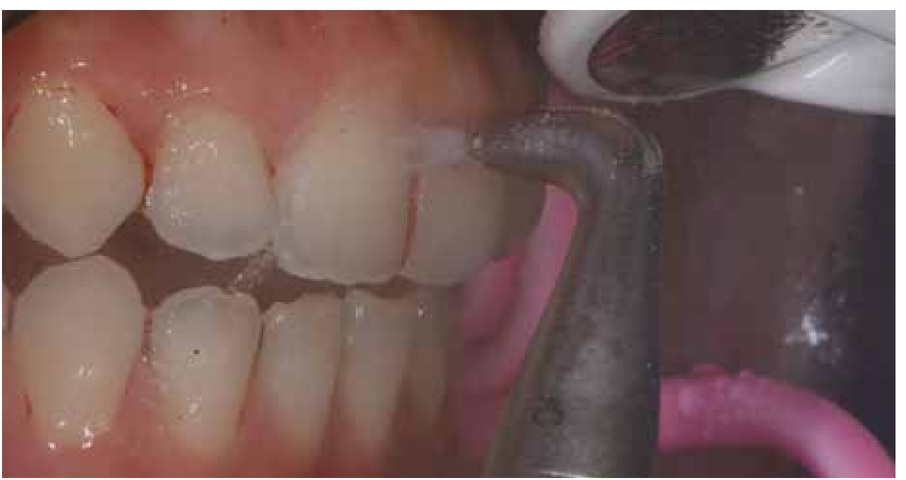


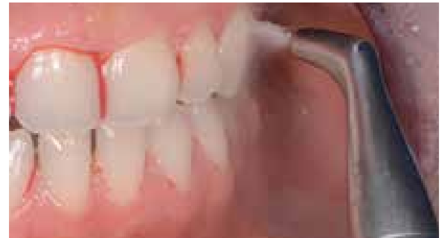
moval and control is mainly important in the prevention and management of the same diseases.
In the end, the clinician will be easy to choose the appropriate tool for the age, to manage clinical, anatomical and tissue conditions, by selecting with the patients themselves the most suitable operational protocol to enhance the home-based and professional bacterial biofilm control.

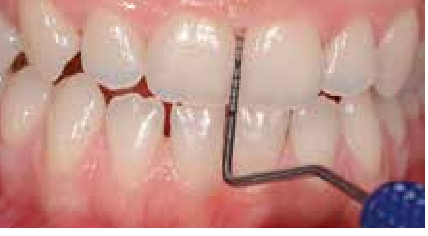
Tailor-Made Approach: from Compliance to Concordance

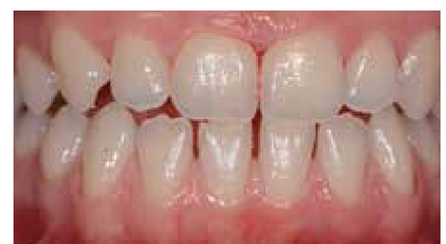
The patients can be guided towards healthy oral hygiene lifestyles, through a careful analysis of their clinical and extra-clinical needs, which will motivate them to initiate an internalisation process that will help the **change** towards correct health habits. The professional's goal is not the mere communication of "behavioural rules" and the accurate but bare **passive** execution of instructions, but rather an **effective modification** of behaviours which are deemed incorrect and are often deeply-rooted and part of daily-life routines.
In order to achieve an efficient control over the bacterial biofilm, it is suitable to go from the **compliance** approach, in which the patient is passively subjected to the professional's teachings, to the **concordance approach**, where the patients can actively join the choice of tools and operational protocols. This innovative method easily enables **the change** to a healthier lifestyle and therefore a more **effective adherence** to operational home-based hygienic protocols. Hence, it is important to switch

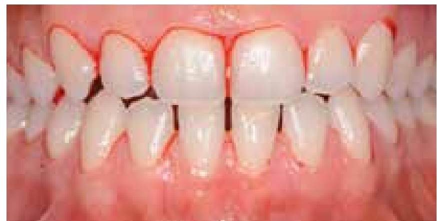
from a plain empathy-based relationship with the patient to a genuine discussion based on receiving useful feedback in an interactive climate. The patients must not be considered passive manual components in a relationship based on their subjection to the professional: the latter should understand the patients' needs in depth and offer them the chance of choosing a personalised protocol of home-based hygiene maintenance, which is designed by the professional himself and later shared with them (Nardi et al., 2014).
Many clinical aspects still need to be analysed: tissue biotype, presence/absence of diastemata, dental alignment, manual skills and perceived predisposition of the patients toward technologies (Nardi et al., 2014). It is therefore obvious how teaching the patient about "dental plaque removal" with brushing techniques from 1948, characterized by the use of tools specific of this time, is not enough anymore.







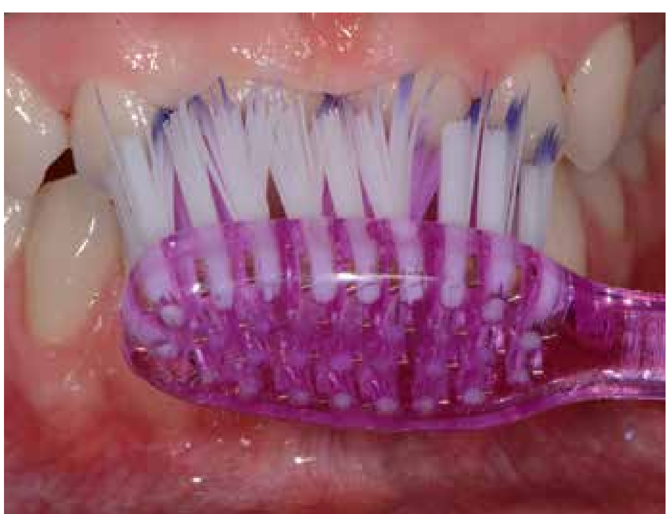


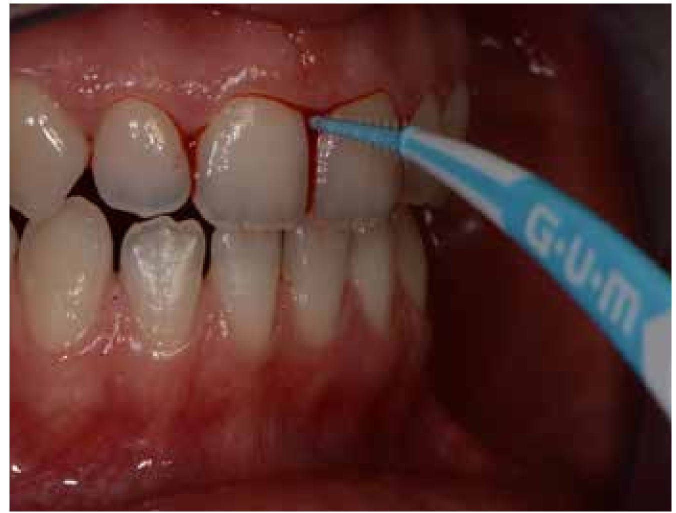


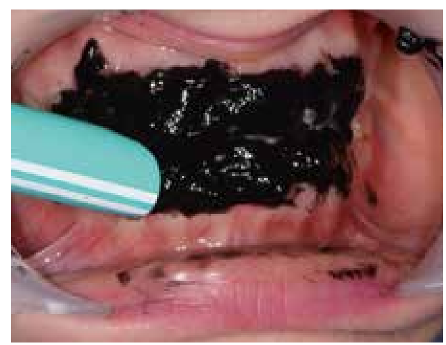
The **Tailored Brushing Method** (TBM), when "customized" for each patient and later "shared" with them, does not suggest the right movements but the appropriate toothbrush, brush heads, and filaments technology. Additionally, this method adds tools designed for the management of the bacterial biofilm in interproximal spaces: these instruments are customised depending on the biological sizes of the gaps and are then shared with the patients according to their own manual ability (Nardi et al., 2016).

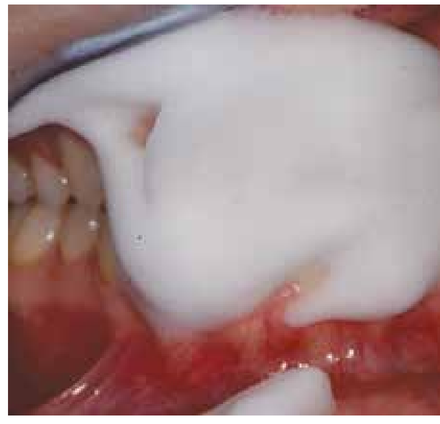
The use of advanced technologies should also provide a greater protocol effectiveness to the professional hygiene management. This is the case of periodontal deplaquing and debriment that are carried out with the **Comby Touch** (Mectron) device: this technological tool comprises a multifunctional piezoelectric dental scaler and a water, air and sodium bicarbonate and glycine powders jet, and is specific for the complete treatment of supra- and subgingival prophylaxis. The Comby Touch *manipolo* is used for air-polishing with glycine powder, which is composed by smaller particles (<63 μm) (Fig. 11-12) suitable for deplaquing. The employment of 90°- or 120°-oriented *manipoli* helps in efficiently respecting the fragility of tissues and implantology artefacts, by dispensing the jet in a customised and focused manner.

After a session of professional oral hygiene care, the potential inflammation of gingival tissues can be tended with the application of 10 minutes long Bioptron phototherapy, a medical device emitting incoherent, soft low intensity and polychromatic light. This advanced technology is functional in treating periodontal patients (Nardi et al., 2018) since it encourages the healing and regenerative processes of the organism (Aragona et al., 2017), harmonizes the metabolic paths and favours the healing of wounds. There are therefore many fields where this therapy can be applied, especially in the medical and dental clinical practice. Scientific evidence show









how phototherapy can lead to the regression of inflammatory injuries (Aragona et al., 2017). The operative protocols in non-surgical periodontal therapy that employ the polarized Bioptron light improve the micro-circulation, enhance the regeneration, favour the healing processes and soothe the pain without any collateral damages.
Therefore, it is necessary for the professionals to choose the appropriate innovative operative protocols to improve the patients' quality of life, because of their least invasive, ergonomic and efficient nature in the health maintenance of the oral cavity.

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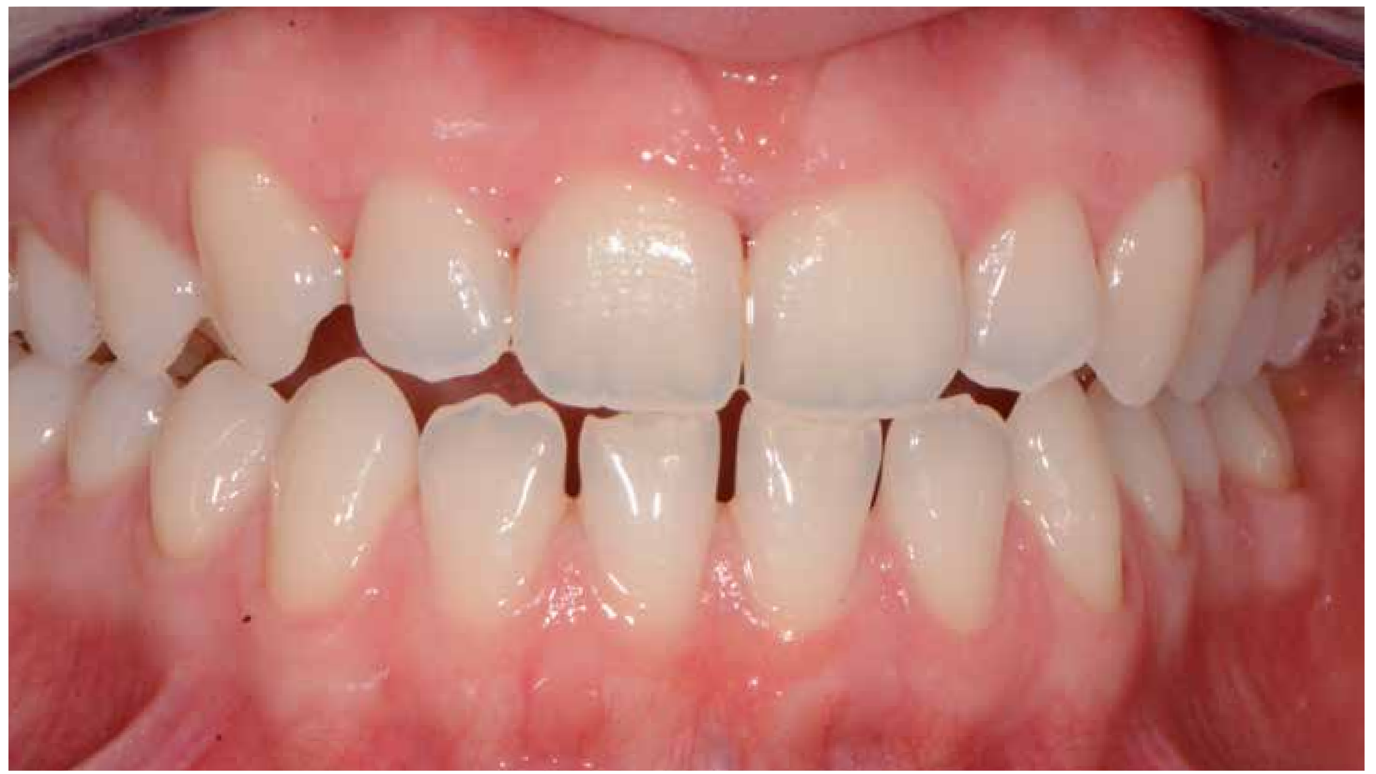

So Much Work To Do

Alice for Children's projects are settled in Kenya and their beneficiaries are the most vulnerable subjects in the population: we are talking about children living in Nairobi's slums and in Rombo, with the Maasai community. In Africa and specifically in these areas children's death race is very high, because of malnutrition, lack of drinkable water and AIDS. In our children homes and schools, we offer support and education to about 2,500 children.

- **Kenya is at the 145th position in the Human Development Index.**
- **46.1% of people live below the poverty line and child labour still affects 26% of children between 5 and 14 years old.**
- **6% of people being more than 15 suffer from AIDS and 26% of children under 5 are underweight and suffer from malnutrition.**
- **40% of people can't use drinkable water, while 70% of them have no access to services and electricity.**
- **Life expectancy is about 60 years, but 40% of deaths are caused by infections and parasites, like TB, Malaria, HIV, hepatitis and diarrhoea.**

Why in Nairobi and its Slums?

Nairobi has 5,000,000 inhabitants and 60% of them live in 110 slums. Slums are abusive urban settlements that lack of hygienic services, drinkable water, electricity and where there are open-air dumps and open sewers. An agglomeration of shabby houses, which, especially in Korogocho and Dandora, grows up next to one of the biggest African dumpsites, where the emergency is permanent. Korogocho is the second slum in size and in population density, where life expectancy goes down to 30/40 years old.

70% of slum's population lacks hygienic services and drinkable water. Here, the percentage of people affected by AIDS goes up to 60%, most of which are women and children. Families, usually formed by 6 people, live in 13 square metres shacks made of wood, mud and metal sheet. 80% of these shacks are for rent, which costs 10 $ a month.

Teachers/students ratio inside schools is 1:60.

Dandora slum rises from the dumpsite, one of the biggest in Africa:
-850 tons of rubbish each day
-10,000 people working inside it and collecting recycling
-55% of workers are children, who run away from school to help with the families' incomes
-one day of work inside the dump corresponds to 2 euros of income
-50% of children suffer from respiratory diseases and severe infections

Why at Kilimanjaro's slopes, in Maasai Land?
Maasai families live of agriculture and breeding. Therefore, lack of water is the greatest problem, as it affects the income of the family, which can't afford to enroll children in school. 80% of Maasai people in this area lack drinkable water and hygienic services. According to Maasai traditions, young girls undergo circumcision at the age of 12/13, in order to become women. After that, they are ready to get married. This tradition leads to a high rate of illiteracy and of school leaving among girls.

Twins International is an Italian private Onlus association, apolitical and irreligious, which works in Africa. Since 2007 it has been developing Alice for Children's projects in Kenya to support especially distressed and vulnerable children.

About Twins International
Twins International is an Italian private Onlus association, apolitical and irreligious, which works in Africa. Since 2007 it has been developing Alice for Children's projects in Kenya to support especially distressed and vulnerable children. We support about 2,500 orphans and we operate in Nairobi's slums and in the rural area of Rombo, at Kilimanjaro's slopes. Alice for Children's projects work in Africa in order to start programs which guarantee a right nutrition and to give more and more orphans the opportunity to enter schools, to have a high-quality education, to attend vocational courses and to get all instruments which can be fundamental to have a future, an adequate job and to live in dignity. We pay special attention to the fight against AIDS/HIV; in particular, we guarantee medical assistance to all people who benefit from our projects. We try to make women's voice heard, in order to claim for their right to equality, which is too often denied in developing countries like Kenya. Twins International Onlus works thanks to a structure that is as simple as possible, having the smallest number of employees and groups of volunteers who help both in Africa and in Italy. To learn more **www.aliceforchildren.it/en**

Source: *taken from Alice for children website - http://www.aliceforchildren.it/en/why-in-kenya/*

dentaid

Dentaid Open Day

Dental charity Dentaid has celebrated its moved to new premises near Southampton with an open day for its friends and supporters.

Guests including Chief Dental Officer Sara Hurley, councillors, business leaders and dental professionals gathered at the charity's new headquarters to meet staff and trustees on Friday, June 7.

Among the guests was Dentaid's earliest supporter Vic Jackopson, who helped found the charity after a British dentist sent a reconditioned dental clinic to a Ukrainian prison in 1996. Dentaid trustee Fiona Ellwood also attended, the day before the announcement of her British Empire Medal for Services to Dentistry in the Queen's Birthday Honours List.

Dentaid's former premises were crumbling temporary offices and a separate warehouse on a remote site in Landford, Wiltshire which was inaccessible by public transport and no longer fit for purpose. The new headquarters are a converted warehouse in Totton, near Southampton, which has space for volunteers to recondition and refurbish dental equipment sent overseas, parking for the mobile dental unit which provides outreach care for homeless and vulnerable people in the UK, and office space for the charity's staff.

Dentaid CEO Andrew Evans said "I have been overwhelmed by the generosity of our supporters and the volunteers who made this dream a reality. The demand for Dentaid's projects increasing access to safe, sustainable dental care in the UK and overseas is growing all the time and our new headquarters will give us a great base from which we can expand our work and help more people."

The move would not have been possible without the generosity of Bishop's Move removals company and a team of volunteers who worked tirelessly to renovate the building in just 3 months. Funding for the project came from The Valentine Charitable Trust, The Beatrice Laing Trust and individual donors.

An octet from Ocean Harmony barbershop chorus performed at the open day as guests enjoyed refreshments, videos showing Dentaid's work and tours of the workshop where volunteers make portable dental units sent to Dentaid's partners around the world.

In his speech, chairman of trustees Jeremy Hett thanked Dentaid's supporters past and present and everyone who had been involved with the project. "After 20 years at Dentaid's rural Landford base, the charity has moved to smart new premises in

Totton<2 he said. "It was wonderful to celebrate an exciting new phase for the organisation, as it seeks to build strategic relationships with the local community."

Dentaid CEO Andrew Evans said "I have been overwhelmed by the generosity of our supporters and the volunteers who made this dream a reality. The demand for Dentaid's projects increasing access to safe, sustainable dental care in the UK and overseas is growing all the time and our new headquarters will give us a great base from which we can expand our work and help more people."

Sara Hurley added: "Dentaid has always had a great heart and now it also has a wonderful home."

About Dentaid Overseas

Dentaid is a busy and exciting charity that has worked in more than 70 countries since it was founded in 1996.

We are committed to supporting the work of in-country dentists and health-care professionals by providing equipment, funding outreach programmes and sending teams of volunteers to work alongside them.

We are passionate about empowering dental professionals and making a difference to people's lives.

Around the world there are 3.9 billion people with dental decay which can affect their general health and wellbeing.

Many don't have access to safe, sustainable dental care and Dentaid works tirelessly to change this.

Our volunteering teams provide free, pain relieving dental care for thousands of people every year. Dentaid also provides training, peer support and resources for our dental partners. Equally important are our oral health education projects which are delivered around the world.

Dentaid is pleased to receive requests from NGOs, individuals, overseas dental organisations and partner charities that work to improve access to dental care and oral health education.

Any organisation seeking our support must complete our project assessment form providing as many details about their requirements as possible.

Please note that unless you have funds available, Dentaid will need to fundraise to support your project.

In the last year Dentaid has supported projects in countries including Malawi, Sri Lanka, Vanuatu, Ethiopia, Uganda and Cambodia.

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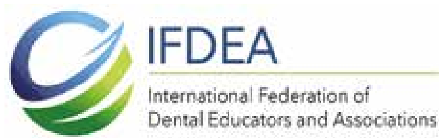

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MEET IFDEA

The International Federation of Dental Educators and Associations (IFDEA) is **a global community of dental educators,** who have joined together to improve oral health worldwide by sharing knowledge and raising standards. University professors and Dental Educators refer to this Federation.

IFDEA TASKS

IFDEA contributes to improving global health by improving oral health. IFDEA serves as an axis of information, best practices, exchange programmes, news and professional development for the many dental education international associations (**ADEE** in Europe, **ADEA** in North America, **AfDEA** in Africa, **SEAADE** in South East Asia, in Latin America and Japan), dental academic institutions and individual dental educators worldwide.

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