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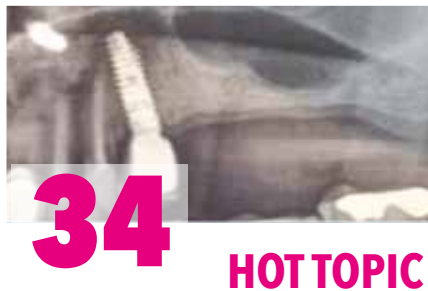
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Uncertainty, the Enemy of Business



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

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

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

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WELLNESSworld LLC
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**inews Special Edition AEEDC 2020 -
supplemento a Infodent International 4/2019**
Infodent International magazine, connecting dental business
worldwide aut. trib. VT n°496 del 16/02/2002



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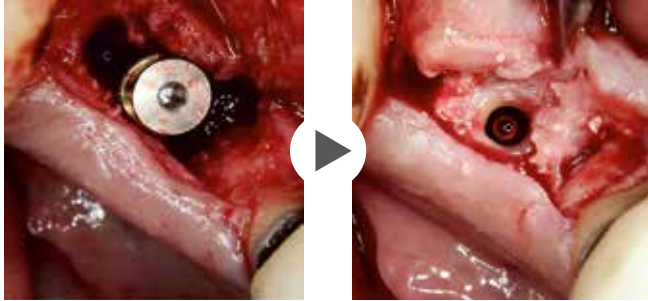
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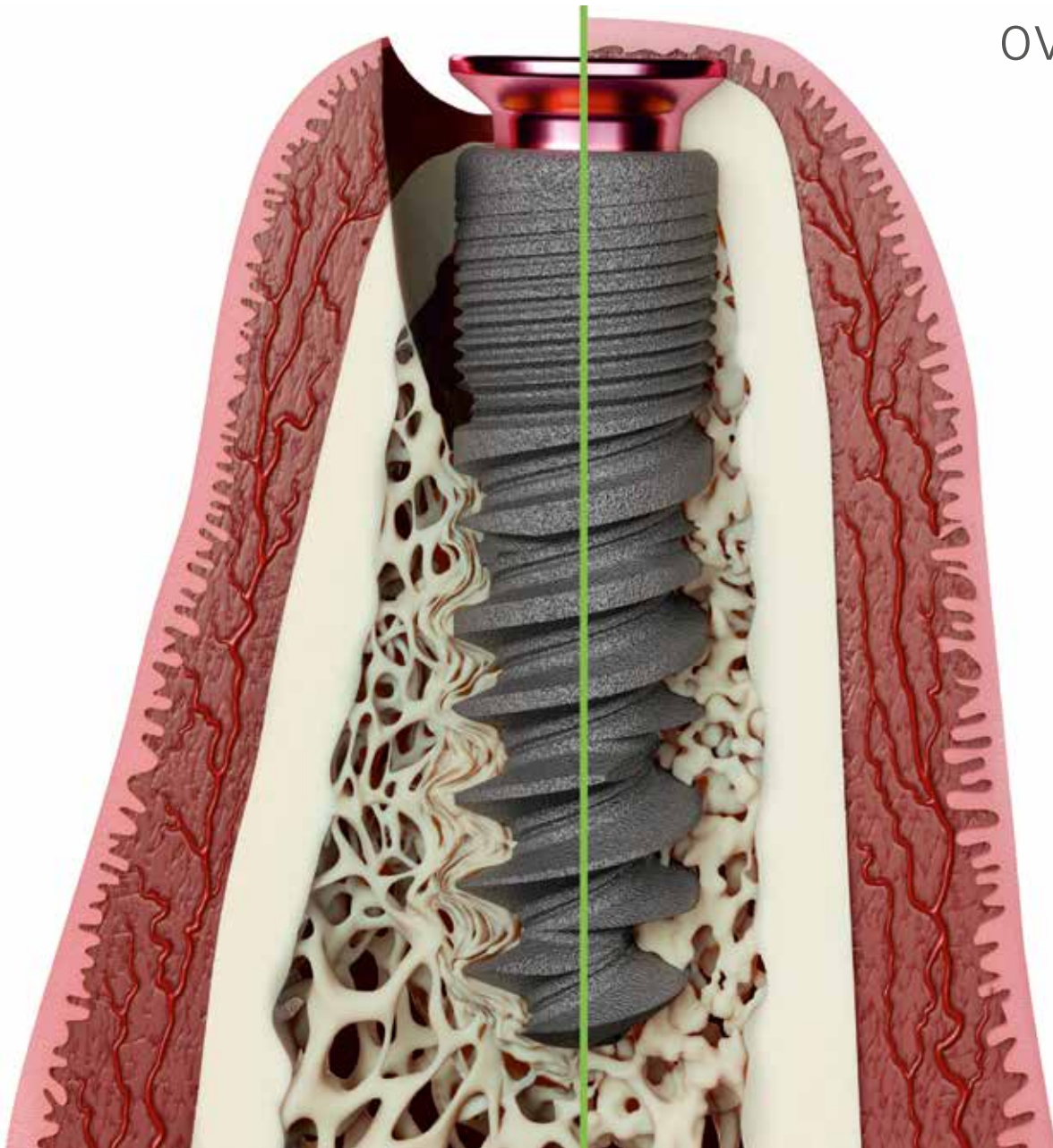
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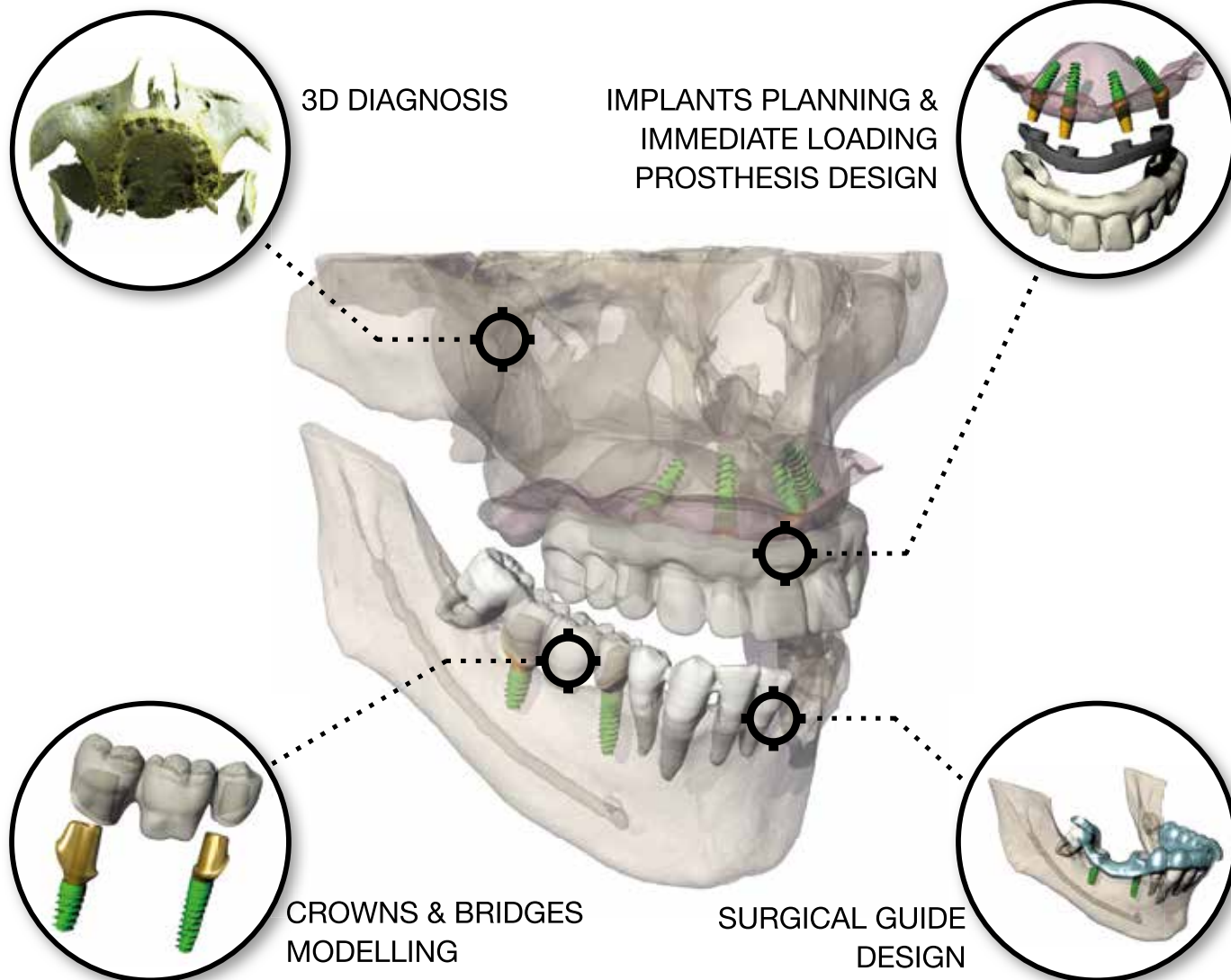
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A white rectangular box with a green hexagonal pattern and the text 'Kimera GC' is the central focus. In front of the box are several colorful plastic X-ray holders: a white ring-shaped holder, a dark blue rectangular holder, and several curved holders in blue, yellow, and red. The items are set against a plain white background.

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"NNN Veneers" from Berlin & Dubai to the whole wide world

Dr. Mohamed Naji

Established in 2012 in Berlin - Germany, "NNN Veneers" has taken the world of aesthetic dentistry by storm as they have been manufacturing their products with the most biocompatible materials, and gained a lot of popularity for having their natural looking hybrid manufactured veneers professionally designed and painted by their international dental technicians.



Located in the heart of Dubai, and for the first time in the Arab world, "NNN Veneers" invaded the dental market by opening their new headquarters office which is currently producing and distributing the latest generation of the minimal-preparation veneers for the region. However, this time it's done in the least invasive way in which no drilling, no pain, and no anesthesia is required, and can be completely done in just 2 visits within 30 days utmost.

However, the company has recently decided to expand and introduce their latest "NNN Zirconia" products to satisfy the needs of the patients that require preparation veneers or complete crown coverage, and reliable internal sources have informed us that NNN will soon be launching their own dental implant system which is currently in its final development stages before it is introduced to the market.



Apart from their dental products, as of early 2019 "NNN Veneers" have also commenced their academic courses in the Middle East which have been instantly sold-out upon their announcement. Many dentists traveled from around the globe to attend those courses due to the renowned instructors, prestigious equipment preparation, and delivered in the world's most glamorous venues. Mr. Evan Yonocef the Managing Director of the "NNN Veneers" Academic Department



Many dentists traveled from around the globe to attend those courses due to the renowned instructors, prestigious equipment preparation, and delivered in the world's most glamorous venues.



in Europe was constantly present during the courses to ensure the quality of the material presented to the attendees and to personally present them with the certificates upon completion of the course.

The high demand of the "NNN Veneers" in the Middle East triggered their expansion into this part of the world, and from being just exclusively available at selected dental clinics, the brand is now going viral by facilitating their access to all the dentists around the world via their smart website concept, which enables any dentists to register, receive his online training and certificate in a matter of 30 minutes.



capabilities and level of practice before getting certified. As well to ensure their quality of work, the company stated that their products will never be sold to any dentists that are not registered, trained, and certified by them. In addition to that, Mr. James Andrickot the Regional Manager of "NNN Ve-



neers" in MENA, recently announced the launch of their media campaign to raise awareness of the dangers of the artificial veneers supplied in the market under branded names which are causing horrendous side effects to the patients. And to avoid such incident, unlike all other manufacturing companies, "NNN Veneers" is the first

Yet, although the process is easy, the "NNN Veneers" management were very keen on maintaining the high standards of their product and kept their online registration system monitored by their professionals, in which even the dentists applying online will go through a background check to ensure their



company to get in direct contact with the patients to ensure their safety, satisfaction and protect them from getting scammed. The online system forces their certified dentists to enter full contact information of the patient upon ordering a case for him/her. Thus, once the order is made the patient will

receive an email from the management of "NNN Veneers" informing them about the order placed for them, and the name of the dentist that placed the order. Just like that the patient will immediately know that his veneers are original and they are being delivered from a legitimate source. And to ensure

that the dentist is certified, the patients can simply visit www.nnnveneers.com where all the certified dentists around the world are listed, and the patients can also locate the one nearest to their location.

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Tissue regeneration for head and neck region

Dr. Lama Awad

A new product has hit the market for the tissue regeneration is called the PRP. PRP stands for platelet rich plasma, it's also known as Platelet rich growth factor (FGS) or Platelet rich fibrin matrix (PRF) or Platelet centrate. [1] This term of PRP was actually given by Hematologist in the 1970 [2], where 10 years later the PRP started to be used in Maxillofacial surgeries. The fibrin had the potential for adherence and hemostatic properties while the PRP with its anti-inflammatory characteristics simulated cell proliferation [3]. The images (1, 2) illustrate the above.

These characteristics of the PRP enable the cosmetic dermatologists to use it to stimulate human dermoid fibroblast proliferation and increase type 1 collagen synthesis in their cases; they injected the PRP in the human deep dermis and immediate sub-dermis to help them induce the soft-tissue augmentation, activation of fibroblast and adipose tissue, new collagen deposition as well as new blood vessel formation [4][5]. Not only has that but also enabled to improve burn scar and acne scar [6]. This is illustrated in image (3, 4).

PRP stands for platelet rich plasma, it's also known as Platelet rich growth factor (FGS) or Platelet rich fibrin matrix (PRF) or Platelet centrate.

In 2006 a breakthrough has been discovered in using PRP, it was used to promote hair growth in the treatment of Alopecia whether it's Alopecia Areata or Androgenic Alopecia [7]. This is illustrated in image (5).

In this case the patient came in to do an implant in the upper region however, we discovered a thin bone area in the Sinus which needed Sinus lift. We performed bone implantation with plasma (as it has a growth factor that improves healing). There is a 1.5 years difference between the Before/After pictures. The plasma created a strong fibrin matrix which facilitates slow release of growth factor.

Patient is 36 years, she complains of tall teeth. After clinical examination gingival recessions were noticed on 11 and 21 with thin biotype gingiva. The suggested treatment was the gold standard which is connective tissue graft from the palate but the patient refused any second surgery site, so it was treated with PRGF. We can notice a thicker biotype and coverage of the recession within 1 week.

This is a non-surgical hair loss treatment, the above is a result of a 4 session treatment of PRP to regrow hair and improve growth factor to create or stimulate new hair follicles and make the hair thicker.





This is a one session PRP treatment (the difference between the before/after pictures is 9 months). We rejuvenated the skin.

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Aesthetics in Dentistry

Restoration of the Perioral Area

Dr Roberto Proietti Piorgo

The spreading of aesthetic medicine is visible to everyone and, in any case, closely linked to an individual's state of health. Appearing healthy is almost as important as actually being.

We can say that, in aesthetic medicine, the most important and, at the same time, the most difficult thing is understanding a patient's expectations, therefore it is essential

to know a patient's "aesthetic" history in depth. Knowing what kind of treatments the patient has previously been through is crucial to understanding if it is possible to treat him/her. Never treat patients who have been previously administered non-absorbable materials of any kind.

The same applies to patients who do not re-

member or do not have the documentation relating to previous treatments.

All non-absorbable materials can remain in place for years without generating any problems, but if we are going to inject a material of another nature, even a filler based on hyaluronic acid (HA), in the same area, devastating reactions may occur, to say the least.



SMILE ANATOMY

1. Dental aesthetics
2. Shape and size of lips at rest
3. Shape and size of the vermillion area
4. Proportions between upper and lower lip at rest and in motion
5. Appearance of labial commissures
6. Tubercle shape
7. Shape of lower lip depression
8. Appearance of skin surface (tone-texture)

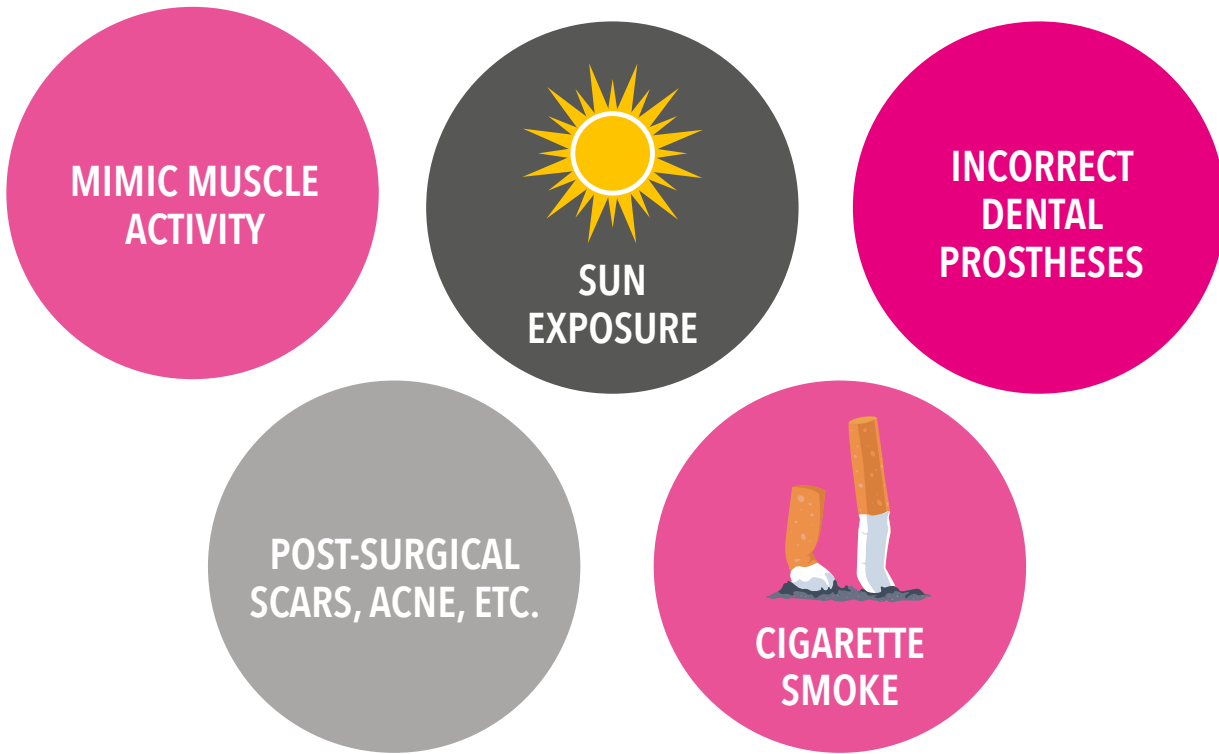
The smile is the means by which an individual transmits pervading positive emotions. It's not just about beauty, but it is something deeper. That's why aesthetics plays a fundamental role in an individual's life. In our case,

if we are talking about oral health, we can say that its physical expression is the smile, and it is thanks to this connection that we can understand the importance of aesthetics in dentistry. It is not mere aestheticism but

a biological connection that can be used to promote a patient's well-being. To succeed in this, it is essential to know all about its anatomical structure.

FACTORS RESPONSIBLE FOR THE SENESCENCE OF THE PERIORAL AREA

The smile, like all precious things, is fragile. Dentistry can preserve well-being but, as with many other things, our lifestyle or, even worse, the incapability of others, can accelerate aging. Let's see the factors determining faster aging and anatomy alterations.



CLINICAL CASES



Clinical case 1



Clinical case 2



Clinical case 3

**FIG. 1**

Aging determines the reduction of both the upper and lower lip vertical thickness. In the first case there will be a reduction in incisors exposure, while in the case of the lower lip there will be an increase in the exposure of the incisors, especially when in motion.

FIG. 2

In addition, there will be a reduction of the anterior-posterior dimension and the flattening of the edge of the vermilion and cupid arch. Of course, at the same time, the nasolabial folds will be more evident and in addition, all the areas below the lower lip up to the chin will lose volume.

**FIG. 3**

We only use completely absorbable hyaluronic acid (HA) fillers. Complete resorption occurs in about 6-9 months. HA fillers are sterile cross-linked isotonic solutions. HA is naturally present in our body and regulates the hydration and volume of the dermis, as well as intervening in the wound repair process and in renewing the skin. The difference between a crosslinked filler and non is that the former is used for volume increases, it is injected deeply into the dermis and, as mentioned, lasts about 6 months, while the latter has a lower molecular weight and is injected more superficially as a bio-revitalizer, repairing collagen.



Let's now talk about its complications. The few complications are treated locally with hyaluronidase and systematically with cortisone.

Hyaluronidase is an enzyme capable of neutralizing previously injected HA, degrading it to the point of complete elimination. It works within an hour and tangible effects are visible within 24 hours.

Belonging to the hydrolases enzyme class, it catalyzes the HA hydrolysis, which is among the main constituents of the intestinal barrier, lowers HA viscosity and increases tissue permeability.

My Filler is a cross linked gel based in Hyaluronic Acid for intradermal implantation.

My Filler counts with the cross linking technology, which grants a superior performance of the hyaluronic acid after its injection: longevity and moisture retention.

For more information please visit:
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My Filler is supplied in individual syringe and it is packed for single patient use, ready to inject. Each syringe contains a solution of hyaluronic acid gel.

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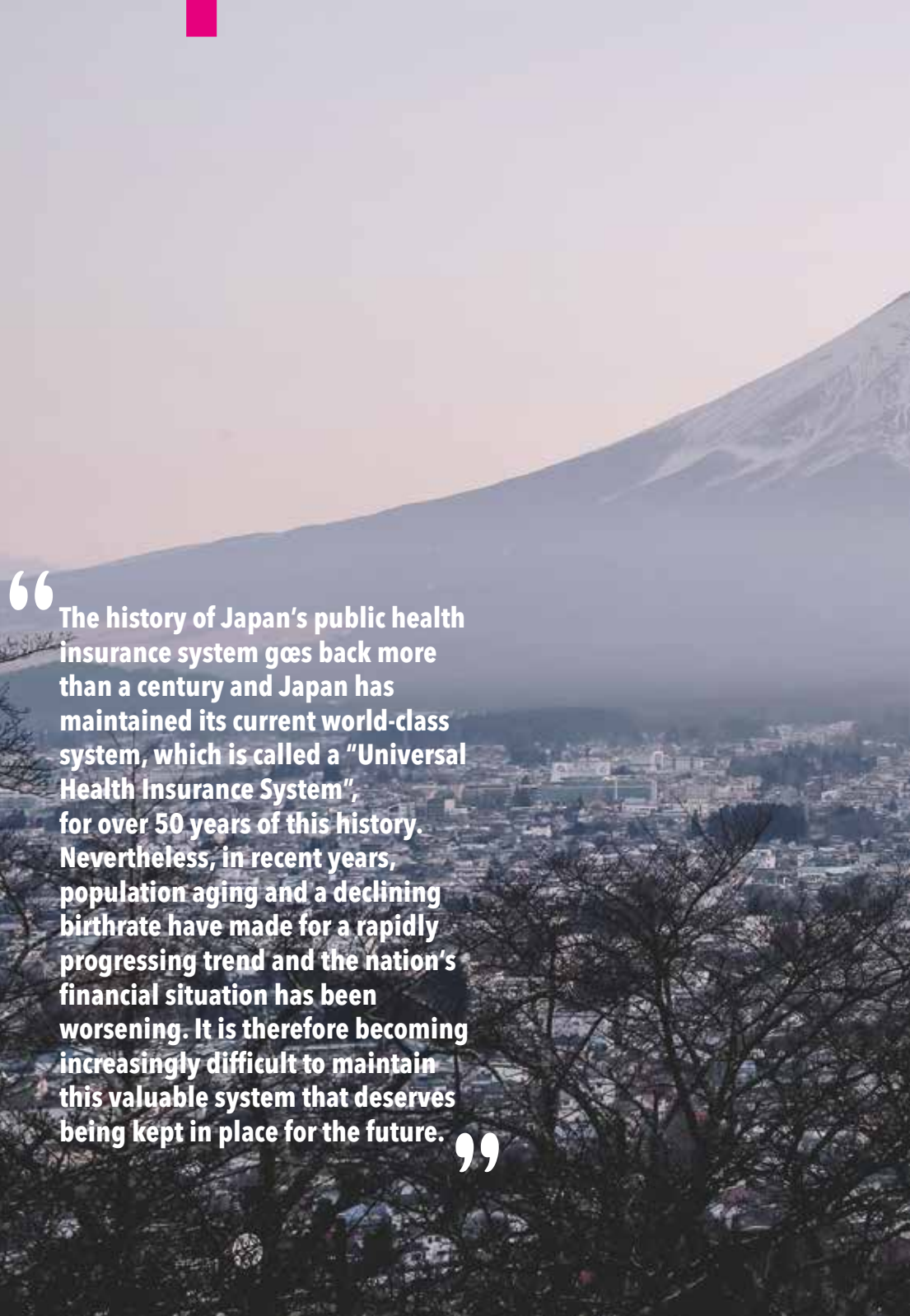
Author: **Silvia Borriello**
silvia.borriello@infodent.com

Oral Health at a Glance, Japan

Total Population
127 million

GDP per capita,
USD (PPP) 40,686

Constitutional
monarchy with
a parliamentary
system of
government



“The history of Japan’s public health insurance system goes back more than a century and Japan has maintained its current world-class system, which is called a “Universal Health Insurance System”, for over 50 years of this history. Nevertheless, in recent years, population aging and a declining birthrate have made for a rapidly progressing trend and the nation’s financial situation has been worsening. It is therefore becoming increasingly difficult to maintain this valuable system that deserves being kept in place for the future.”

World's
third-largest
economy

No. of Dentists,
104,533

Ratio
dentist-population
82.4:100 000

No. of Active
Dental Technicians
– 34,640

With a high standard of living, level of development, safety and stability, Japan has made many noticeable successes in health since its universal health insurance system was founded in 1961. Japan is called a welfare country and the Ministry of Health, Labour and Welfare (MHLW) is the central leading organization in the Japanese healthcare system, characterized by excellent health outcomes at a relatively low cost. Its full implementation of universal insurance coverage, provides comprehensive coverage to all Japanese citizens, achieving the world's highest life expectancy. **The system emphasizes equity, facilitated by universal insurance coverage through social insurance premiums and tax subsidies, with virtually free access to healthcare facilities. The universal health insurance system covers almost all medical procedures, dental care and drugs and is operated by either the national or local government.**

While there are several official Japanese health insurance systems, all citizens must be covered by one of them. There are two major types of insurance schemes: *Employees' Health Insurance and National Health Insurance (NHI)*. Employees' Health Insurance is provided to employed workers (company employees and public servants) and their dependents, while the NHI is designed for self-employed and unemployed people and is run by municipal governments (i.e., cities,

towns and villages). Employees' Health Insurance is further divided into four major categories: Japan Health Insurance Association (JHIA), Society Managed Health Insurance (SMHI), Mutual Aid Association and Seamen's Insurance. **Japan does not have a single insurance fund as insurers are divided into approximately 3,000 organizations. Moreover, the premium rate largely differs from one insurance scheme to the next. This fragmentation is a source of inefficiency in the system and inequity in premiums.** Although there are several cross-subsidy systems among insurance schemes, mainly for the financially weak NHI, financial sustainability and equity among insurance schemes remain

major challenges for the Japanese health financing system, especially when considering the rapidly ageing society.

The government regulates and controls nearly all aspects of the health system, at three levels: national, prefectural (regional) and municipal (cities, towns and villages), where service delivery and implementation are mainly handled by prefectural and municipal governments. Several professional organizations such as the Japanese Medical Association, the Japanese Dental Association and the Japanese Nursing Association are also actively involved in health policy processes. The way in which the MHLW interacts with these professional organizations, including the private

Its full implementation of universal insurance coverage, provides comprehensive coverage to all Japanese citizens, achieving the world's highest life expectancy.

Trends in Healthcare Expenditure in Japan, 1995–2014

Expenditure	2000	2014
Total health expenditure (% GDP)	8	10
Public expenditure on health (% of THE)	81	84
Private expenditure on health (% of THE)	19	16
Government expenditure on health (% of GTE)	15	20
OOP payments (% of PHE)	81	85
OOP payments (% of THE)	16	14

Notes: GDP: gross domestic product; THE: total healthcare expenditure; GTE: government total expenditure; PHE: private health expenditure; OOP: out-of-pocket **Source:** World Health Organization, 2017



sector, care providers and patients, is however notably complex. The Central Government sets the nationally uniform fee schedule for insurance reimbursement and subsidizes and supervises local governments, insurers and healthcare providers. Almost all practicing doctors and dentists are registered

in the public national health insurance scheme as insured doctors and provide treatment according to a fee-for-service system. In general, after receiving treatment by an insured doctor or dentist, patients make partial payments (co-payments) of the total cost to the clinic or hospital. **The nationally uniform fee schedule (i.e.,**

amount of reimbursement, including the patients' co-payment) covers most healthcare procedures and products, including drugs.

The health insurance pays 70–90% of the cost while the remainder is paid by the insured as co-payment. The co-payment rate as of March 2017 is as follows: pre-elementary school = 20%; elementary school up to age 69 years = 30%; age 70–75 years = 20% and age 75 years or above = 10%. Thus, the cost of insurance treatment provided is the same, throughout the nation, fixed by the fee schedule. There is no price difference between private and public institutions. There are certain exemptions. Low income earners do not necessarily have to pay the cost directly to the clinic. In addition, elderly, as specified above, may pay directly but at a reduced rate (10–20% of the cost) according to their income. Furthermore, the Japanese health insurance system has a reimbursement scheme for patients who

The system has now come to have an important role as designed to assure an affordable and comfortable life for elderly people and their family members.

receive costly treatment services such as cardiac surgery, where the patient's payment over a certain amount is refunded later. Under this health insurance system, Japanese people can receive quality healthcare services at a relatively low cost, both in public and private institutions.

Healthcare is predominantly financed by publicly sourced funding. In 2015, 85% of health spending came from public sources, well above the average of 76% in OECD countries. Direct out-of-pocket (OOP) payments contributed only 11.7% of total health financing. Despite the relatively low OOP payments, the key challenges in Japan are population ageing, rapid increases in chronic illness, escalating medical expenditure, contracting fiscal space and pressures on the healthcare workforce. Reforms of the financing system and greater efficiencies in health systems will be necessary to sustain good health at low cost with equity in the future.

To deal with the rapidly increasing aging population, in April 2000 Japan introduced the "long-term care insurance system" to deliver health and welfare services for the elderly (65 years or over), so that they can live independently as much as possible. The long-term care insurance covers 90% of the service-related costs, while the remaining 10% of costs are paid by the user. The services provided under this scheme include home visit nursing, day-care or short-stay

Workforce Data (2016)

	Total Number	Female
Physicians	319,480	67,493 (21.1%)
Dentists	104,533	24,344 (23.3%)
Pharmacists	301,323	184,497 (61.2%)

Source: Ministry of Health, Labour and Welfare Survey of Physicians, Dentists and Pharmacists in 2016. Available online: www.mhlw.go.jp/english/database/db-hss/dl/spdp_2016.pdf

medical service, etc. In-home healthcare guidance, doctors, nurses, dentists, dental hygienists or other medical professionals visit the homes of users who have difficulty in making a hospital visit. The system has now come to have an important role as designed to assure an affordable and comfortable life for elderly people and their family members.

Furthermore, in 2000, a National Health Promotion Campaign for the 21st century, "Healthy Japan 21", was proposed to prevent lifestyle-related diseases (non-communicable diseases (NCDs) such as cancers, cardiovascular diseases, diabetes and chronic obstructive pulmonary disease). "Healthy Japan 21" set

Number of Dental Schools

- 11 National**
- 1 Local Governmental**
- 17 Private Universities**
- Total enrolment (2017) – 2,720**

Numbers of dentists in Japan (2016)

	Number	%
Dental practice	101,551	97.1%
Private office (employer)	(59,482)	(56.9%)
Private office (employed)	(29,684)	(28.4%)
Hospital	(3,077)	(2.9%)
Education institute	(9,308)	(8.9%)
Research institute	1,195	1.2%
Administration/public service	348	0.3%
Others	1,430	1.4%
Total	104,533	100.0%

Number of Hygienists (2016)

Active Dental Hygienists	123,831
Working in private dental clinics	112,221 (90%)
Working in hospitals	6,259 (5%)
Working in Public Sector (i.e. prefectures, municipalities, health centers)	2,754 (2.2%)
Teaching staff in Education Institutes	873 (0.7%)
Dental hygienists' education institutes	166

Number of Dental Technicians (2016)

Active Dental Technicians	34,640
Working in dental laboratory offices	24,972 (72.1%)
Working in hospitals or dental clinics	9,166 (26.5%)
Dental Technicians' schools	54



up national goals for improving lifestyles, reducing risk factors and decreasing diseases. Oral health was one of the NCDs conditions identified and specific goals were set to prevent tooth loss. In the second "Health Japan 21" specific goals are indicated and include: (1) nutrition and dietary habits; (2) physical activity and exercise; (3) rest; (4) alcohol use; (5) tobacco use and (6) oral health. Among the goal related to oral health for 2022 are the increase in proportion of persons aged 60–69 years with good mastication function to 80%; increase in the proportion of 40-year-old persons with no missing teeth to 75%; decrease in the proportion of persons in their 40s with progressive periodontitis to 25%; increase in the number of prefectures where 12-year-old children have fewer than 1 DMFT and increase in the proportion of persons who received a dental check-up during the past year to 65%.

Dental care in Japan dates to the late 1980s. In 1989, the Ministry of Health and Welfare started to advocate for the "8020" (eighty-twenty) campaign, in the attempt to improve dental health among those aged 80 years or older by maintaining the presence of at least 20 natural teeth. Because major reasons for the natural loss of teeth are periodontal disease and cavities, attention has been paid to these diseases, including annual check-ups for elementary and junior high school students. People can use the dental healthcare services provided by the health insurance system and dentists are paid using a fee-for-service system, although some restrictions apply to the materials that can be used. **Consequently, dental services under the national health insurance system are available for most restorative, prosthetic and oral surgery treatment. They include services such as fillings, endodontic treatment, crowns, bridges, dentures and extractions. Higher cost items (e.g. gold crowns and bridges, metal plate dentures, implants and orthodontic treatment for cosmetic purposes) are excluded. Preventive oral services are also excluded as the current health insurance system only covers treatments for existing diseases.** In such cases, dental fees are negotiated between the dentist and patient, with the patient paying the entire sum out-of-pocket directly to the practitioner. Delivery of dental treatment services to bed-ridden people at home or in aged care centers by dentists are also covered in this public health insurance scheme. Therefore, all people can receive dental treatment at a relatively low cost, with the same fees applying

Prevalence of Dental Caries in Deciduous Teeth

	Year 1957	Year 2016
5-year-old	94.5%	39.0%
3-year-old	81.8%	8.6%

In all age groups, the proportion of those retaining 20 or more natural teeth has increased, with a substantial increase observed, especially in older age groups.

throughout the nation. These services are mainly conducted by private dental practitioners under contracts with local governments.

Dental Workforce

Three regulatory professional dental licenses are issued in Japan: dentists, dental hygienists and dental technicians. There is no licensing system for dental chairside assistants. **In 2016, the total number of dentists was 104,533. The dentist ratio per 100,000 people is 82.4 practitioners and as in many nations, the distribution is unequal.** The highest dentist to population ratio is in Tokyo (118.2) and the lowest is Fukui Prefecture (54.7); more than twice the regional difference of dentist distribution is observed. Compared with the OECD average, Japan has a larger number of dentists. **There are over 68,730 dental facilities (mainly private dental clinics) in total throughout Japan.**

Decayed, Missing and Filled Permanent Teeth (DMFT) of 12-year-olds (National School Oral Health Survey data)

Year	
1985	4.6 DMFT
2016	0.8 DMFT

Mean Number of Natural Teeth Present for Adults

	Year 1957	Year 2016
35–44 years age group	25.1	28.2
65–75 years age group	10.1	20.8

% of Elderly with No Natural Teeth

	Year 1957	Year 2016
65-74-year-old age group	35.5%	4.1%
75 years and over	57.2%	14.3%

More than 97% of the dentists engage in providing dental treatment at private or public dental institutions. The number of public dentists who engage in full-time administration work is only 348 (0.3%). Consequently, most of the public dental activities are conducted by private dentists on a part-time basis. For example, a local government municipality contracts with a private dental

practitioner to carry out the role of a school dentist. Local government pays the contracting dentist as a school dentist and the dentist is responsible for the performance of school oral health activities, usually in a part-time capacity. This public and private mixed dental **performance is one of the unique characteristics of the Japanese oral healthcare system.**

After a 6-year course at dental school, all students must take a national board dental examination. The MHLW manages this national board examination and regulates the issuing of dental licenses. The pass rate of the national board examination is relatively low, around 65–70%. In 2018, 3,159 dental students took the examination and 2,039 passed (64.5%). At least one year's worth of clinical postgraduate training has been mandatory since 2006.

Most hygienists' institutions are 3-year-period vocational schools. Eleven schools however provide a 4-year-period university bachelor's degree programs in the universities. Hygienists also need a national license and the proportion of dental hygienists who pass the national examination is high and around 95%. Every year around 6,500 new dental hygienists are produced.

Most of the schools provide 2-year-period education. Three universities have 4-year-period bachelor's degree programs for dental technicians. After graduation, a pass in the national board examination is necessary to get a license to practice as a dental technician.

Oral Prevention

Pre-school children - In Japan national programs for pre-school children are conducted by local government free of charge. They include physical, medical and dental examinations of all children. Private practitioners (i.e., doctors and dentists) contribute to the conduct of these examinations in turns at the community health centers. This means they become part-time "public doctors/dentists". Medical or dental treatment is not provided at the health centers and only preventive services are available. Oral health education is also offered to mothers and children by dental hygienists.

Schoolchildren - Every public primary, junior and senior high school has an appointed school dentist. The roles of school dentists include the conduct of an oral health examination at least once a year on each child at school and contributing to implementing the school's oral health educa-

tion. According to the standard procedures and guidelines, school dentists check the oral health status of all the students for conditions such as dental caries, malocclusion, gingival status, dental plaque and temporomandibular disorders. School dentists do not provide dental treatment in the school but if oral health problems are detected, the school dentist recommends that they should seek dental treatment under the public health insurance scheme. Schoolchildren can receive comprehensive dental care at any public or private dental office.

Adults - According to the "Industrial Safety and Health Act", employers must provide annual medical check-ups for all the employees in any company which has more than 50 workers. On the other hand, the Act does not include a duty for dental check-ups for employees as such, the number of companies providing good oral health promotion programs is very small. According to the "Health Promotion Law", local governments (municipalities) are to provide free or low-cost "periodontal disease examination programs" for their adult population by way of contracts with private dental practitioners. However, the rate of participation for the eligible persons in these programs is very low, about 10–15%.

Therefore, in Japan, the oral health program for the adult population is based on an individual's personal responsibility for care, self-support and self-motivation. **Many dental facilities and a public insurance system contribute to easy access for dental treatment for adults, but the proportion of regular (check-up or preventive) visits to dental clinics is not high.**

Elderly - Over the past several decades, Japan has become increasingly concerned at the pace of population aging and the challenges this brings to dealing with changing social systems. Dentistry is no exception. The concept of the "8020" campaign, a community and clinic-based initiative, started in 1989 to ensure that all Japanese people were able to enjoy a healthy diet and a good social life by preventing tooth loss that leads to masticatory dysfunction. **The "8020" campaign has contributed to a dramatic improvement in the oral health of older people in Japan.** This was followed by an accumulation of evidence, culminating in oral health being integrated into health policy in the form of the "Act on the Promotion of Dental and Oral Health" in 2011, for the purpose of oral disease prevention and general health improvement. **Latest findings show that the proportion of the elderly aged 80 years and above who have at**

least 20 teeth has increased from 40.2% in 2011 to 51.2% in 2016.

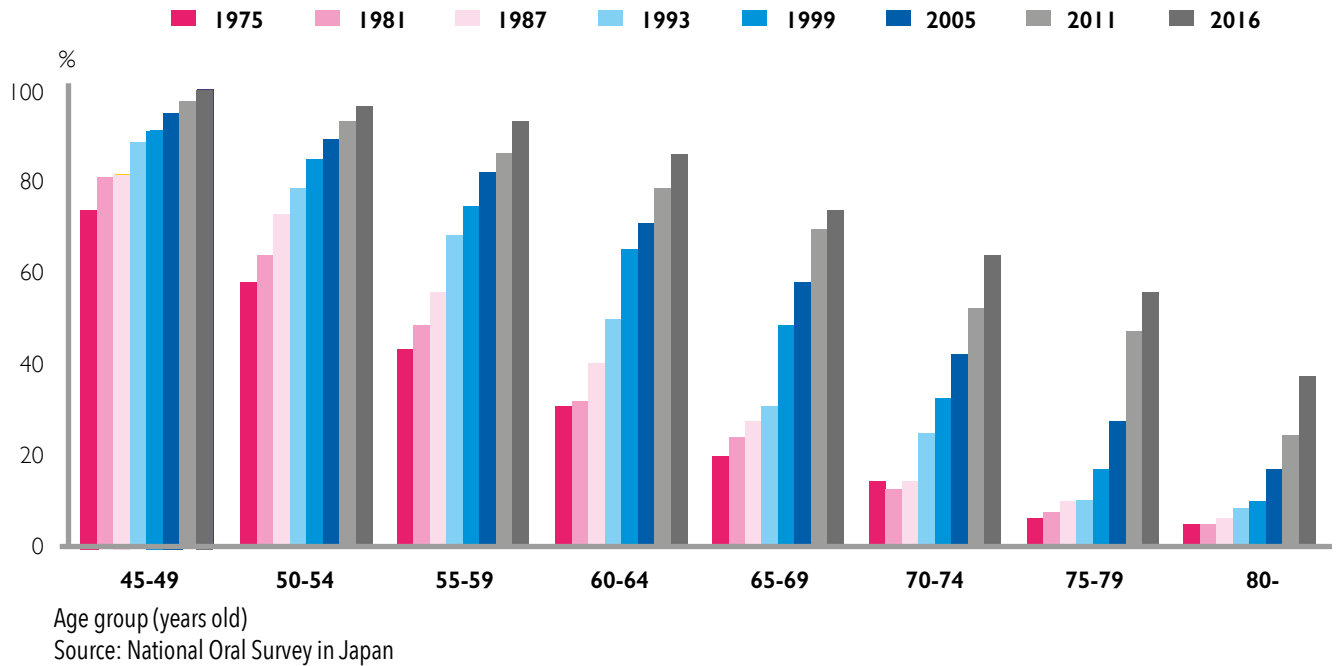
Oral Health Status

Japan has developed a system for providing high-quality and appropriate oral healthcare efficiently. **Therefore, the overall oral health status of Japanese population has improved markedly. Dental caries in children has decreased remarkably. In adults and older populations, untreated decayed teeth have decreased, and people are keeping more natural teeth than ever before.** Many factors are thought to contribute to these changes. Public oral health services are provided according to the life stage of their populations and these services are mainly conducted by private dental practitioners under contracts with local governments. The number of dental facilities has increased, and the health insurance system helps by providing easy access to receiving dental treatment at reasonable price. Fluoride usage has increased, and sugar consumption has decreased. People's awareness and behavior toward oral health have also improved. **The eleventh national survey on oral health was conducted by the MHLW in 2016. Surveys are now conducted every five years and according to data the changing patterns of oral health status of Japanese population can be well described below.**

In 1957, most carious teeth were untreated, and 5-year-olds had on average 8.7 decayed teeth. As time went on, children could access and receive dental treatment and the number of filled teeth increased. Also, the number of healthy teeth increased remarkably in all ages.

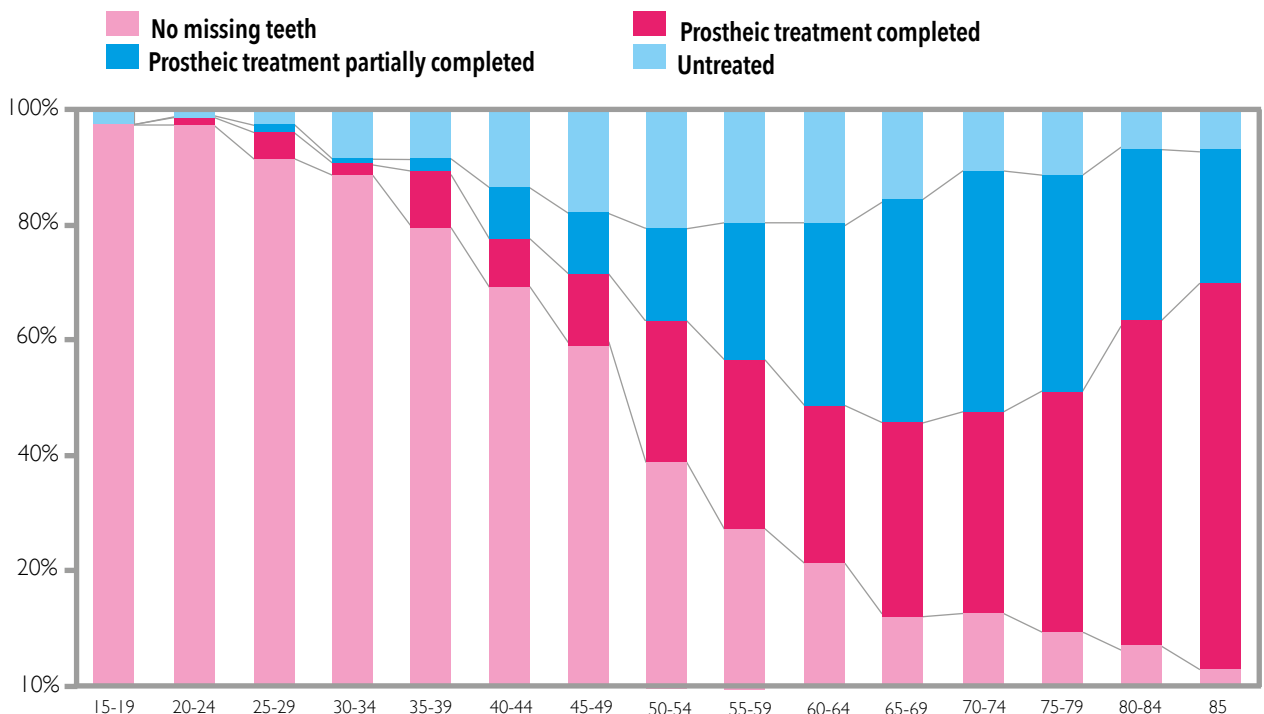
For the 65–74-year age group, the increase in the number of natural teeth was more remarkable than younger adults; that is twice the number of natural teeth present over this time period. This implies that recent Japanese populations, especially elderly people, are keeping more natural teeth than the past. On the other hand, the proportion of edentulous persons decreased each year in all age groups. The graph below shows the changing pattern of the proportion of persons with 20 or more teeth. In all age groups, the proportion of those retaining 20 or more natural teeth has increased, with a substantial increase observed, especially in older age groups. This might be attributed to the national "8020" campaign, which was initiated in 1989, and people's awareness for oral health which has been improving and changing oral health behaviors.

PROPORTIONS OF PERSONS WITH 20 OR MORE TEETH BY AGE GROUP

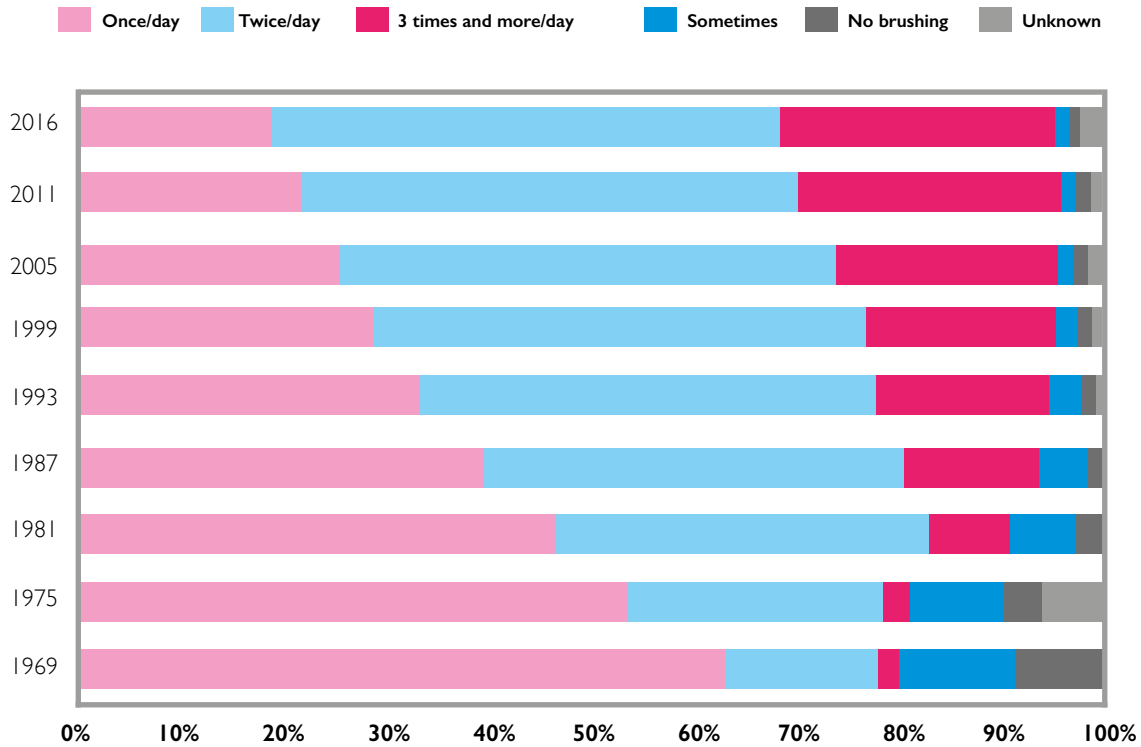


According to the graph below, in total, the proportion of Japanese without missing teeth (not needing prosthetic treatment) was 34.0%, and those who completed prosthetic treatment was 28.3%. In Japan, the public insurance covers most prosthetic treatments, such as dentures and bridges. Therefore, people can receive the prosthetic treatment they require also at a reasonable price.

PROPORTIONS OF PERSONS WITH 20 OR MORE TEETH BY AGE GROUP



REPORTED TOOTH BRUSHING HABIT (1969-2016). 1 YEAR OF AGE AND OVER



Source: National Oral Survey in Japan

In Japan there is no systemic fluoride use and only topical fluorides are available. **In 1969, only 6% of children received topical fluoride application. Recent data shows that this increased to about 60% and indicated a 10-times increase in exposure.** The market share of fluoride toothpaste has also increased dramatically from 12% (1985) to 91% in 2015. According to the National Oral Health Survey, tooth brushing behavior also improved for the whole population. Sugar consumption per person per year decreased from on average 27.5 kg per person in 1970 to 16.1 kg in 2015, a difference of 11.4 kg. These factors, as well as the sufficient numbers in the dental workforce and the universal coverage of the public health insurance system have contributed to the improved oral health of all Japanese people.

Although data show that the oral health of the Japanese population has improved over the last several decades, future challenges and perspectives for Japanese dentistry include: tackling the regional differences in oral health, decreasing the cost of health expenditure, establishment of sustainable emergency oral

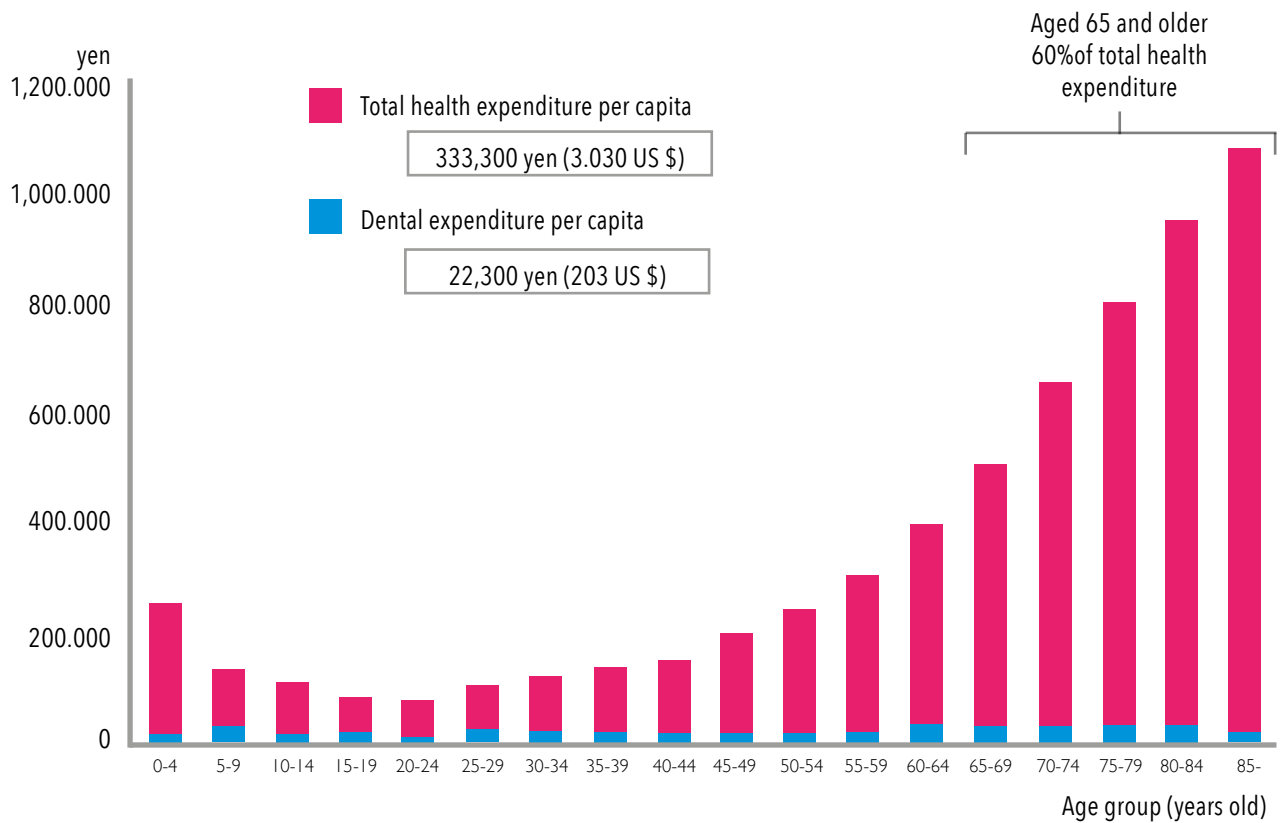
These factors, as well as the sufficient numbers in the dental workforce and the universal coverage of the public health insurance system have contributed to the improved oral health of all Japanese people.

healthcare services in times of disaster and the development of a new tele-dental system for remote or rural areas with limited or no access

to dental professionals. In such situations, oral self-care and prevention of dental diseases are the most important strategies.

According to the Survey on Economic Conditions in Health Care in 2015, the proportion of dental expenses provided by the public health insurance scheme is about 85.8% of total dental health expenditure. The proportion of medical expenses borne by private fees was only 1.2% in 2015. So, this figure can explain the general outline of Japanese health expenditure between the medical and dental components of the insurance scheme. **Personal contributions for dental services are far higher than for medical care.** Total government health expenditure per capita is 333,300 yen (3030 US\$) and dental expenditure per capita is 22,300 yen (203 US\$). Dental expenditure occupies 6.7% of total expenditure in general. It is amazing that those aged 65 years and older use 60% of the total health expenditure. Effective oral health promotion programs targeting younger generations can therefore be expected to contribute to the escalation of medical health expenditure for the elderly population.

TOTAL HEALTH EXPENDITURE AND DENTAL EXPENDITURE PER CAPITA BY AGE GROUP, JAPAN, 2015 (110 YEN= 1USD)



Source: Ministry of Health, Labour and Welfare National Health Expenditures in Fiscal Year 2015 (accessed on 6 June 2018) www.mhlw.go.jp/toukei/saikin/hw/k-iryohi/15/index.html. [Ref list].

USEFUL CONTACTS

- Japan Dental Association (JDA)**
 Over 65,000 dentists in Japan are members of the JDA
 4-1-20, Kudankita, Chiyoda-ku, Tokyo 102-0073, Japan
 Phone: +81 3 3262 9212
www.jda.or.jp/en/introduction.html
- Japanese Association for Dental Science (JADS)**
 (Academic organization organized within the Japan Dental Association)
www.jads.jp/about/outlineenglish.html
- Japan Dental Trade Association**
 Nihon Shika Kikai Kaikan 1F,16-14, 2-chome, Kojima
 Taito-ku, Tokyo 111-0056, Japan
 Phone: +81 338510324
 Fax: +81 338510325
 E-mail: info_office@jdta.org
www.jdta.org/eng/index.html

Sources:

-Extracts and graphs/charts taken from "The Oral Healthcare System in Japan" by Takashi Zaitso, Tomoya Saito, and Yoko Kawaguchi (Healthcare (Basel). 2018 Sep; 6(3): 79. Published online 2018 Jul 10. doi: 10.3390/healthcare6030079). For full and detailed report: www.ncbi.nlm.nih.gov/pmc/articles/PMC6163272/

-Extracts and graphs/charts taken from: "Japan Health System Review" - Health systems in transition. Vol-8, Number-1. ISBN 978-92-9022-626-0. Suggested citation: Sakamoto H, Rahman M, Nomura S, Okamoto E, Koike S, Yasunaga H et al. Japan Health System Review. Vol. 8 No. 1. New Delhi: World Health Organization, Regional Office for South-East Asia, 2018. For full and detailed report: http://apps.searo.who.int/PDS_DOCS/B5390.pdf

-Japan Dental Association: www.jda.or.jp/en/introduction.html



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This Italian company was established as a result of the will of a group of young dental professionals eager to put to good use their experience and to create their own brand. The company has thus started the production of implants, within its plant in the industrial complex of Buccino, just 100km south of Naples.

MaCo Dental Care has recently marked a significant turning point in its market approach, investing significantly in the digital sector: an increasing number of professionals, in fact, rely on the use of advanced tools and applications for their daily work.

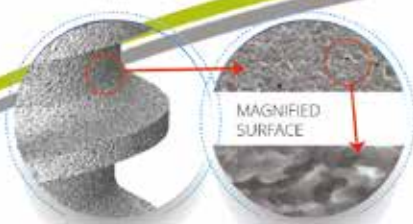
The aim of the company is to offer its customers, alongside reliable and innovative implant systems, core business for which it is already known and appreciated, all the tools required to advanced dentistry to operate and keep up with the times: desk scanners, intraoral scanners, micromotors, biomaterials and, specially, its own guided surgery system that allows to manage all the digital flow and to operate with a dedicated surgical instrumentation. MaCo Dental Care is always looking for new energies and new distributors willing to accept this completely "Made in Italy" challenge.

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info@macodentalcare.com

	<p>CONICAL ACTIVE</p> <p>DIAMETERS</p> <ul style="list-style-type: none"> Ø 3,5mm Ø 3,9mm Ø 4,4mm Ø 5,5mm 	<ul style="list-style-type: none"> Conical connection with internal antirotation hexagon Switch platform system. Anti percolation tapered connection
	<p>SEVENTEEN-ONE</p> <p>DIAMETERS</p> <ul style="list-style-type: none"> Ø 3,30mm Ø 3,75mm Ø 4,20mm Ø 5,00mm Ø 6,00mm 	<ul style="list-style-type: none"> Internal hexagonal connection Switch platform system. Coronal microthread
	<p>IM MACON</p> <p>DIAMETERS</p> <ul style="list-style-type: none"> Ø 3,1mm Ø 3,6mm Ø 4,1mm Ø 4,6mm Ø 5,1mm 	<ul style="list-style-type: none"> Short implant with tapered connection High prosthetic stability without fixing screw Sloped platform design with wide bone-implant surface
	<p>EASY</p> <p>DIAMETERS</p> <ul style="list-style-type: none"> Ø 2,3mm SUPERIOR Ø 2,0mm INFERIOR 	<ul style="list-style-type: none"> Mini implant designed for stabilization of total prostheses. Sphere of 1,8mm Simplified and minimally invasive surgical protocol



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MARKETS INSIGHTS

Author: Silvia Borriello
silvia.borriello@infodent.com

Oral Health at a Glance, South Africa

Total Population

57.3
million

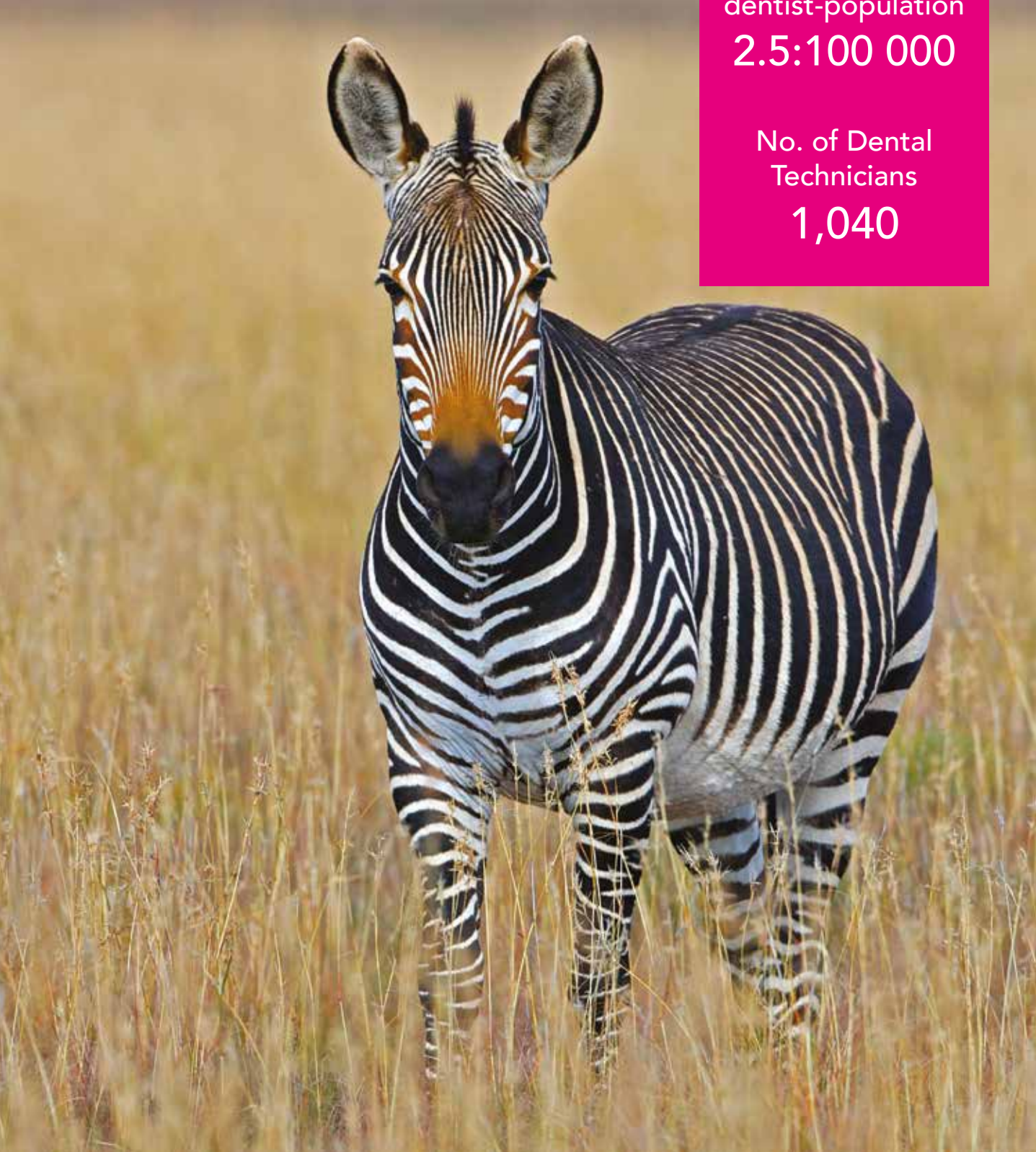
GDP per capita,
USD 6,609

Second-largest
economy
in Africa,
34th-largest
in the world

Parliamentary
Representative
Democratic
Republic

“ Since first free elections in 1994, many were the efforts made by South African governments to combat health inequalities. As the government moves ahead with plans to implement mandatory national insurance to find solutions to universal, sustainable and effective healthcare services there are still extreme differences and disparities and a magnitude of challenges to face. ”





No. of Dentists,
6,466

Ratio
dentist-population
2.5:100 000

No. of Dental
Technicians
1,040

Healthcare services and products in South Africa are provided by parallel running public and private healthcare systems. **The public system serves most of the population (around 80%) through government-run public clinics and hospitals, the wealthiest 17-20% of the population use the private system and are far better served.**

The Bill of Rights in Section 27 of the Constitution of the Republic of South Africa of 1996 states unequivocally that access to healthcare is a basic human right. It guarantees everyone "access to health care services" and states that "no one may be refused emergency medical treatment." Hence, all South African residents, including refugees and asylum seekers, are entitled to access free basic medical care. South Africa spends on average 8.4%-8.8% of its GDP on healthcare, or around US\$437 per capita. Of that, approximately 42% is government expenditure while, a disproportionate 52% comes from private expenditure, even though private healthcare is only available to a very small section of South African society (around 17,1%).

Due to its chronically underfunded system, public hospitals and clinics are often lacking modern equipment and especially personnel. Many doctors prefer to work at private clinics or abroad, since public clinics do not pay well and imply difficult general conditions. According to the General Household Survey 2017, conducted by Stats SA (the national statistical service of South Africa), about seven out of every 10 (71,2%) households used public-health facilities as their first point of access when family members needed healthcare services for an illness or injury. Although some of the provinces in South Africa contain large cities, the bulk of the population lives in rural communities (about 64.7%), which are however only staffed by some 30% of the doctors available and with only 3% of newly qualified doctors taking jobs there. The remaining 70% of doctors work full-time in the private.

Since coming to power in 1994, the African National Congress (ANC) has implemented a number of measures to combat health inequalities in South Africa. These have included the introduction of free healthcare in 1994 for all children under the age of six together with pregnant and breastfeeding women making use of public sector health facilities (extended to all those using primary level public sector healthcare services in 1996) and the extension of free hospital care (in 2003) to children older than six with moderate and severe disabilities.

Furthermore, a National Health Insurance

South Africa spends on average 8.4%-8.8% of its GDP on healthcare, or around US\$437 per capita. Of that, approximately 42% is government expenditure while, a disproportionate 52% comes from private expenditure, even though private healthcare is only available to a very small section of South African society (around 17,1%).

(NHI) initiative, aiming at eradicating financial barriers to healthcare access is now in a pilot phase prior to being implemented across the country in a phased approach from 2016 - 2025. The NHI system aims to ensure universal health coverage for all citizens and residents of South Africa, irrespective of socioeconomic status, to have access to good-quality, affordable health services.

The NHI is speculated to propose that there be a single National Health Insurance Fund (NHIF) for health insurance that would buy services from accredited public and private facilities, which would then provide care for registered members. This fund is expected to draw its revenue from general taxes and some sort of health

insurance contribution. Currently, most healthcare funds come from individual contributions coming from upper class patients paying directly for healthcare in the private sector. There is in fact a discrepancy between money spent in the private sector which serves the wealthy (about US\$1,500 per head per year) and that spent in the public sector (about US\$150 per head per year) which serves about 84% of the population. The NHI proposes that healthcare fund revenues be shifted from these individual contributions to a general tax revenue. Because the NHI aims to provide free healthcare to all South Africans, the new system is expected to bring an end to the financial burden facing public sector patients.

Registered Persons, HPCSA, October 2018	
Dental Assistants	4,908
Student Dental Assistants	1,949
Oral Hygienists	1,226
Student Oral Hygienists	400
Dental Therapists	743
Student Dental Therapists	282
Dentists	6,466
Student Dentists	1,158
Medical Practitioners	46,091
Medical Students	13,158

Source: HPCSA, www.hpcs.co.za/Publications/Statistics

The oral healthcare system very much reflects general health. **The richest part of the population is privately insured, and oral care is comparable to the European standards but the majority of South Africans have no access to private services and are dependent on the government for oral health-care; but just around 10% of the population uses public oral health services.** This underutilization is due to limited resources and inaccessibility. Consequently, oral diseases are widespread and affect large numbers of people in terms of pain, tooth loss, disfigurement, loss of function. There are 6,466 dentists including 481 dental

specialists registered within the Health Professions Council of South Africa (HPCSA). Dental specialists are mostly divided into maxillo-facial surgeons (30%), orthodontists (30%) and prosthodontists (17%). The number of dentists has increased at around 2% per annum and most dentists and dental specialists reside in the most metropolitan provinces of South Africa. In the past decade, the number of female dentists has almost doubled, and the number of Colored, Black and Asian/Indian dentists and dental specialists has increased sharply, which could be a result of increased admission of previously disadvantaged students to dental schools. In line with the sentiments of

#feesmustfall protesters who in 2015 sparked a nationwide revolt against high university fees as a barrier for deserving poor students, the Government's policy to fully subsidized higher education and training for poor and working-class students will in fact further ensure access to more students to enroll in health studies. Only one in six registered dentists works in the public sector. **There are fewer than 2.5 dentists per 100 000 people in the country. The situation is even more complicated when it comes to dental specialists, with only 160 in the public sector in the entire country. This translates into fewer than half a specialist (0.4) per 100 000 people.**

Number of Dental Practices by Province									
Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Limpopo	Mpumalanga	Northern Cape	North West	Western cape	TOTAL
298	209	2,322	924	361	276	72	233	1,099	5,794

Source: www.medpages.co.za/sf/index.php?page=stats&countryid=1. Medpages Database. Both public and private practitioners are included, though private sector data is more complete than public sector (Medpages database is not the official statistics institution)

DENTAL SCHOOLS

- **Cape Peninsula University of Technology**
The Faculty of Health and Wellness Sciences
www.cput.ac.za/academic/faculties/healthwellness/departments
- **Durban University of Technology**
The Department of Dental Sciences
www.dut.ac.za/faculty/health_sciences/dental_sciences
- **Sefako Makgatho Health Sciences University**
www.smu.ac.za
- **University of Pretoria - Faculty of Health and Sciences**
www.up.ac.za/school-of-dentistry
- **University of the Western Cape**
www.uwc.ac.za/Students/Admin/adminreq/Pages/Faculty-of-Dentistry.aspx
- **University of the Witwatersrand, Johannesburg**
www.wits.ac.za/course-finder/undergraduate/health/dental-science

The Competition Commission is a statutory body constituted in terms of the Competition Act, No 89 of 1998 by the Government of South Africa empowered to investigate, control and evaluate restrictive business practices, abuse of dominant positions and mergers in order to achieve equity and efficiency in South Africa in order to:

- Promote the efficiency, adaptability and development of the economy;
 - Provide consumers with competitive prices and product choices;
 - Promote employment and advance the social and economic welfare of South Africans;
 - Expand opportunities for South African participation in world markets and recognise the role of foreign competition in the Republic;
 - Ensure that small- and medium-sized enterprises have an equitable opportunity to participate in the economy; and
 - Promote a greater spread of ownership, in particular to increase the ownership stakes of historically disadvantaged persons.
- www.compcom.co.za

Ratio Per One Oral Health Professional to Population in 2010, by Province

Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Limpopo	Mpumalanga	Northern Cape	North West	Western Cape
30,514	19,214	6,217	15,540	32,967	15,797	20,070	14,957	5,167

Source: Lehohla PJ. Mid-year population estimates by province. Statistics South Africa. Statistics release [serial online]. (P0302); 2010:4 [cited 2012 May 19]. Available from: www.statssa.gov.za/publications/P0302/P03022011.pdf

Fisher R. Oral health professionals' statistics by provinces. The who, what & where of health care. Medpages Statistics [serial online]. 2010:1-2 [cited 2012 Jun 20]. Available from: www.medpages.co.za

As consequence,
public health dentists focus largely on
extraction rather than any restorative
procedures or prevention.

**NATIONAL ORAL HEALTH SURVEY
(1999-2002)**

- Caries free, 6-year-olds - 39.7%
- DMFT, 12-year-old group - 1.1 (from 2.5 in 1982)
- Children with signs of dental fluorosis - 20.2%



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Fisher R. Oral health professionals' statistics by provinces. The who, what & where of health care. Medpages Statistics [serial online]. 2010:1-2 [cited 2012 Jun 20]. Available from: www.medpages.co.za

With more than 90% of South African dentists working in the private sector, treating only 17-20% of the population (those covered by some form of private health insurance), most South Africans look to the public sector for their healthcare needs; a public sector under immense pressure and ill-equipped. As consequence, public health dentists focus largely on extraction rather than any restorative procedures or prevention.

Due to the general lack of oral health facilities and workforce, exacerbated by an unequal distribution of dental services in the country, oral health disparities continue to widen, more so amongst the disadvantaged

and vulnerable groups. To escalate matters further, the high burden of infectious diseases such as HIV and TB faced by the country impacts upon budgetary priorities reducing the availability of funding for oral health matters.

There are currently no oral health surveillance data being collected on a regular basis besides that of services provided. There are few school-based oral health programs in the country and regrettably, there is no monitoring and evaluation. These factors raise questions with regards to the reliability of what is now known about the state of oral health in the country. The last available National Oral Health Survey seems to have been conducted well over a decade

ago (1999-2002). The results showed a general reduction in dental caries severity of the permanent dentition of 12-year-old children; they however also revealed that the greatest need for the treatment of dental caries in South African children was for preventive services, restorations and extractions. **Approximately 60% of primary school children suffered from dental decay and, more concerning, over 80% of these children remained untreated due to the overburdened oral health system and poor health seeking behavior.** Oral health needs vary widely from province to province. The greatest need was recorded in the Western Cape, where almost

DENTAL SCHOOLS

- **Cape Peninsula University of Technology**

The Faculty of Health and Wellness Sciences

www.cput.ac.za/academic/faculties/healthwellness/departments

- **Durban University of Technology**

The Department of Dental Sciences

www.dut.ac.za/faculty/health_sciences/dental_sciences

- **Sefako Makgatho Health Sciences University**

www.smu.ac.za

- **University of Pretoria - Faculty of Health and Sciences**

www.up.ac.za/school-of-dentistry

- **University of the Western Cape**

www.uwc.ac.za/Students/Admin/adminreq/Pages/Faculty-of-Dentistry.aspx

- **University of the Witwatersrand, Johannesburg**

www.wits.ac.za/course-finder/undergraduate/health/dental-science

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- Promote employment and advance the social and economic welfare of South Africans;
- Expand opportunities for South African participation in world markets and recognise the role of foreign competition in the Republic;
- Ensure that small- and medium-sized enterprises have an equitable opportunity to participate in the economy; and
- Promote a greater spread of ownership, in particular to increase the ownership stakes of historically disadvantaged persons. www.compcom.co.za

REGISTERED DENTAL TECHNICIANS/ DENTAL

Year	Total Registered	New Registrations	Deregistered
2016/2017	1,121	36	86
2017/2018	1,040	7	2

Source: <https://sadtc.org.za/education/>

RACE	GENDER	GEOGRAPHICAL LOCATION
Black: 126 Colored: 79 Indian: 83 White: 747 Other: 5	Female: 256 Male: 784	Eastern Cape: 41 Free State: 34 Gauteng: 476 Kwa-Zulu Natal: 152 Limpopo: 22 Mpumalanga: 33 North West: 31 Northern Cape: 10 Western Cape: 238 Overseas: 3

Source: <https://sadtc.org.za/education/>

	2017/18	2016/17
Lab Owners (Dental Technicians/Technologists)	622	660
Lab Owners (Dentists)	51	51
Dental Traders	9	9
University Lecturers	15	14
CDP Providers (Continuing Professional Development)	24	24
Graduates (Technicians and Technologists)	91	93

Source: <https://sadtc.org.za/education/>

REGISTRATION OF DENTAL LABORATORIES

Year	Total Registered	New Registrations	Deregistered
2017	641	24	35
2018	605	2	5

Source: <https://sadtc.org.za/education/>

80% of children needed oral healthcare and the lowest need in Limpopo province. It was further indicated that 32% of children required orthodontic treatment because of premature dental extractions. A considerable majority of adolescents and adults presented with gingivitis and periodontal diseases. With the high prevalence of HIV/AIDS, many of the infected patients also suffer oral HIV-associated lesions. The Dental Aesthetic Index was used to assess the prevalence of malocclusion and 32.3% of 12-year-old children needed definitive orthodontic treatment.

According to a research by Oral-B in 2014 (survey of 1,000 male and female South Africans who live in South Africa and are the primary oral care shoppers, aged 18+), in which the vast majority of South Africans say that their oral health is important to them, 42% had not seen a dentist in the 12 months before being surveyed. **About half of those who did visit a dentist also highlighted that they only did so because of a specific problem and not because it was time for a general check-up.** High levels of oral diseases and curative treatment is economically draining for a country like South Africa, resulting in a greater need for highly skilled oral health professionals, expensive equipment, oral health facilities and the necessary financial resources. An effective way to address these issues could be the need for a population-based system with a focus on prevention of oral disease and oral health promotion, as opposed to the existing curative-driven and individually focused system. Among the expertise, dental public health specialists, also known as community dentistry specialists, are particularly trained to work for the public to assess the dental needs of the population. They are not primarily clinical specialists but rather focus on the oral health status of the whole population as opposed to that of individuals. They are trained to plan appropriate evidence-based interventions and preventive programs, to formulate, supervise and evaluate oral health policies and strategies to benefit the whole population and to manage the oral health services of the country. While there are 36 of these professionals registered within the HPCSA, their skills seem to be largely underutilized in the public health system arena, most of them being employed in academia institutions, primarily due to lack of employment opportunities in the public sector.

Furthermore, the current number of oral health professionals in South Africa is not enough and there is shortage of adequately trained oral

health professionals to meet oral health needs of the population in the public sector. Provinces such as Limpopo and Northern Cape have few oral hygienists employed in the public sector. This is of concern because preventive and/or promotive community oral health services are driven primarily by oral hygienists.

Even on the dental technology sphere, the current status quo regarding limited or non-existent accessibility to affordable services offered by dental technicians to ordinary South Africans is a real problem affecting millions of people, especially those from the previously disadvantaged background. In such a context, the proposed National Health Insurance (NHI) becomes key. An increasingly-ageing population requires an efficient and more feasible prosthetic service, without compromising on standards, to meet the needs of the edentulous population in South Africa. Within the framework of gloom economy is the difficulty for dental laboratory owners to employ graduates, or for graduates to set up their own dental laboratory. There is a mismatch between student graduate numbers and the graduates that enter and stay in the profession due to barriers in opening and running their own laboratories. Furthermore, there is stiff competition, dominance and protectionist practices by established technicians. The concentration of technicians and technologists in urban areas further compounds the

On the positive side, however, is the Government's policy announcement to provide free tertiary education which will mean more students will enroll to pursue studies in dental technology.

situation. On the positive side, however, is the Government's policy announcement to provide free tertiary education which will mean more students will enroll to pursue studies in dental technology. Up until now students, especially from disadvantaged backgrounds, had to either be funded through student loans (if they qualified) and had to endure harsh socio-economic conditions in universities.

Dental technology practitioners that practice in the Republic must be registered within the South African Dental Technicians Council (SADTC). According to the Council, the breakdown of the racial and gender profile of registered practitioners and students within the profession remains largely skewed. Three universities in South Africa offer training for dental technicians/ technologists as well as dental assistants (Cape Peninsula University of Technology, Durban University of Technology, Tshwane University of Technology).

Medical and Dental Industry

Even if actual growth does not match that of other African economies, South Africa is the most advanced, diversified and productive economy in Africa, enjoying relative macro-economic stability and a largely pro-business environment. It is, for this, the primary business hub for the medical device industry in Sub-Saharan Africa as a substantial portion of medical device and lab equipment exports are sent to other parts of Africa.

Even if underdeveloped and **considerably restrained by funding issues, poor infrastructure and staff shortages, particularly in the public sector, South Africa's health market offers potential for growth, also influenced by national legislation related to the implementation of government's National Health Insurance program.** This combined with the Competition Commission's market inquiry into private healthcare costs and further changing legislation will effect radical change to the purchasing and provision of private and public healthcare in South Africa. Despite recent cutbacks, the government sector is still the major purchaser of healthcare equipment and supplies. Opportunities will exist for exporters of medical equipment, especially new and innovative equipment, as extensive upgrades and development of hospital infrastructure is being considered. **Nonetheless, the best prospects for advanced technology and equipment remain in the private sector as**

very sophisticated and boasts world class facilities with several centers of excellence.

The government's encouragement of public private partnerships in the development of hospitals is a new area of growth.

There is limited medical device production in South Africa and the market is largely dependent on imports (around 90%). Local firms tend to be small or medium sized businesses with less than 50 employees and often combine distribution activity with manufacturing. Multinational companies often operate in a joint venture capacity with local firms. Most South African manufacturers specialize on producing basic medical equipment and supplies. According to an "Africa Health" report by Informa, a leading international events, intelligence and scholarly research group, the output by the domestic medical manufacturing industry is estimated to be around USD 200mn-USD 300mn, of which more than half is exported. Production is focused on bandages and dressings, medical furniture and low technology items. The import market is dominated by the United States and Germany followed by China, Switzerland, the United Kingdom and Japan in all categories, but particularly in orthopedics, prosthetics, patient aids, other devices and consumables. Buyers are increasingly looking towards sourcing from Asian markets to save on costs. China is making significant inroads, increasing by around 10% in terms of market share. Consistent with healthcare infrastructure upgrades, the demand

for diagnostic imaging equipment is forecast to grow approximately 12% between 2016 and 2021. Although dental equipment represents the smallest product area (3.6% of all medical imports), it grew at a CAGR of 10.2% in the past year even if access to good dental health remains a problem for most of the population in the public sector. Because of the high quality of dental care available in private settings and in combination with its general tourism appeal, South Africa has seen an increase in dental tourism industry. First class surgeons work to extremely high standards in clinics, offering procedures at a fraction of the cost of European and US centers. Cape Town and Johannesburg are particularly popular. People are in fact not just visiting for simple treatments like fillings, whitening, dentures and implants but many come seeking wisdom tooth extraction, cleft lip and palate surgery and even surgery for the replacement of damaged or lost bone.

Regulations - The Department of Health has issued (2016) new regulatory requirements for medical and in vitro diagnostics (IVD) devices which will be overseen by a recently established regulatory authority, the South African Health Products Regulatory Authority (SAHPRA). This entity has adopted harmonization initiatives that will ultimately see an alignment of registration and product approval requirements with those of regulatory authorities in other regions.

Also, the National Treasury published new revised Preferential Procurement Regulations in January 2017, which came into effect on April 1, 2017, replacing the previous regulations from 2011. The revised preferential procurement regulations will help optimize procurement strategies in South Africa, although corruption remains a critical issue hindering effective procurement. Multinational medical device companies will aim to develop strategies that are in line with the country's socio-economic policies to counter the increasing preference for local suppliers. The revised preferential procurement regulations will make it harder for foreign companies to win government tenders, making local companies more competitive. Tenders are now geared further to supporting the government's broader objectives: favoring small, medium and micro enterprises (SMMEs), which complement the government's aims of employment creation and income generation using local suppliers.

Among Main Sources:

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- Extracts from "Market Insights: South Africa Medical Devices Market" for Africa Health Exhibition & Congress, by Informa, a leading international events, intelligence and scholarly research group. For full report: [AFH19_Industry_Insights_Medical_Devices_Market_REPORT.pdf](#)
- Extracts from "How new regulation could impact the USD1.27 billion medical device market in South Africa", Africa Health by Informa Markets, for full article: [www.](#)

SOUTH AFRICA MEDICAL DEVICE MARKET VALUE BY PRODUCT CATEGORY, 2018

Devices	USD Millions
Consumables	241.00
Diagnostic Imaging	199.30
Orthopedics & Prosthetics	153.70
Patient Aids	156.00
Dental Products	41.30
Other Medical Devices	487.10
TOTAL	1,278.40

Source: AFH19_Industry_Insights_Medical_Devices_Market_REPORT.pdf

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 -"South Africa Medical Devices" and "South Africa Market Overview" by Export.gov. For detailed articles: www.export.gov/article?id=South-Africa-medical-devices and www.export.gov/article?id=South-Africa-Market-Overview
 Prepared by our U.S. Embassies abroad. With its network of 108 offices across the United States and in more than 75 countries, the U.S. Commercial Service of the U.S. Department of Commerce utilizes its global presence and international marketing expertise to help U.S. companies sell their products and services worldwide.
 -South African Government, www.gov.za/about-sa/health-statistics South Africa's (Stats SA), the national statistical service of South Africa: www.statssa.gov.za
 -The South African Dental Association: www.sada.co.za/dental-schools/
 -Health Professional Council of South Africa (HPCSA), <https://www.hpcsac.co.za/Publications/Statistics>
 -"SA Dentistry Tourism Booming in 2017", by Joanne Miller, www.news24.com/MyNews24/sa-dentistry-tourism-booming-in-2017-20170401
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 -"Wits Oral Health sinks its teeth into World Oral Health Day" University of the Witwatersrand, Johannesburg, Dr.

Mpho Molete, <https://www.wits.ac.za/news/sources/health-news/2018/wits-oral-health-sinks-its-teeth-into-world-oral-health-day.html>
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 -South Africa Overview: <https://countries.bridgat.com/south-africa/>
 -OECD Economic Surveys: South Africa 2017: www.oecd-ilibrary.org/economics/oecd-economic-surveys-south-africa-2017_eco_surveys-zaf-2017-en
 -"Minimum Data Sets for Human Resources for Health and the Surgical Workforce in South Africa's Health System" authors Percy Mahlathi and Jabu Dlamini (African Institute of Health & Leadership Development). For full report: www.who.int/workforcealliance/031616south_africa_case_studiesweb.pdf

TOP SUB-SAHARAN DESTINATIONS FOR MEDICAL DEVICES FROM SOUTH AFRICA, 2017

Country	USD Millions
Namibia	31.46
Botswana	18.85
Uganda	9.80
Swaziland	9.69
Zimbabwe	9.55
Zambia	5.90
Kenya	5.85
Mozambique	4.82
Lesotho	3.91
Malawi	3.47
Tanzania	3.29
Mauritius	2.64
Democratic Republic of Congo	2.23

Source: AFH19_Industry_Insights_Medical_Devices_Market_REPORT.pdf by Africa Health, an Informa Experience

USEFUL CONTACTS

- Health professional Council of South Africa (HPCSA)
553 cnr Hamilton and Madiba Streets,
Arcadia, 0001 Pretoria, South Africa
Tel: (+27) 12 338 9300
info@hpcsa.co.za // www.hpcsa.co.za

The HPCSA is a statutory body committed to promoting the health of the population, determining standards of professional education and training, and setting and maintaining excellent standards of ethical and professional practice, ensuring continuing professional development and fostering compliance with healthcare standards. All individuals who practice any of the health care professions incorporated in the scope of the HPCSA are obliged by the Health Professions Act No. 56 of 1974 to register with the Council. Failure to do so constitutes a criminal offence.

- The South African Dental Association (SADA)
31 Princess of Wales Terrace, Johannesburg
2193 South Africa
Phone +27 11 484 5288
info@sada.co.za // www.sada.co.za

- South African Dental Therapy Association (SADTA)
32 Inanda Rd, Hillcrest, Durban
3650 South Africa
https://dentaltherapysa.co.za

- South African Medical Devices Industry Association (SAMED)
Hammets Crossing Office Park
Prince House 816/4
No 2 Selborne Road, Johannesburg North, Randburg,
South Africa
Phone +27 11 704 2440
info@samed.org.za // www.samed.org.za

SAMED promotes, represents and safeguards the interests of the South African Medical Device and In-Vitro Diagnostics (IVD) industry, focuses on healthcare matters relevant to its members' interests. The association aims to provide member companies - local and multinational - with a collective, objective and credible platform to engage with stakeholders. SAMED's members include individual medical technology companies, associated members and associations

- South African Dental Technicians Council (SADTC)
954 Cnr Hill & Arcadia Street,
Arcadia, Pretoria, Gauteng
Postal Address: P.O. Box 14617,
Hatfield 0028
Tel +27 12 342 4134 /4230
Fax +27 12 342 4469
info@sadtc.org.za // www.sadtc.org.za

- Oral Hygienists Association of South Africa
501 Thibault House,
Hans Strijdom Avenue
Cape Town, 8001
Tel: +27 21 419 4857
www.ohasa.co.za

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20/20 VISION

The Oral Reconstruction Foundation is committed to science and education for the good of the patient. The Foundation invests in research, supports interdisciplinary knowledge exchange and promotes training and education in implant dentistry and related fields.

This is reflected perfectly in the 2020 Oral Reconstruction Global Symposium with the theme "20/20 Vision". A world-renowned lineup of speakers from implant dentistry related disciplines will cover a wide range of contemporary issues in implant dentistry and tissue regeneration. A multitude of breakout sessions and hands-on exercises on topics such as digital workflow, immediate full arch treatment, L-PRF applications, hard and soft tissue grafting, immediate placement and temporization, prevention and management of peri-implant diseases, and many more are planned. The Symposium will also include lectures on extraction site management, tissue regeneration, digital workflow, long-term sustainability, and experts' discussions of challenging cases.

The Global Symposium offers the perfect opportunity to stay abreast of the latest treatment options while enjoying time with colleagues in the heart of Times Square.



The city is home to numerous museums, parks, trendy neighborhoods and shopping streets.

The city is home to numerous museums, parks, trendy neighborhoods and shopping streets. promoted training and continuous education. It has established a networking platform for international experts in a wide range of disciplines to foster the permanent exchange of knowledge and ideas. The Foundation firmly believes that the best way to consolidate the scientific basis of oral reconstruction and serve patients' needs is to promote close international collaboration between universities, practitioners, technicians, and industry. Activities organized or planned under the patronage of the OR Foundation respect these principles in the same way they support the Foundation's objective: teaming up science and education to serve the patient.

Mark your calendar for the Oral Reconstruction Global Symposium 2020 at the iconic New York Marriott Marquis

April 30 – May 2, 2020 · New York City, USA
New York City, the largest city in the U.S., is an architectural marvel with plenty of historic monuments, magnificent buildings and countless dazzling skyscrapers. Besides the architectural delights, New York is an urban jungle that has everything to offer to visitors.

About the Oral Reconstruction Foundation

The Oral Reconstruction (OR) Foundation was originally founded in 2006 as the CAMLOG Foundation by the CAMLOG Company in Basel, Switzerland and relaunched in 2016 as the independent OR Foundation. The US Section of the OR Foundation was founded that same year. From the outset, the OR Foundation has supported basic and applied research projects, granted research funding to young scientists, and

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