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2 -2016
May - August

Inside:

- Focus: **Ageing and Health A global priority.**
- Special Report: **Developing Countries and the Burden of Orthopaedic Rehabilitation**
- Market Overview: **Doing business in Azerbaijan**

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Automatic Pressure Infusor

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The company based in Austria / Europe introduced the AUTOPRESS device as an important part of its fluid warming philosophy. Autopress works directly with Biegler blood and infusion warmers to deliver blood and fluids at high flow rates or as a stand-alone unit to deliver fluids at constant pressure up to 300 mmHg wherever needed.

Pressure infusing bags are mainly used for irrigation purposes during arthroscopy, laparoscopy and hysteroscopy. The adjusted pressure is constantly maintained and therefore does not require manual compensation.

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Editorial

A RAPIDLY CHANGING WORLD

The world stands on the threshold of an unprecedented demographic transformation as global populations are rapidly ageing and few countries in the world are prepared to deal with their increasing needs. Life expectancy continues to rise in almost every country; the proportion of people aged over 60 years is growing faster than any other age group as a result of both longer life expectancy and declining fertility rates.

The increase in longevity, especially in high-income countries, has been largely due to the decline in deaths from cardiovascular disease mainly because of simple, cost-effective strategies to reduce tobacco use and high blood pressure as well as improved coverage and effectiveness of health interventions.

This population ageing can be seen as a success for public health policies and for socioeconomic development, but it also challenges society to adapt, in order to maximize the health and functional capacity of older people as well as their social participation and security. On this purpose Infomedix has focused its main article on ageing and health as a global priority.

Older people are often assumed to be frail or dependent, and a burden to society. Age discrimination is publicly not considered as a serious concern. Other than other forms of discrimination, it is largely accepted that, for example, older people get less services or that they are expected to consume less public funds. If you compare rehabilitation services, which are needed both by younger and older persons, we find that older persons get much less. Public health, and society as a whole, need to address these and other ageist attitudes, which can lead to discrimination, affect the way policies are developed and the opportunities older people have to experience a healthy ageing.

Our special orthopaedic section is strictly connected to the ever-increasing geriatric population as the global orthopaedics products market is on the rise, expected to reach nearly US$ 47 billion by 2020. Such rise is certainly linked to global ageing, the increasing rate of osteoarthritis, osteoporosis and obesity as well as other factors. Just like all health sectors, orthopaedics too has its issues to solve and we have engaged our research on the difficulties encountered by developing countries in orthopaedic rehabilitation.

We believe that it is in the interest of all of us to contribute in the awareness that an action to formulate evidence-based policies that strengthen the abilities of older persons is required. Health systems need to be better organized around older people's needs and preferences, by strengthening universal healthcare and people-centered and integrated health services; by reducing the incidence of chronic disease and disability; by keeping them economically engaged for a much longer time; by developing systems that provide long-term care to meet the needs of older people; by creating age-friendly cities and communities and a lot more to be done...

The proportion of people aged over 60 years is growing faster than any other age group as a result of both longer life expectancy and declining fertility rates.

Collectively, we need to look beyond the costs commonly associated with ageing to think about the benefits that an older, healthier, happier and more productive older population can bring to society as a whole. With good policymaking, most of the burdens can be ameliorated and most of challenges overcome. Whether we consider the economic or the human benefits, nothing will do more to address the global ageing challenge than to ensure that health spans rise along with life spans.

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2-2016
May / August

Contents

We are excited to develop an innovation in our Infomedix magazine. Starting from the upcoming issue our focuses are changing, nevertheless remaining loyal to our articles on the economic and medical markets as well as worldwide industry news.

FOCUS - AGEING AND HEALTH A GLOBAL PRIORITY

"Many countries - especially in the developed world - are now bracing themselves for the fact that their fastest-growing demographic is the over-80s. By 2040, the populations of Brazil and Mexico will be nearly as old as that of the United States..."

HOT TOPIC - DEVELOPING COUNTRIES AND THE BURDEN OF ORTHOPAEDIC REHABILITATION

"Studies on living conditions of people with musculoskeletal impairments in developing countries reveal large gaps in the provision of medical rehabilitation and assistive devices. Regional and socioeconomic inequalities in access are evident and..."

contents

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Back Cover
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Calze Olona Top Quality Italian Company Production

Calze Olona Srl, established in 1964, is located in Locate Varesino, in the province of Como, where it manufactures a large and qualified range of graduated compression elastic hosiery for the care and prevention of varicose veins, with graduated compression from 7 mm Hg to 30 mm Hg, in different models that include woman hosiery, man socks, anti-thrombosis and medical hosiery.

Calze Olona Srl facility is more than 3000 sqm, with over than 100 computerized circular looms with electronic controls and 40 machineries for a production of more than 3,000,000 pairs a year, with the use of high quality yarns.

The first step of the production and all the following ones, from the sewing of the toes to the pantyhose assembling, from the application of the thigh-high bands to the waist band ones, from the application of the personalized labels to the packaging, are completely done inside the two facilities of the company in order to be able to submit the whole production to constant internal controls of the quality and of the graduated compression levels. The only external operations are the fixing and the dyeing because, for ecological reasons, they are done by another company in northern Italy, highly specialized and with suitable environmentally certifications for the health protection.

Therefore we can say that Calze Olona produces elastic hosiery of high quality, long duration and elegance Made in Italy, in a wide range of colors, in order to meet the market request and for the customer satisfaction.

Despite the high quality of the Italian production, the dynamic and simple organization of Calze Olona is able to guarantee very competitive prices.

Calze Olona company is an Italian company appreciated all over the world, that offers its own production in private label to the Italian and foreign companies which deal with orthopedics, pharmacies, parapharmacies, rest homes, rehabilitation centers and hospitals. The wide range of our articles allows customers to customize their own products according to the needs of their own final markets. Calze Olona is always looking for new partners with whom starting important business cooperation.

Contact us: **www.calzeolona.it** and require the video of the Calze Olona production.

Calze Olona: main facility located 31km from Milan

CALZE OLONA IS SPECIALIZED IN THE PRODUCTION OF A LARGE RANGE OF GRADUATED STOCKINGS, COMPRESSIONS FROM 7 to 30 mm Hg ACCORDING TO THE MODEL, THAT INCLUDES:

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An Italian Example in the Elastic Stockings and Orthopedic Products Field

We turn to doctor Natale Molinari, founder of Luropas company, leader in the elastic stockings and orthopedic field with the Scudotex brand, to know this typical Italian working activity.

Q: Dr. Molinari when did you decide to start your company activities?

A: In 1977 when my wife and me decided to found Luropas company in order to sell our production line and to register it under the Scudotex brand.

Q: Which is the main Luropas production?

A: The main fields we deal with are the ones of the graduated compression hosiery, with the complete range of Scudotex elastic stocking that includes different compressions, from the preventive ones (7 mm Hg) to the therapeutics ones (30 mm Hg), besides the knee-highs for man and the anti-thrombosis models. We also offer a complete line of post-surgical belts, orthopedic corsets and medium-strong corsetry.

Q: Which new markets are you interested in?

A: Scudotex is leader in the Italian market and it is present in more than 40 Countries all over the world, from Europe, to America, to Asia. Our main foreign customers are important companies that mainly deal with pharmacies, orthopedic and sanitary shops or that provide hospitals. Our company mainly sells its products under the Scudotex brand, even if in particular occasions we can offer private label supplies. Being producers, we are also able to provide elastic fabrics for the production of elastic belts and corsets.

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Q: If everything is manufactured in Italy, can your Scudotex products have competitive prices with the competitors?

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Luropas – Scudotex: main facility located 30 km from Milan

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• Biegler Medizinelektronik - More than 40 Years of Experience in the Medical Field

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Focus

Ageing and Health a Global Priority

Many countries - especially in the developed world - are now bracing themselves for the fact that their fastest-growing demographic is the over-80s.
By 2040, the populations of Brazil and Mexico will be nearly as old as that of the United States - and China's will be older. Meanwhile, South Korea will be vying with Germany, Italy and Japan for the title of oldest country on earth.

Author: Silvia Borriello

KEY FACTS

- Nearly one in six Europeans is already aged over 65, a figure higher than the proportion under 15
- By 2020, the number of people aged 60 years and older will outnumber children younger than 5 years
- Rich countries as a whole are seeing fairly uniform growth in life expectancy of around five or six hours per day
- According to United Nations Population Division (UNPD) data, humanity's median age has climbed by five years in the last 20, to an expected 29.1 years in 2010. The next two decades are likely to see a similar increase
- In the oldest society, Japan, the median age is already nearly 45
- Between 1950 and 2005, global fertility per woman nearly halved, reaching 2.6 children - a decline that is expected to continue, albeit more slowly
- Between 2015 and 2050, the proportion of the world's population over 60 years will nearly double from 12% to 22%

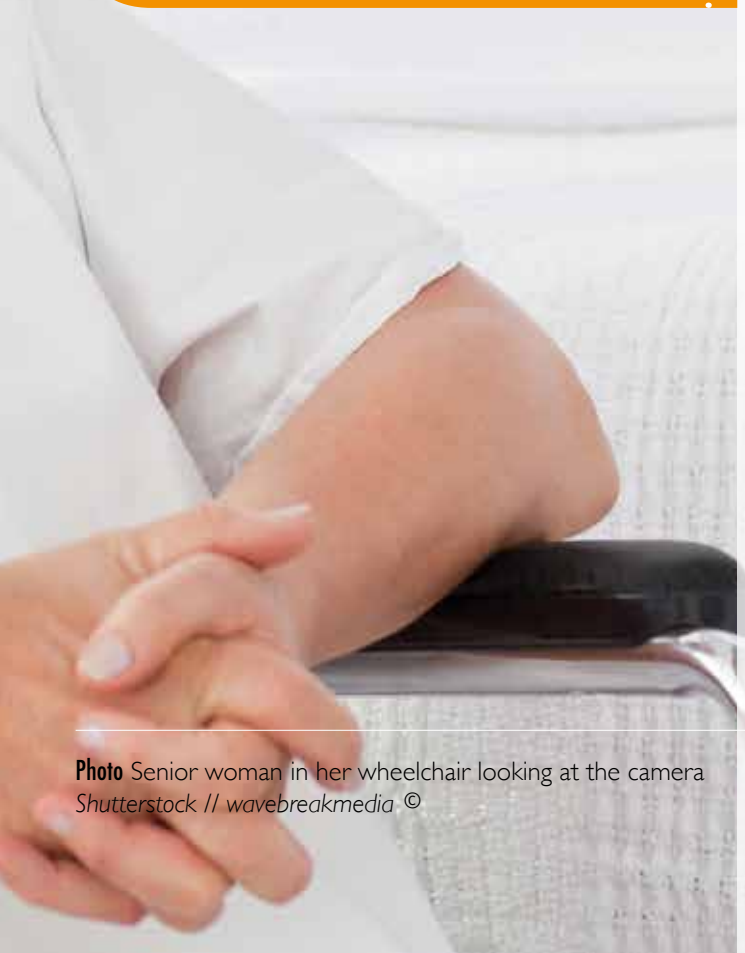

Photo Senior woman in her wheelchair looking at the camera
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According to the World Health Organization, existing healthcare systems are not designed to respond to ageing and older people. There must be a fundamental shift in the way society thinks about this problem. If older people can experience these extra years of life in good health and if they live in a supportive environment, their ability to do the things they value will be little different from that of a younger person. If these added years are dominated by declines in physical and mental capacity, the implications for older people and for society are more negative. Planning cities and communities in this perspective would provide a better old age for many.

Unlike most long-term predictions, there is nothing hypothetical about global ageing, as the demographic transformation is known. Post-second world war baby boom in many countries is one reason for the change but the two more important are a reduction in the fertility rates and a sustained increase in longevity.

According to the World Health Organization (WHO) Report on ageing, by 2050, the world's population aged 60 years and older is expected to total 2 billion, up from 900 million in 2015. **Today, 125 million people are aged 80 years or older. By 2050, there will be almost this many (120 million) living in China alone, and 434 million people in this age group worldwide.** By 2050, 80% of all older people will live in low- and middle-income countries.

The pace of population ageing around the world is also increasing dramatically. France had almost 150 years to adapt to a change from 10% to 20% in the proportion of the population that was older than 60 years. Places such as Brazil, China and India will have slightly more than 20 years to make the same adaptation.

While this shift in distribution of a country's population towards older ages – known as population ageing - started in high-income countries (in Japan 30% of the population is already over 60 years old), it is now low- and middle-income countries that are experiencing the greatest change. By the middle of the century many countries for e.g. Chile, China, the Islamic Republic of Iran and the Russian Federation will have a similar proportion of older people to Japan.

In many countries, the fastest-growing demographic group is the over-80s or -85s, often termed "the oldest old". **Such greater longevity, suggesting that ageing is a biological process, rather than a chronological one, may bring some people to spend nearly as much time in retirement as they did in their working lives.** A longer life brings with it opportunities. There is, however, little evidence suggesting that older people today are experiencing their later years in better health than their parents. While rates of severe disability have declined in high-income countries over the past 30 years, there has been no significant change in mild to moderate disability over the same period. Additional years provide the chance to pursue new activities such

as further education, a new career or pursuing a long neglected passion. Older people also contribute in many ways to their families and communities. Yet the extent of these opportunities and contributions depends heavily on one factor: health.

Economic Impact of Ageing on Health Systems

Although it is extremely difficult to predict the impact that population ageing will have on healthcare expenditures, it is also true that demographic change has had less of an impact on health spending than is widely believed. Even if older age is generally associated with an increased need for care, the link between the need for care and utilization is weak. For example, despite the high burden of disease in low income countries, older people tend to use health services significantly less often than younger adults. Even in high-income countries, poorer older people, who generally have greater needs, tend to use services less often than their more financially secure peers. Indeed, there is growing evidence from high-income countries that starting at around age 70, healthcare expenditure per person falls significantly while expenditures made outside the traditional health system increase.

Research in high-income countries suggests that predicting increases in healthcare costs on the basis of population ageing is simplistic and unlikely to lead to good policy decisions.

The link between age and healthcare costs is strongly influenced by the health system itself. For example, one study of OECD countries (Organisation for Economic Co-operation and Development) suggested that age-related increases in cost are much higher in Canada and the United States than in Spain and Sweden, with costs in Australia, Japan and the United Kingdom lying somewhere between. This is likely to reflect different provider systems, incentives, approaches to interventions in frail older people and cultural norms, particularly near the time of death.

In reality, birth and death account for the majority of an individual's lifetime healthcare costs; the time to death is in fact a better predictor of healthcare expenditure than chronological age. What is becoming more apparent is that healthcare spending on the average individual rises rapidly in the year or two before death, whether the person is 8 years old or 88. Moreover, this near-death spending constitutes the dominant proportion of lifetime health expenditure, consuming about one-quarter of the total cost. It only looks as though the elderly spend dramatically more on health because statistically more people die after the age of 65. Research from Australia and the Netherlands estimated that around 10% of all healthcare expenditures reflect the cost of caring for people during their last year of life and that these costs fall with increasing age. In the United States, around 22% of all medical costs may be spent on patients during the last year of life. Because it is these last years of life that are by far the greatest driver of increasing healthcare expenditures, the economic

Photo Doctor or nurse talking to patient in hospital
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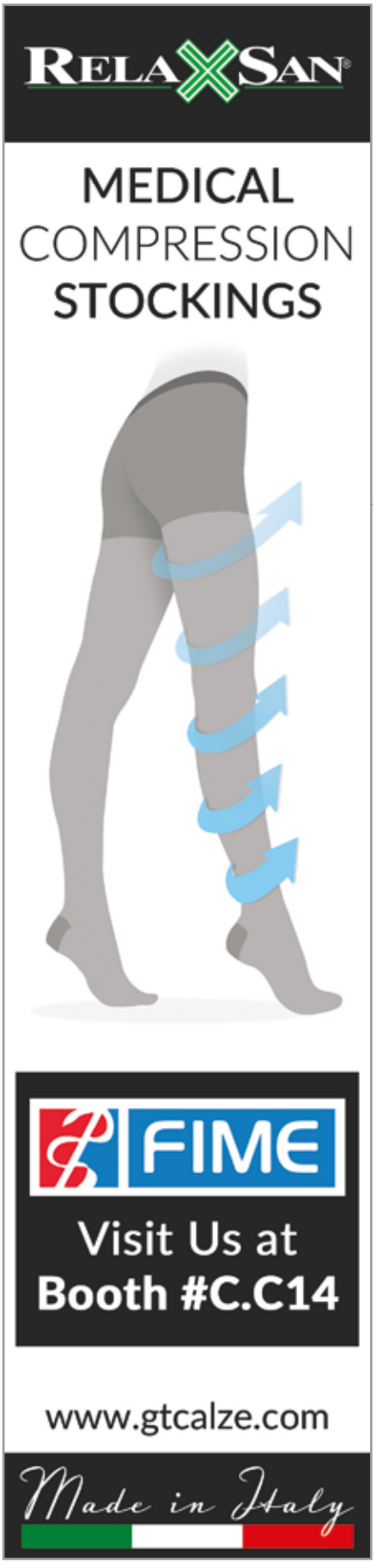
modelling of future costs needs to consider these trends alongside changes in the proportion of older people in a population.
Of course, rising life expectancy means that the last years of life will increasingly occur in advanced old age. Because this is an age group among which health-service expenditures tend to fall, enabling people to live long and healthy lives may actually ease pressures on the inflation of healthcare costs.
One concern may be that interventions in midlife might merely postpone expenditures to a later period in life and result in greater cumulative costs across an individual's life course. Although there is only limited research in this field, this does not appear to be the case, with the immediate benefits and the delayed costs appearing to balance out over time. Furthermore, one study from the Netherlands (a country with a comprehensive system of long-term care) mirrors the trend noted above, with better health in early older age resulting in lower hospital expenditures during the remaining lifetime but in higher expenditures for long-term care (costs are likely to be higher when death in hospital is the norm).

Research in high-income countries suggests that predicting increases in healthcare costs on the basis of population ageing is simplistic and unlikely to lead to good policy decisions. This is reinforced by historical analyses which suggest that ageing may be a much smaller influence on growth in healthcare expenditures than several other factors. For example, research in the United States between 1940 and 1990 (a period of significantly faster growth in the proportion of older people in the population than has occurred since) found that ageing contributed to only around 2% of the increase in health expenditures observed during that period. In comparison, technology-related changes in practice were responsible for between 38% and 65% of growth, increasing prices were responsible for between 11% and 22% and growth in personal income was responsible for between 5% and 23%. Similarly, research on expenditures in France between 1992 and 2000 found the contribution of ageing to be relatively small, with the impact of changes in clinical practice being almost four times as large.
There are other factors to consider for future policy decisions. The real financial issue related to ageing is a decrease in the proportion of people in the workforce. The impact of this goes far beyond healthcare. **But it is worth noting that even if ageing populations are not significantly driving up health costs, medical provision will take place in a context of fiscal constraint. This may limit what societies will be able to do for older citizens.**

For developing countries such as India, for example, on the one hand, a huge population cannot afford decent healthcare even at current cost levels, this is a problem common to many less-developed countries. On the other hand, demographically, these states are potentially in a slightly better situation than already developed countries. In most, the proportion of people of working age—who generate the income to pay for medical care—will increase, even as the number of elderly grows because of the drop in the number of children. This is a phenomenon known as the demographic bonus. This means that the dependency ratio (the number of non-working age to working age people in a society) will decline or stay stable in less-developed regions—with the exception of China—until at least 2050, according to UN figures. Of course, this is only a temporary solution. Eventually, lower fertility means the balance will tip in favour of an ageing population. What's more many developing countries are exporting their demographic bonus to the rich world through a huge level of out-migration.
In developed countries, an ageing population problem is already a reality. The OECD, comparing the previous and next three decades, says that economic growth could be cut by one-third because of age related labour force changes.



Reasons given by adults ages 60 years or older for non accessing health-care services, by countries' income category

Reason for not accessing healthcare services	Country income category (% of respondents)			
	High-income	**Upper-middle income**	**Lower-middle income**	**Low-income**
Could not afford the visit	15.7	30.9*	60.9*	60.2*
No transport	12.1	19.9*	20.7*	29.1*
Could not afford transpot	8.7	12.9*	28.1*	33.0*
Healthcare provider's equipment inadequate	11.2	10.5	14.1*	16.7*
Healthcare provider's skills inadequate	19.0	8.3	7.8	13.1*
Previously treated badly	23.8	8.7	7.9	8.3
Did not know where to go	12.2	9.7	9.8	7.8
Was not sick enough	21.5	31.8	27.3	25.8
Tried but was denied healthcare	20.0	16.2	8.3	8.5*
Other	43.8	22.5	23.5	13.9

*Results are significantly different (P<0.05) from those reported by adults younger than 60 years.
Source: WHO World Health Survey: 2002–2004. In: World Health Organization, Health statistics and information systems [website]. Geneva: World Health Organization; 2015 (http://www.who.int/healthinfo/survey/en/, accessed 23 June 2015).

The idea that people should feel obliged to stop working and retire in their mid-60s, when many are healthy, alert and at the peak of their experience, is often perverse.

The greatest burden of mortality in older people all over the world comes from ischaemic heart disease, stroke and chronic obstructive pulmonary disease.

Aside from helping address skills shortages and financial pressures by paying taxes for longer, there can be health benefits too: one recent study highlights clear mental health benefits to part-time working after retirement. All this emphasizes another key point about the nature of ageing populations. People will continue to vote, irrespective of their age. This will make the older population the most important voting bloc in years to come. In any future healthcare reform, it will be essential for governments to address the needs of this generation if they are to remain in power.

More Training Toward Geriatric Care

Health professionals are often unprepared to deal with the healthcare needs of older adults. This is especially true as the existing population of healthcare professionals starts to retire. Canada, for example, has just one-fifth of the 1,000 geriatricians it currently needs—and 20% of them are near retirement. The US has about half the geriatrics specialists it needs, but their absolute number has actually fallen over the past decade.

Improving knowledge and skills in geriatric care is crucial for all health professions. This will require overcoming a widespread lack of faculty, lack of funding, lack of time in curricula that are already full and the lack of recognition of the importance of geriatric training. What's more, not enough interest will gravitate towards geriatric care until the field is given the attention it deserves. Harvard Medical School did not require basic training in geriatrics for all medical school students until some years ago. In many other countries, geriatric training is barely provided. Financial incentives play a part, too. While a radiographer earns an average of US$400,000 per year in the US, geriatricians make about US$150,000. To make the field more attractive, some thought will need to be given as to how prospects might be improved for future graduates.

A survey of 36 countries found that 27% of medical schools did not conduct any training in geriatric medicine: this included 19% of schools in high-income

countries, 43% of schools in economies in transition, and 38% of all schools in other countries. Moreover, medical trainees often fail to learn the sort of comprehensive biopsychosocial approaches necessary to treat older populations. Instead, their training is biomedical and often compartmentalized according to their disease specialty. These training deficiencies also extend to other health workers. This gap is particularly important in low- and middle-income countries where these professionals are likely to form the front line in engaging with older people.
Ensuring that healthcare workers have skills and knowledge in geriatric care will probably not be sufficient on its own. Most health workers will also need competency in several nonmedical processes, including using shared decision-making, implementing team-based care, using information technology and engaging in continual quality improvement. They will also need to be trained to overcome the ageist attitudes that are widespread in healthcare settings.
Older people may also suffer from healthcare rationing based on the notion that health services are a limited resource and must be allocated to achieve the greatest good for the greatest number of people. Chronological age is an ethical, objective and cost-effective criterion for allocating health care because older people have already enjoyed life and have less future life to enjoy.

There are strong counter-arguments to these approaches, ranging from equity-based and rights-based perspectives emphasizing that at any point in time older people have made the greatest contributions to the socioeconomic development that allowed the services to be created, so they should at least be entitled to some of the benefits. But perhaps the greatest argument against the age-based rationing of healthcare is the lack of a clear association between chronological age and health. Prioritizing services for someone aged 55 years who has multimorbidities and a limited life expectancy over services for someone aged 70 years who is in good health and has a longer life expectancy is not consistent with the argument used to justify the age-based rationing of services. The rationing of health care based on chronological age is simply an example of discrimination against older people.

Health Conditions in Older Age: New Needs, Risks and Concerns

As bodies age, their needs and vulnerabilities change, as do their medical requirements. What healthcare systems will need to provide in the coming decades should shift accordingly.
The common causes of disabilities in people older than 60 years is estimated to come from sensory impairments (vision and hearing, particularly in low- and lower middle-income countries), cardiovascular disease, back and neck pain, chronic obstructive pulmonary disease (particularly in low- and lower-middle-income countries), asthma, cancer, depressive disorders, falls, diabetes, dementia (particularly in high-income countries) and osteoarthritis.

The greatest burden of mortality in older people all over the world comes from ischaemic heart disease, stroke and chronic obstructive pulmonary disease. The burden from all these conditions is far greater in low- and middle-income countries than in high income OECD countries. Degenerative diseases such as osteoporosis and dementia are even more closely associated with age than chronic ones, again because they take their toll over time. The higher burden from dementia in high-income settings is likely to at least partly reflect the older average age in these countries and greater awareness and diagnosis of these conditions. Only 2% of European sufferers are under 65, but after that age the risk doubles every five years so that among the over 90s, 22% of men and 30% of women have dementia. Similar figures apply in the US.

One of the problems facing policymakers and healthcare professionals is widespread ignorance about responsiveness to and tolerance for drug treatments in a population of over-65s—let alone one of over-80s. **Clinical trials for new drugs rarely address populations of over-75s. Rising pressures will compel policymakers to insist on more research.** As the elderly become the biggest demographic, new opportunities will emerge for pharmaceutical and related companies. Beyond this, a greater understanding of the needs of the elderly is also required. Older bodies are different—they have different conditions and they metabolise differently to younger people. And they simply get frailer as they age. Some of this is well known, but even in the medical community there is a lack of awareness about the seriousness of falls, or the high suicide rate, among the elderly.
Psychological health in general is in fact a major concern for older populations. Typically, the proportion of those suffering clinical depression—a condition sufficient to impede a person's everyday life for an extended time—among the over-65s is around one in six. This may have as much to do with social isolation and sense of worth as physical difficulties.
Falls too are a serious issue for the elderly. A 2006 Norwegian survey of people aged 67-97 found that nearly one-quarter had experienced a fall in the preceding six months. Developing countries with ageing populations are likely to face the same problems, as well as additional problems that wealthier health systems are currently able to address.
As people age, they are more likely to experience

multimorbidity – that is, the presence of multiple chronic conditions at the same time. Predictably, multimorbidity is also associated with higher rates of healthcare utilization and higher costs. One large systematic review of studies in seven high-income countries concluded that more than half of all older people are affected by multimorbidity, with the prevalence increasing sharply in very old age. One large study from Scotland found that the onset of multimorbidity occurred 10–15 years earlier in people living in the most deprived areas compared with the most affluent. It is also more prevalent in people with low socioeconomic status. This reinforces the theme that good health in older age is closely related to high socioeconomic position.

Despite the large numbers of older people experiencing multimorbidities, most health systems are not equipped to provide the comprehensive care needed to manage these complex health states. Clinical care guidelines typically focus on a single condition, rarely incorporating information on potential comorbidities and frequently contradicting recommended treatment or lifestyle changes for other conditions.

According to the American Academy of Orthopaedic Surgeons, by 2050 there will be an estimated 650,000 hip fractures annually in the US.

The Prevalence of Orthopaedic Injuries

As the older population continues to increase, musculoskeletal injuries can be expected to become more prevalent and have a profound effect on both society and its healthcare system. As it is becoming increasingly important to keep older adults functional and independent, societies are struggling to find ways to provide high-quality, cost-effective care. This demographic tsunami will drive the need for more research and innovation in the care of the elderly orthopaedic patients. Today, more than ever, many geriatric patients lead active and productive lives. Unfortunately, such a lifestyle can be dramatically changed by an inadvertent slip or fall that causes an orthopaedic injury.

According to the American Academy of Orthopaedic Surgeons, by 2050 there will be an estimated 650,000 hip fractures annually in the US. At a cost of USD 26,912 per patient, these injuries represent a staggering economic burden. Only 25% of these patients will make a full recovery, 30% will require nursing-home care and 50% will need either a cane or a walker. Within approximately 1 year, 30% of these elderly patients will die. Data from Europe indicate that hip fractures are a similarly serious problem. Such statistics point out the need for expert and efficient musculoskeletal care.

One of the major contributing factors to the occurrence of musculoskeletal injuries is osteoporosis. Osteoporosis is a systemic disorder characterized by decreased bone mass and an increased vulnerability to pathological fractures. Fractures in osteoporotic

Vertebral Compression Fractures (VCFs)

Calcium and vitamin D supplementation, antiresorptive and anabolic agents and weight-bearing exercises are helpful in preventing secondary VCFs

Vertebroplasty or kyphoplasty should be considered for patients in whom a progressive kyphotic deformity or intractable pain develops.

VCFs are common but often silent consequences of osteoporosis

Magnetic resonance imaging of the spine is probably the single most useful test for evaluating a fracture

the risk of death is increased several-fold during the year following a VCF

bone occur most frequently in the metaphyseal region. In total, 50% of women and 18% of men older that 50 will sustain an osteoporotic fracture.

Treatment of this problem must be part of comprehensive fracture care. Bone mineral density testing should be performed on all patients over the age of 50 to rule out osteoporosis and, if necessary, an appropriate treatment regimen initiated to minimize further bone loss.

Mild to severe vertebral compression fractures (VCFs) are the most common consequence of osteoporosis. Of the 1.5 million fractures that occur each year in the US, 700,000 are spinal fractures. One in two women and one in four men aged 50 years and older will have an osteoporosis-related fracture in their remaining lifetime. The incidence of vertebral compression fracture increases progressively with age throughout later life.

Active efforts to diagnose vertebral compression fractures are critical because only about one-third of radiographically diagnosed vertebral compression fractures cause symptoms, often just moderate back pain. Still, vertebral and other osteoporotic fractures produce cumulative and often irreversible damage, fracture-related medical problems and increased risk of death.

Osteoporotic vertebral compression fractures represent a significant challenge for primary care physicians in their diagnosis and management, and they are likely to become an increasingly important health issue for many patients as the population ages. Individuals with a vertebral compression fracture experience a decreased quality of life and also show increases in digestive and respiratory morbidities, anxiety, depression and death. Most importantly, these patients have as much as a fivefold increased risk of another fracture within 1 year of the initial fracture. Up to two-thirds of these fractures are undiagnosed and, even if diagnosed, many patients are treated only acutely; only very few are managed long-term for the prevention of fractures.

According to the National Osteoporosis Foundation, primary care physicians need to take a proactive role in assessing the risk for or presence of vertebral compression fractures and in maintaining or improving general bone health: many patients consider back pain a normal part of ageing and do not discuss it with their physician. Further, the primary care physician needs to act as the central point of care for a patient with a vertebral compression fracture, working with an orthopaedist, physical therapist, clinical social worker, pharmacist and dietician to provide optimal management.

Rheumatic conditions are also increasing considerably, especially among the ageing population and therapists should be aware of the sign and symptoms, current research, medical management and therapeutic interventions. It is important to note

that there are more than 100 types of arthritis and many people live with chronic joint symptoms but have not yet been diagnosed with a disease. The clinician should engage in prevention and self-management education, make appropriate referrals to other healthcare providers and advocate for access to advances in medical care, surgery and physical rehabilitation.

Reconsidering Care Options

Although the focus of ageing in place has frequently been on ensuring appropriate and affordable housing and age-friendly built environments, as well as providing instrumental support, health services also have an important role to play by providing care that reaches people where they live. Most countries addressing this issue are understandably focusing on ways to improve the provision of home care, rather than invest in more institutional care, much more in line with the wishes of the care receiver and family members providing care.

In the UK, where healthcare is overwhelmingly state-funded, the private sector is now the main provider of nursing home beds. In the US, where the cost of one care-home bed is US$70,000 a year, the government is proposing a new insurance scheme to help people to stay out of nursing homes for longer.

Once out of fashion, home-based care is coming back into vogue as governments grapple with the costs and management challenges of aged care and because older individuals, ever more likely to exercise their consumer power, prefer to live at home. Medical professionals agree. In a survey conducted in early 2009 by the Economist Intelligence Unit, care in the home was selected by medical professionals as the second most important area for healthcare investment, after hospitals and clinics. Depending on how it is set up, community or home-based care can offer strong economic benefits. In the US state of Illinois, for example, the Department on Ageing spends about US$117 per day for people in nursing homes, versus a monthly total of US$650 for home care. In Western Europe, according to the OECD, usually between 10% and 20% of the population over 65 requires such care, at a cost of 1% and 2% of total GDP. The OECD also expects need and spending to increase, as both correlate statistically with age.

One pressing issue in the near future will be finding enough carers. The UK's Office of National Statistics reported that by 2001 more than 20% of women and 15% of men aged between 45 and 65 provided some unpaid home care. In developing countries, such care is even more family-based. According to the UNPD (United Nations Development Programme), by 2005 more than 60% of

Photo Daughter caring about elder mother
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people aged over 60 in Africa, Asia and Latin America lived with children or grandchildren, compared with roughly 20% in Europe or North America. As populations age, however, there will be fewer people able to provide such care. Providing such care effectively requires a comprehensive strategy including income replacement, job protection for home-carers if they have to take time off work and training.
Meanwhile, community day-care programmes are also taking off in more traditional societies—such as Japan and Taiwan—where two-career couples or adult children living far from their parents are seeking care arrangements that allow both oversight and a degree of independents for the elderly. Yet many such programmes are more social than medical in nature. About 1.8m Americans still live in nursing homes, but integrated community care would be a better alternative for most. Thus, models of care will need to be reoriented towards prioritizing primary care and community-based care. This encompasses a shift from inpatient care to ambulatory and outpatient care, to more home-based interventions, community engagement and a fully integrated referral system. Several approaches may be effective. For example, home visits delivered by health professionals in the context of community-based programmes have been shown to have positive effects. The greatest overall effects were made in reducing the number of visits to emergency departments, hospital admissions, the length of stay, the number of falls, and improving physical functioning. Healthcare and long-term care systems should work in an integrated fashion to ensure the delivery of efficient and effective care. A recent study by the International Labor Organization (ILO) on long-term care finds more than half of all people 65 years and older have no access to urgently needed long-term care. The study of 46 countries covers 80% of the world population aged 65 and over. It finds an alarming lack of social protection for this ageing population and a global shortfall of 13.6 million workers to care for its needs. According to the report, 300 million elderly people are incapacitated in various ways. Many have lost their mobility and cannot walk, some may have mental illnesses, such as Alzheimer's, while others may need daily assistance to tend to their basic health needs. The whole long-term care issue is largely neglected due to both age and gender discrimination. According to the report, in Africa, which lacks 1.5 million long-term care workers, more than 90% of older persons do not receive care. The need for long-term healthcare workers in absolute numbers is greatest in Asia and the Pacific. This region lacks 8.2 million workers, depriving 65% of the over 65 population of assistance.

Older people generally do better in Europe. But, the report notes even European countries spend on average only 2% or less of their GDP on long-term care for the elderly. Due to the shortage of health care workers, the ILO reports that unpaid female family members end up caring for up to 80% of all older people in need of assistance. Increasing the long-term care workforce would provide quality care for older people and generate much needed jobs.
Technology too will play an increasingly active role in providing care to ageing populations. At a basic level, it can be applied to support medical professionals by relieving them of routine, mundane tasks. In Japan, "robot nurses" already provide assistance in the form of cleaning, assisting patients from wheelchairs and onto beds, for example. More broadly, the wider adoption of telemedicine and remote monitoring systems will likely assist in making home-based care more feasible and safe. The European Commission has suggested that member states should go as far as establishing a legal framework to promote telemedicine. But technology alone is not the whole answer. Some people find certain technologies rather inhumane and frightening, and more needs to be done to address the fear that they could replace the more human aspects of care for the elderly.

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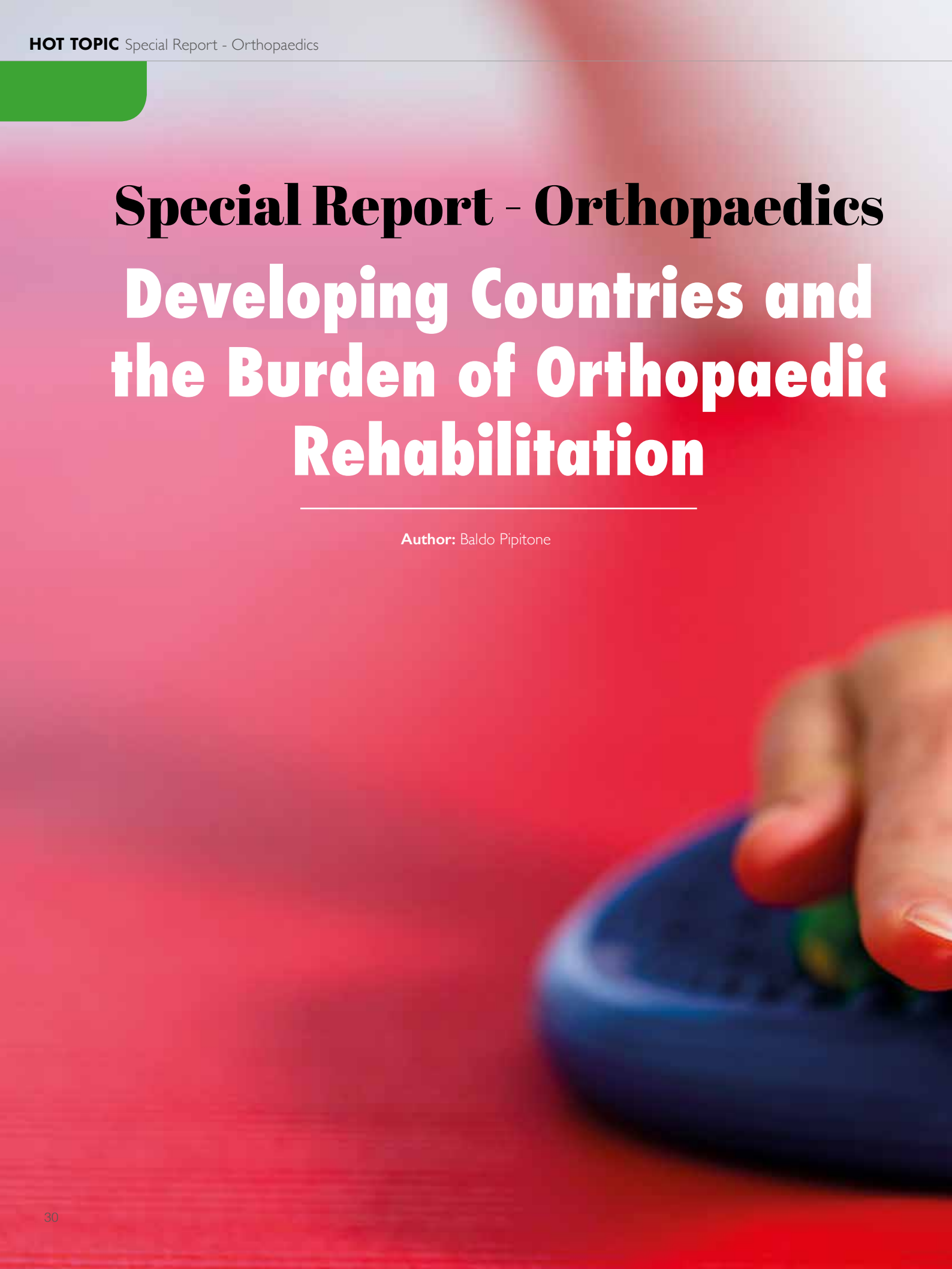
Technology too will play an increasingly active role in providing care to ageing populations.

Special Report - Orthopaedics

Developing Countries and the Burden of Orthopaedic Rehabilitation

Author: Baldo Pipitone



hot topic

Studies on living conditions of people with musculoskeletal impairments in developing countries reveal large gaps in the provision of medical rehabilitation and assistive devices. Regional and socioeconomic inequalities in access are evident and training facilities for orthopaedics, rehabilitation professionals and other providers of essential rehabilitation services are deeply inadequate in relation to the need. These negative outcomes lead to broad social and financial implications for individuals, families and communities.

HIGHLIGHTS

- 80% of trained orthopaedic surgeons in the world live and practice in the 26 developed nations. If the United States had the same orthopaedist-to-population ratio as Malawi, then the United States would have 30 orthopaedic surgeons.
- In rural areas of Africa, about 70% of patients with closed fractures are treated by traditional bonesetters. While many fractures heal properly with traditional treatment, the rate of complications following treatment by traditional bonesetters remains unknown.
- Orthopaedic education in developing countries should not be structured to suit the marketing needs of the industry.

Orthopaedic issues in the developing world usually involve – paediatric deformity – degenerative conditions – musculoskeletal oncology – spinal deformity – trauma – injury from road traffic crashes, conflict and disaster. Injury is the leading cause of death and disability worldwide in people under 60 years of age. For each person who dies from trauma, 3-8 more are permanently disabled. Road traffic crashes are the most common, responsible for approximately 1.2 million deaths per year or an average of 3,242 every day, disabling between 20 million and 50 million people each year. The majority of injuries affect people in low and middle-income countries. The estimated costs for low and middle-income countries are equivalent to 1-2% of their gross domestic product, which for many countries exceeds yearly developmental aid given to them. While only 32% of the world's vehicles are found in low-income countries, 85% of the deaths and 90% of the disabilities are attributed to road traffic crashes. Just to mention some figures, the number of motorized vehicles in China increased from 60,000 to more than 50 million over the past 50 years. In Thailand the number increased from 4.9 million in 1987 to 17.7 million in 1997. In developing countries safety norms are not universally enforced, hence road traffic accidents are multifold; 92% and 147% rise in fatalities are anticipated in China and India respectively, on the contrary 28% reduction in fatalities is expected in high-income countries.

As most injured patients worldwide have no access to an orthopaedic surgeon, the majority of treatment is provided by: traditional practitioners (bonesetters), general medical doctors, general surgeons and other healthcare workers.

The global burden of musculoskeletal injuries is in low and middle-income countries, where extremity injuries are an important cause of permanent disability. In addition to the loss of the productivity of the individual, these injuries can drain significant resources from family and community. There may be permanent job loss, and the family often has to allocate significant resources (savings, belongings, cattle, land) to cover the costs of treatment.

Up to 50% of those injured receive no medical care and a significant number will receive services at a non doctor staffed primary health facility. Utilization of formal medical services for non fatal injuries correlates strongly with transportation access in non urban areas and a number of patients never make it to the hospital. Without adequate access to hospital care, many patients with orthopaedic injuries have delayed presentations, leading to increased incidence of chronic bone infections, non-reduced dislocations, mal-unions and non-unions, making definitive treatment more costly and difficult.

In India, with the highest number of blind people and people afflicted by leprosy, tuberculosis and locomotor disabilities in the world, the majority of the population has to travel 50-100 km to reach the nearby health centre for immediate medical help, which may be equipped only to provide elementary orthopaedic care. People usually do not have enough financial resources to reach the district hospital. As a result they are treated by non-specialists or osteopaths. There are cases in various stages, from fresh to neglected untreated fractures. A large number of people report infected non-union as open reduction and internal fixation has been performed in suboptimal operation theatre with non-standardized implants. The infection in general and osteoarticular TB in particular has never gone into remission, contrary to developed countries.

Many are the barriers reducing rehabilitation and quality of services in low and middle-income countries such as deficient infrastructure, both in prehospital and hospital-based services, lack of trained health professionals, lack of resources and inadequate access to health information.

In a survey on the reasons for not using needed health facilities in two Indian states, 52.3% of respondents indicated that no healthcare facility in the area was available. A study of users of community-based rehabilitation in Ghana, Guyana and Nepal showed limited impact on physical well-being because community-based workers had difficulties providing physical rehabilitation, assistive devices and referral services. In a study of people identified as disabled from three districts in Beijing, China, 75% of those interviewed expressed a need for a range of rehabilitation services, of which only 27% had received such services.

The social environment and its values play a part too as the disability weight for the same condition might vary significantly based upon the local infrastructure and the availability of support from family members and the society. More weight is often given to patients with disabilities in young adulthood as young adults contribute more to the economic well being of a country than the young (children) and elderly. A national survey of musculoskeletal impairment in Rwanda concluded that 2.6% of children are impaired and that about 80,000 need physical therapy, 50,000 need orthopaedic surgery and 10,000 need assistive devices.

In many countries rehabilitation is not integrated in healthcare and financed under the national health system but it is divided between different ministries and rehabilitation services are often poorly integrated into the overall system and not well coordinated. A report of 29 African countries found that many lack coordination and collaboration among the different sectors and ministries involved in disability and rehabilitation and 4 of the 29 countries did not have a lead ministry.

Current estimates suggest that there is a global shortage of 4 million healthcare workers worldwide. This global "human resource crisis" is defined not only by deficiencies in the absolute number of workers, but also by inadequacies in the distribution of workers both between and within countries. This is particularly significant in the developing world, especially in Africa where 24% of the world's disease burden is found. This continent has only 3% of the world's health workers and only 1% of the world's resources for health. In contrast, while only 10% of the world's disease burden is found in the region of the Americas (including the United States and Canada), this region accounts for 37% of the world's health workforce and more than 50% of the world's health spending.

80% of trained orthopaedic surgeons in the world live and practice in the 26 developed nations. If the United States had the same orthopaedist-to-population ratio as Malawi, then the United States would have 30 orthopaedic surgeons. Malawi has 12 million people, 85% of whom live in rural areas. There are only 4 orthopaedic surgeons in the country. 70 orthopaedic clinical officers are employed in government district hospitals and missions throughout the country. Orthopaedic clinical officers provide the majority of orthopaedic care and usually work in isolation. An extensive survey of rehabilitation doctors in sub-Saharan Africa indentified only 6, all in South Africa, for more than 780 million people, while Europe has more than 10,000 and the US more than 7,000.

The lack of women in rehabilitation professions and the cultural attitudes towards gender affect rehabilitation services in some contexts. The low number of women technicians in India, for example, may partly explain why women with disabilities were less likely than man to receive assistive devices. Female patients in Afghanistan can be treated only by female therapists, and men only by men. Restrictions on travel for women prevent female physiotherapists from participating in professional development and training workshops and limit their ability to make home visits. As most injured patients worldwide have no access to an orthopaedic surgeon, the majority of treatment is provided by: traditional practitioners (bonesetters), general medical doctors, general surgeons and other healthcare workers. In a large portion of the developing world, fractures continue to be treated by traditional bonesetters. In rural areas of Africa, about 70% of patients with closed fractures are treated by traditional bonesetters. While many fractures heal properly with traditional treatment, the rate of com-

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plications following treatment by traditional bonesetters remains unknown, catastrophic consequences such as gangrene and Volkmann's ischemic contracture are numerous.

The low quality and productivity of the rehabilitation workforce in low-income countries are disconcerting. The training for rehabilitation and other health personnel in developing countries can be more complex than in developed countries. Training needs to consider the absence of other practitioners for consultation and advice and the lack of medical services, surgical treatment and follow-up care through primary health care facilities. Many developing countries do not have educational programmes for rehabilitation professionals. Furthermore, differences across countries in the type of training and the competency standards required influence the quality of services. University training for rehabilitation personnel may not be feasible in all developing countries because of the academic expertise required, the time and expenses as well as the ability of national governments and NGOs to sustain the training. Long-term funding commitment from Governments and donors is required. The main reason for the unprofessional and unethical deviations of some of orthopaedists during and after their training is the poor example set by their teachers. The residents or trainees knowingly or unknowingly imitate the example that is set by many of their teachers and in due course such behaviour becomes their own. A surgeon starts his career where his teacher, role model and mentor leave. That is how medicine grows. Good clinicians, teachers, role models, authors, editors are groomed. Unfortunately, the quality of role models is dwindling drastically.

In addition to the need to train non-physician medical personnel, efforts must be made to improve the quality of care provided by physicians. One problem facing rehabilitation personnel- commonly institutional and urban-based - is that much of their training may not be relevant to the needs of the population, especially in rural communities. **Most of the teaching time is spent on certain aspects which are seldom practiced. Books are mainly edited by western authors and are written according to their needs. Many western authors do not cover osteoarticular and spinal tuberculosis, one of the most commonly diagnosed and treated conditions in the developing countries.** Post-polio residual paralysis, neglected and complicated fractures and dislocations are not covered in detail. It is important to develop a balance in the curriculum between the needs of developed countries and recent advances. In Afghanistan one study found that physical therapists with two years of training had difficulty with clinical reasoning and that clinical competencies varied, especially for managing complex disabilities and identifying their own training

Photo Broken leg
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needs. Orthopaedic education in developing countries should not be structured to suit the marketing needs of the industry. More courses are needed to discuss the principles of treatment, when to operate and when not to operate, how to choose an option out of an available list of operations rather than training for a particular orthopaedic operation. Technical advances have led to a phenomenal development in orthopaedics while more real comprehensive information about the technology is needed. For example, the industry now sees India as a great potential market in view of the number of patients. Even if 10% of the population (approx. 120 million) can afford high cost of treatment, it would be bigger than the whole of UK. The industry due to market-driven forces spends lots of money in scientific meetings with their sponsored speakers who will not reflect the true picture of a gadget in terms of advantages and complications. In this way, a picture is created in the minds of registrants which suggests that particular implant is a panacea. In this way, the industry-driven projection of such a few surgeons undermines 80% orthopaedic surgeons delivering service to 90% of the population in a poorly equipped district hospital. The complexity of working in resource-poor contexts suggests the importance of either university or strong technical diploma education. The feasibility of establishing and sustaining tertiary training needs is determined by several factors including political stability, availability of trained educators, availability of financial support, educational standard within the country and the cost and time for training.

Even where training programmes exist, staff is often difficult to retain, particularly in rural and remote areas. Despite a huge need for rehabilitation services in both urban and rural Cambodia, for example, hospitals cannot afford to hire rehabilitation professionals. Like other health staff, retaining rehabilitation professionals is affected by poor working conditions, safety concerns, poor management, conflict, inadequate training and lack of career development and continuing education opportunities. International demand for skills also influence where rehabilitation workers seek work. Healthcare workers often relocate from low-income countries to high-income countries, in search of better living standards, political stability and professional opportunities. While most attention has been given to medical and nursing professionals, a wave of physical therapists have also emigrated from developing countries such as Brazil, Egypt, India, Nigeria and the Philippines.

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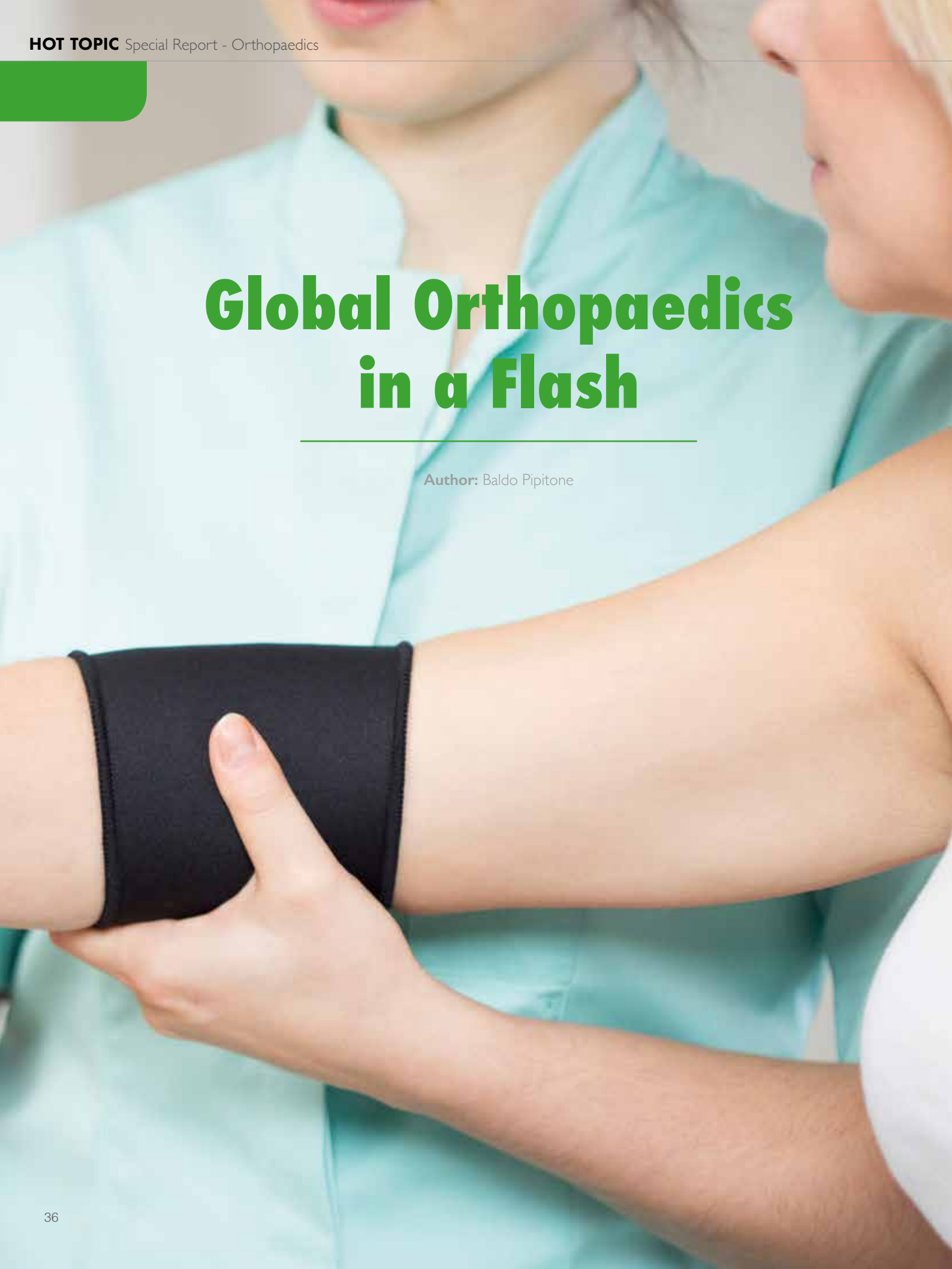
Global Orthopaedics in a Flash

Author: Baldo Pipitone



The global orthopaedics products market is expected to reach nearly US$ 47 billion by 2020. The increasing rate of sports injuries, osteoarthritis, osteoporosis and obesity, combined with the ever-increasing geriatric population all over the world is the key growth drivers of the global orthopaedic products market.

Spine holds the maximum share of the market followed by knee which is the second leading segment in the orthopaedic products market amounting to US$ 6.94 billion (estimated). Hips is at the third spot with US$ 5.84 billion estimated (+2% increase from previous years), followed by sports medicine. Trauma and Dental Implants are the fifth and sixth leading segment in the global orthopaedic products. Extremities with US$ 1.09 billion estimated (+7%) are also witnessing increase in its market share. Nearly 2.9 million joint replacement procedures take place worldwide, annually – including more than 1.4 million hip, over 231,000 in the U.S. alone and more than 100,000 shoulder replacements.

Among the leading players of the market are DePuy Synthes , Zimmer Biomet, Stryker, Medtronic, Smith & Nephew, Arthrex, Globus Medical, Wright Medical and Tornier. They control 95% of the market and very little share shift is estimated in the next 10 years. In the dental implant market, among the leading players are Straumann, Nobel Biocare, DENTSPLY, Zimmer Biomet.

In the near future joint replacement technologies will not change dramatically, nor will the overall market or the competitive standing of companies. The increasing number of people preferring minimally invasive surgeries and technological advancement will further fuel the growth, nevertheless, restraints, such as adverse effects on patients, unfavourable reimbursement issues, more price conscious environments, rationing of care and an increased pursuit of evidence-based medicine that challenges joint replacement as an option to treat arthritis will restrict the growth of the global orthopaedic products market.

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Photo Using elbow stabilizer
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Doing Business in Azerbaijan

The country with its macroeconomic and political stability is considered one of the leading economies globally in terms of economic growth and an excellent logistics hub for any business entering the markets of the Caspian Sea region.

Author: Silvia Borriello

Capital: Baku
Language: Azerbaijani
Currency: Azerbaijani Manat (AZN)
Population: 9,413,000 (2013)
Literacy level: circa 99.6%

Azerbaijan is located on the western coast of the Caspian Sea to the south of the Caucasus Mountains and is bordered by Armenia, Georgia, the Russian Federation, Turkey and the Islamic Republic of Iran. It is divided into two parts, the main territory of Azerbaijan and the exclave autonomous republic of Nakhichevan, which are separated by Armenian territory. The country has considerable mineral wealth, including oil and gas reserves. At the beginning of the 20th century, Azerbaijan supplied almost half of the world's oil, and oil has remained central to the country's economy into the 21st century.

The population is evenly distributed between urban and rural areas, with 53% residing in towns and cities. The workforce accounts for 4.7 million people; over 39% is employed in agriculture and related activities with 8% working in industry and construction. Azerbaijani labour is multilingual. Apart from Azerbaijani one can expect a local employee to speak Russian and Turkish. English is slowly but surely becoming the "office" language at least in Baku.

Reintroduced on the political map of the world after the collapse of the Soviet bloc, Azerbaijan regained its Independence only in 1991 and is now a Presidential Republic. A succession of weak, largely incapable governments ended in 1993 when veteran politician Heydar Aliyev was elected President. A decade of rehabilitation and growth started and from 1997 onwards, major political reforms aimed at bringing Azerbaijan to international standards. Integration into European common space, the creation of a market economy and socially oriented policies are being continued by his successor Ilham Aliyev.

A record GDP growth was observed in 2006 accounting for 34.5%, which was the highest performance in the world. Even in the period of global financial turmoil, Azerbaijan managed to maintain high economic growth rates. As a result, Azerbaijan's economy grew threefold in the past 10 years. Certainly, such rapid growth is associated with the development of oil and gas industries. At the same time, in order to reduce dependency on oil revenues, diversification of economy and development of non-oil industries became key strategic goal for the country. Presently, non-oil sectors make over 51% of the total GDP with sustainable economic growth rates. Economic growth has a direct link to the reduction of poverty. The implementation of major reforms, including the State Programme on Poverty Reduction and Sustainable Development have contributed to reducing poverty by 8 times since 2003 and dropped to 6% at the end of 2012. These achievements would be impossible without a strong private hand. As a result of several stages of privatization policy, nowadays the share of the private sector in the economy is over 85%. Azerbaijani economy is the biggest in the region of South Caucasus making up 73% of its GDP. During the last 18 years, almost 145 bln USD has been invested in Azerbaijan economy, where the shares of domestic and foreign investments are nearly equal. Moreover, increasing economic opportunities and financial means allowed Azerbaijan to emerge as a prominent foreign investor which actively invests in many countries, including those in close proximity like Georgia, Turkey, Kazakhstan, Russia, Ukraine and those a little further like Romania, Switzerland, Serbia, Montenegro, France, UK and more to come.

Azerbaijan has made the gradual transformation from planned economy to full-fledged market economy based on a mature and active private sector. Revolutionary legal reforms have enabled significant development of the private sector and made legis-

lation more transparent and investor-friendly. Generally, Azerbaijani legislation establishes a very open national regime for Foreign Direct Investment (FDI), where foreign investors are welcome in any sectors that local investors are allowed to invest in. This regime also applies to the participation of foreign investors in the privatization of state-owned property. The Government has lifted limitations on foreign participation in the banking sector. There are no special permissions or specific registration requirements for foreign investment. Licensing has been substantially simplified, with foreign investors' interests in mind. No discrimination policy and guarantees such as full repatriation of profits, compensation of damages and moratorium against adverse changes in legislation are some of the measures which create favorable conditions for investing. Any FDI restrictions are strictly limited to national security matters. The introduction of "one-stop-shop" system of business registration in 2008 was designed explicitly to reduce the red tape, costs and paperwork associated with the process of business registration (registration is handled through a single state authority– the Ministry of Taxes of the Republic of Azerbaijan). Moreover, Azerbaijan introduced a fully digitalized taxation system which is quite competitive even compared to developed countries. According to the World Bank's Doing Business Report, Azerbaijan improved in seven of 10 indicators, catapulting 64 places in the rankings, the biggest jump ever recorded. Moreover, Azerbaijan applies one of the simplest business registration procedures in the world and ranks 18th place in starting business among 185 countries. As for the Global Competitiveness Report 2012-2013 Azerbaijan is placed 46th in the world ranking of 144 countries.

Countries Rank, Global Competitiveness

Azerbaijan 46
Iran 66
Russia 67
Kazakhstan 51
Georgia 77
Armenia 82

Measures have been taken to establish Special Economic Zones (SEZ) where a concessional tax and customs regime will be introduced. In terms of trade regulation, there are no general trade barriers or prohibitions on the import of any types of goods and only a minimum level of non-trade barriers for international trade. The country is not yet a member of WTO, although the Government has started the accession process. The government has undertaken a number of steps to liberalize foreign trade. As of the end of 2011, the weighted average import tariff in Azerbaijan was 5.8% i.e. significantly below the

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international average. Import–export is one of the most rapidly developing business segments in Azerbaijan. In recent years, foreign trade has grown by an annual average of approximately 15%. The European Union remains the major destination for the export of Azerbaijani goods. Russia and CIS are the major importers.

Healthcare in Transition

Major reforms implemented in recent years have enabled Azerbaijan's healthcare system to develop in accordance with international standards and to significantly improve the reputation of Azerbaijani healthcare internationally.

Azerbaijan inherited an extensive and highly centralized Semashko system at independence from the Soviet Union. The Semashko system was organized around the principle of universal access to free healthcare. All healthcare workers were employed by the state, and private practice was not allowed. Following independence in 1991, the health system faced increasingly serious economic challenges in financing the inherited extensive services and the quality and access to services deteriorated.

In spite of the extensive network of health facilities there is a very low bed occupancy rate in Azerbaijan, fluctuating around 25–30% since the late 1990s. The number of doctors per capita has fallen since independence (at present there are 3.8 doctors per 1000 population. Average in the WHO European Region is 3.4) and there has been a significant reduction in the number of nurses per capita (7.3 to 1000 population. Matching the average WHO European Region level of 7.3). The Ministry of Health has found it difficult to obtain the right mix of medical specialties in the state sector and an adequate geographical distribution of staff. Recruitment and retention of medical staff in rural areas are long-standing issues and the flourishing private sector in Baku has also attracted many experienced healthcare professionals, thus draining the public sector.

There are approximately 30,766 physicians and 61,582 mid-level health care personnel (medical assistants "feldshers", nurses, midwives and other) in Azerbaijan. Of those, 28,489 physicians and 50,145 mid-level health workers are employed in healthcare system under the Ministry of Health.

There has also been a significant reduction in the ratio of dentists and, in particular, pharmacists to population size since 1995. Salaries in the public healthcare sector remain very low. According to the State Statistical Committee, the average salary was only 89.9 Azerbaijani new manat (AZN) in 2007, which is less than half the average salary in the country.

Allocations for drugs and medical supplies have grown from less than 10% of the total healthcare budget in the late 1990s to 18% in 2008.

Public health funding comes primarily from general government revenues, which includes money from the State Oil Fund and tax revenues. Despite significant increases in public health expenditure in recent years, Azerbaijan is still characterized by relatively low levels of public health expenditure both in absolute terms and as a share of GDP. According to expenditure figures, public health expenditure represents 44% of total health expenditure. Estimates by WHO show less positive trends, with the share of public expenditure in total health expenditure as 29.3%. **The majority of health expenditure comes from the population as out of pocket payments (OOP), reaching almost 62% of total health spending.** Surveys indicate that the utilization of health services is related to socioeconomic status more than need and many households are under threat of catastrophic healthcare costs in the face of serious illness.

Health personnel employed in the Ministry of Health system by selected categories, 2007

Health personnel Actual persons

Doctors 28,489
Nurses 30,041
Midwives 9,416
Feldshers 7,030
Laboratory technicians 3,658

Hospital staff

Doctors 14,984
Nurses 15,558
Midwives 4,241
Feldshers 2,042
Laboratory technicians 1,011

Primary care including polyclinics

Doctors 13,505
Nurses 14,483
Midwives 5,175
Feldshers 4,988
Laboratory technicians 2,647

Photo Sehidler Mescidi Mosque and the Flame Towers in Baku
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The vast majority of health providers are state owned, although the private sector has been flourishing in recent years, providing a growing share of health services especially in the capital. The payment mechanisms for the state owned providers are based on inputs (beds, staffing), which does not foster the efficient use of resources. The Ministry of Health and the Ministry of Finance have agreed on new health financing reforms that will centralize funds and make room for greater provider autonomy and the introduction of contracting as the basis for new payment mechanisms, such as per capita payments in primary care and case-based payments for hospitals. These reforms will underpin the proposed introduction of mandatory health insurance. With the expected imposition of mandatory health insurance, the system of financing the healthcare sector will be radically changed and fully updated.

With the expected imposition of mandatory health insurance, the system of financing the healthcare sector will be radically changed and fully updated.

Although there is state support for private initiatives through low interest loans, the health sector has not been considered a priority area in this regard. In rural areas where there is a low penetration of the private health sector, primary care usually starts from feldsher-midwife points (FAP), village doctor outpatient clinics (SVA- selskaya vrachetnaya ambulatoriga) and outpatient departments of small village hospitals (SUB - selskaya uchastkovaya bolnitsa), which are the main access point to the public system for rural residents. Primary care physicians then refer patients in need of secondary care to central district hospitals. **The provision of high-quality healthcare in rural areas is one of the main challenges facing the Azerbaijani health system.** Among the biggest problems is the shortage of physicians, due to a combination of low salaries and existing physicians retiring and not being replaced.

In urban areas, patients visit polyclinics to obtain primary care services. Patients may then be referred either to a multi-profile city hospital or to a specialized tertiary facility. Urban polyclinics are typically large healthcare facilities where a group of primary care physicians work jointly with approximately 10–20 types of specialists and are supported by laboratory services and more specialized equipment for diagnostic and treatment. There are 141 separate adult and paediatric polyclinics in the country (unpublished data from the Ministry of Health, 2009).

As there is a disrupted referral system, patients can bypass primary care and go directly to the upper levels of care. Self-referral to specialist care is seemingly the preferred option because of the low professional status of primary care physicians and the perceived quality of primary healthcare services and infrastructure. Under such conditions, continuity of care and its integration by primary care physicians are seriously undermined. Almost all pharmaceuticals in outpatient settings are purchased directly by patients through OOP payments. However, drugs for the treatment of certain conditions are guaranteed free of charge by the state (including those for diabetes, TB, HIV/AIDS and others).

In private facilities, the fee-for-service charges have to be covered out of pocket or through voluntary health insurance. In big cities, the private sector effectively competes with public facilities as it has a perceived better quality of services and wider range of diagnostic and laboratory services. As a result, patients with the ability to pay generally prefer to go to private health facilities, which act as multispecialty clinics, often with inpatient surgical departments.

The Ministry of Health hopes to restructure completely the model of ambulatory care described above in coming years. The government considers family medicine as the future direction for primary health care development, which will be implemented first in rural areas. Until around 2005, the urban primary care infrastructure suffered from low investment in capital infrastructure. The situation has improved since then, with polyclinics being rehabilitated and re-equipped. However, the capital investment is directed primarily to facilities in Baku and major cities while polyclinics in most rural districts are still in need of major rehabilitation.

As with outpatient care, the organization of inpatient care differs between rural and urban areas. In each rural district, inpatient care is provided by a network of small village hospitals (SUBs) and a big central hospital that acts as a referral centre for the entire district. There are 349 SUBs in the country, with an average of 32 beds per hospital (unpublished data from the Ministry of Health, 2009). Many have not been renovated and provided with new equipment since independence. In view of the dilapidated infrastructure, the Ministry of Health has developed optimization plans for each district, which envisages the closure of most SUBs, transforming them into primary care centres. Central district hospitals are multi-profile inpatient facilities providing a broad range of secondary care, including emergency care, general surgical, obstetric, gynaecological, paediatric and other services. Central district hospitals also provide certain diagnostic investigations such as X-ray and ultrasound as well as laboratory services typically involving the basic clinical tests required in secondary care. There are 65 central district hospitals in the country, with an average of 217 beds per hospital (unpublished data from the Ministry of Health, 2009). Until around 2005, the central district hospitals suffered seriously from underinvestment in capital infrastructure, which affected the quality and range of services available at these facilities. The situation has

improved since then, and many district hospitals have been renovated or rebuilt. As part of the optimization plans mentioned above, the Ministry of Health is planning to merge many specialized hospitals with central district hospitals to form a single multi-profile secondary inpatient facility in each district to achieve greater efficiency in resource utilization. Also, under the State Programme for Regional Development, SOCAR (State Oil Company) is funding the construction of new treatment–diagnostic centres with the aim of improving the access of rural populations to high-technology medical and diagnostic services such as computed tomography and magnetic resonance imaging, which were previously unavailable outside Baku. In urban areas, inpatient care is provided by city hospitals, which provide a wider range of specialist services and more advanced equipment. Most of the city hospitals are located in the three biggest cities of the country (Baku, Ganja and Sumgayit).

There are 142 city hospitals in the country, with an average of 113 beds per hospital (unpublished data from the Ministry of Health, 2009). Another category of inpatient facility contains the specialized hospitals providing services for certain conditions. The most common types of specialized facility are maternity, TB, dermatovenereal, psychiatric, oncological and endocrinological clinics, which are parts of vertically integrated national systems typically led by a tertiary-level specialized scientific research institution or national centre. The specialized hospitals are not present in every district but are located based on regional principles to cover the entire country, while all tertiary level facilities are located in Baku. In addition to research, tertiary institutions also serve as teaching hospitals where the relevant clinical chairs of the Azerbaijan Medical University are located.

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Understanding Franchising as a Model for Foreign Investment into India

On February 5, 2016, Domino's Pizza opened its 1000th store in India, making India the only country outside of the U.S. with 1,000 Domino's stores. Dunkin' Donuts opened with one store in India in April 2012; the company now has 67 Dunkin' Donuts restaurants in the country. Last year, Anytime Fitness Gym unveiled plans to open 50 more outlets by the end of the year 2015. Each of these franchises is taking advantage of tremendous growth opportunities in India.

By some estimates, franchising is growing faster than any other sector of the Indian economy. The industry has grown from US$13.4 billion to approximately US$24 billion since 2012. In 2015, for the fifth year in a row, the Indian franchise industry saw more than 30 percent growth over the previous year, with the addition of approximately 4,050 new brands. And franchises are expected to add 100,000 jobs in 2016.

As a business model, franchising is well suited to India's business environment. India has no laws that specifically regulate business franchising. As a result, a franchise can be opened without concern for franchise regulations, registration, or accreditation. However, franchisors are governed by a number of different national and regional statutes and codes. To complicate matters, regulations often vary by region, and the lack of legal and regulatory recognition of franchises makes it difficult for them to obtain loans because most lenders do not treat franchisees as a separate customer segment. Perhaps the greatest obstacles, however, involve the stringent foreign direct investment rules. The Indian government considers retail to be either "multi-brand" (retailers like supermarkets that offer multiple brands) or "single-brand" (retailers that sell only their own brands). Most franchisors fall into the single brand category. As of September 2012, the government allows up to 100 percent foreign investment in single-brand retail. However, single-brand ventures with more than 51 percent foreign investment must be locally sourced with at least 30 percent of the value of goods purchased from Indian firms. For many companies, this threshold will be extremely difficult to meet. In addition, India is not a one-size-fits-all market. Tremendous differences in culture, language, preferences, and tastes make it impossible to use just one business model for the entire country. Franchisors and their franchisees must therefore be highly innovative and flexible to succeed in the Indian market. Despite potential challenges, numerous international franchisors have been extremely successful in India. The most successful have entered the Indian market prepared for difficulties and have adapted their products and services to local market preferences. Dunkin' Donuts, for example, realized early that its global model was not an option in India. The majority of U.S. sales happen between 6am to 8am when people stop for breakfast on their way to work. The concept of breakfast on the go does not exist in India. So instead, the company targeted the 50 percent of Indians who are under 35 years old with their slogan "Get your mojo back!". Additionally, more than half of the Dunkin' Donuts India menu has been altered to suit local tastes.

Industries with the best prospects for successful franchising in India include retail, food and beverages, education and training, health and beauty, and consumer services, but other industry sectors with potential also exist. Apparel franchises, travel and tourism, and business and financial services franchises have gained traction in recent years.

As is always the case with India, regulatory improvements would go far in improving both the ease of franchising and the economic gains from growth in the franchise sector. Some reforms, which are already underway, will affect franchising in positive ways. These include improvements to conflict resolution and bankruptcy proceedings and intellectual property protection. However, significant gains could be taken from specific federal franchising laws, pre-contract disclosure requirements, and controls on royalty payments and franchisee fees.

Source: this article was first published on http://www.india-briefing.com/news/franchising-an-important-model-for-foreign-investment-into-india-11746.html/

China's GDP Growth during the First Three Quarters of 2015

Although China's gross domestic product (GDP) of last year has yet to be released, the country's actual 2015 GDP growth is set to come in at about 6.9 percent – slightly below the target for about 7 percent. According to the National Bureau of Statistics, the country's GDP rose 6.9 percent during the first three quarters this year compared to the previous year, beating economists' estimates for 6.8 percent. It is estimated that the tourism sector contributed over 10 percent to the national GDP growth with a total revenue of RMB 4 trillion. While the local economy in some of the first-tier cities of China have hit a plateau, China's Go West and Go Inland campaign have led to increased economic activity in its inland and Western regions. Some of China's inland regions saw local GDP growth of over 10 percent, such as Chongqing (11%) and Guizhou (10.8%) in the first three quarters of 2015. Meanwhile, the establishment of the three new free trade zones in Tianjin, Fujian and Guangdong has greatly contributed to the GDP growth of the three cities. During the first three quarters of this year, Tianjin's GDP growth hit 9.4 percent; Guangdong's provincial GDP increased 7.9 percent. Earlier today, the Fujian government stated that its 2015 provincial GDP growth rate reached 9 percent.

A Brief Introduction of China's Healthcare and Pharmaceutical Industry Reform

In April 2015, the State Council revised the "Administrative Measures on Medicine," which simplified the procedures for the application, modification, and cancellation of the Drug Manu-

facturing License and Drug Distribution License. Later in May, the Chinese government removed the price control on most pharmaceuticals (excluding narcotic drugs and psychotropic substances), a big step towards the marketization of drug prices. In November last year, the China Food and Drug Administration ("CFDA") launched a pilot scheme which allowed qualified drug R&D institutions, research personnel and drug manufacturers to apply for drug market authorization and bring their newly developed medicinal product to the market. Such individuals or institutions own the property right and the right of manufacturing, discharging, and sale of the product with market authorization. Further, the CFDA modified the definition of "new drug," clarifying that "drugs that have not been sold within China or abroad" shall be defined as new drugs. The pilot program was put into effect on December 1, 2015 and will last for three years. Currently, the plan has been implemented in 10 provinces and cities including Beijing, Tianjin, Shanghai and Hebei.

Updates on China's Cross-border E-Commerce Zones

On January 6, Chinese Premier Li Keqiang announced his plan to set up a batch of cross-border e-commerce experimental zones in Central, Eastern and Western China. The new zones will be closely mirroring the structural and legislative policies of the Hangzhou cross-border e-commerce zone. According to the plan, the government will provide subsidies and bonuses to motivate the transformation of traditional foreign trade entities into cross-border e-commerce businesses. For the next five years, the e-commerce zones will seek to make logistics and e-commerce technology more comprehensive and integrated by establishing a one-stop service platform that provides services like customs clearance, foreign trade, and cross-border smart logistics, and cross-border e-commerce **startup incubation.**

Source: *this article was first published on http://www.china-briefing.com/news/2016/01/11/china-market-watch-china-gdp-growth-drug-pricing-reform-e-commerce-zones.html*

Since its establishment in 1992, Dezan Shira & Associates has been guiding foreign clients through Asia's complex regulatory environment and assisting them with all aspects of legal, accounting, tax, internal control, HR, payroll and audit matters. As a full-service consultancy with operational offices across China, Hong Kong, India and emerging ASEAN, we are your reliable partner for business expansion in this region and beyond.
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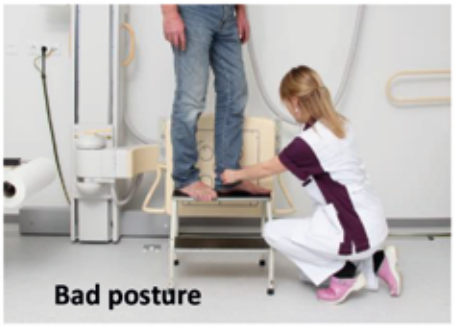

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Getting Into Shape: Exploring China's Health Supplements Industry

Dietary and health supplements are an industry with huge growth potential in China, in particular for overseas companies. The market has almost doubled since 2008, and was worth approximately RMB 102 billion by the end of 2014. Surveys show that very close to half of urban Chinese consumers regularly buy vitamins and dietary supplements.

Social Factor Trends Influencing the Market

The size of the market is likely to grow over the foreseeable future due to a range of social and economic factors, namely:

- **Economic growth:** most obvious is the increase in incomes and the rise of China's consumer class. This includes many cities aside from Beijing and Shanghai.
- **An Ageing Society:** mostly as a result of the previous One Child Policy, demographic trends in China show a society that will be heavily weighted towards older people. This has relevance both in increased demand for health products and the demand for specific health products.
- **Health scares in China:** a mixture of corruption in the industry and health scares associated with domestically produced food and health products has left a legacy of deep skepticism amongst Chinese consumers, creating an opening for foreign brands.
- **E-Commerce:** a set of highly developed e-commerce systems is especially useful for the marketing and distribution of products that are both specialized and easily delivered (like bottles of vitamin tablets).

Additionally, China has long promoted the proactive consumption of various products (herbs, liquids, tinctures, etc.) to maintain a healthy body. Specific health supplement products might be new to China, but the general concept behind them fits very well with existing Chinese culture.

Investment Opportunities and Market Access

Foreign investors looking to access China's health supplement market may either set up a company and a manufacturing base in the country or export their locally produced healthcare products to China directly. According to the "Catalogue for the Guidance of Foreign Investment Industries (2015)," foreign investment is encouraged in the healthcare food manufacturing industry and investors may set up a 100 percent foreign-owned company to produce and sell health supplements in China.

Registration with the CFDA

Both imported and locally produced health supplements need to go through check and registration with the government. The China Food and Drug Administration (CFDA) is in charge of inspection and supervision of the safety of medicine, medical devices, cosmetics and supplements. Vitamins and supplements need to obtain an additional mark from the CFDA. The mark, normally referred to as "blue hat", consists of the characters "保健食品 (supplements in Chinese)" written in a blue font with a standard code beginning with "国食健字J" for imported health supplements; "国食健字G" for health products made in China. CFDA will test and ensure that the medical products are safe, effective and meet the quality standards before they issue the Registration Certificate, and can withdraw it if the supplement is found to cause adverse reactions or is harmful to the human body. Any health supplement without a Registration Certificate are prohibited from being manufactured, imported, sold, or used in China, and those that have been manufactured or imported should be destroyed or disposed under the supervision of local CFDA. The application procedure takes over three months and can be expensive if any testing institution get involved to provide the required documents. For more detailed information and application process, investors are advised to directly read the information on the CFDA website or contact a professional directly at Dezan Shira & Associates.

Relevant legislation includes the 2015 Food Safety Law of the People's Republic of China, the 1996 health food management process (保健食品管理办法) and the 2005 health food registration management process (保健食品注册管理办法).

Risks of Fake Health Food Products

A downside to health food supplements is that various pills and powders are extremely easy to fake. Companies should therefore have a two-pronged strategy: firstly, a proactive policy in defending the company's brand name and IP from fakers.

Secondly, the company should try and distribute their product in a way that can more easily assure a Chinese consumer that they are not being sold a fake. Examples of this might be to promote the product in a trade show in direct cooperation with your relevant embassy, so representative buyers know that your product is legitimate.

Source: this article was first published on http://www.china-briefing.com/news/2016/01/28/chinahealthsupplementsindustry.html

Make In India: An Opportunity for Foreign Investors

February 13-18 marked India's inaugural 'Make In India' week held in Mumbai. Following Prime Minister Modi's launch of the Make In India campaign in September 2014, the Indian government has consistently pursued its vision to invigorate the country's manufacturing sector, which accounted for only 17 percent of India's gross domestic product in 2015. Each year, 12 million young Indian citizens enter the workforce. Most of them however, are low-skilled workers, which the Indian job market does not have the capacity to fill.

With these demographic challenges in mind, Modi's government instituted Make In India in an attempt to shift focus to the manufacturing sector and create jobs for low-skilled workers. Make In India week showcases the government's acknowledgement

that major contributions from foreign investors are critical to the success of the endeavor. Department of Industrial Policy and Promotion (DIPP) Secretary Amitabh Kant noted that "the main aim of the event is to attract more Foreign Direct Investment (FDI) into the country." Indeed, 17 States and 60 countries were in attendance. Make In India represents important opportunities for foreign investors. There are 25 target sectors in which to invest, including chemicals, media, construction, food processing, pharmaceuticals, energy, tourism, and wellness.

Recent policy changes have also made it easier to invest directly in Indian companies. Foreign Direct Investment (which is defined as investment by a non-resident entity or a person in the capital of an Indian company) is perhaps the easiest way to take advantage of the Make In India campaign. Individuals and companies can also invest by incorporating a company in India, forming a sole proprietorship, or establishing a branch office within the country. If choosing the FDI route, companies and individuals can invest through the purchase of equity shares, convertible debentures, or through investments in limited liability partnerships. But each of these investment vehicles has limitations and requirements, such as pre-approval by the central Reserve Bank of India (RBI) Hoping to attract more FDI, the government has eased FDI requirements in 15 major sectors.

For more information on India's Foreign Direct Investment guidelines, see http://www.dipp.gov.in/English/Policies/FDI_Circular_2015.pdf

Significantly, India has also raised FDI caps in more than a dozen sectors including defense, banking, insurance, medical, pensions, and construction. While there are still sectors in which foreign direct investment is not allowed at all, an increase in the FDI caps has opened several sectors that were closed previously. Although caps still exist in many sectors, they have been raised by 25 to 50 percent in most cases, making FDI both possible and more attractive.

Additionally, the government is offering incentives to encourage investment in Make In India. Among the incentives:

Source: this article was first published on http://www.india-briefing.com/news/make-in-india-an-opportunity-for-foreign-investors-11789.html/

Since its establishment in 1992, Dezan Shira & Associates has been guiding foreign clients through Asia's complex regulatory environment and assisting them with all aspects of legal, accounting, tax, internal control, HR, payroll and audit matters. As a full-service consultancy with operational offices across China, Hong Kong, India and emerging ASEAN, we are your reliable partner for business expansion in this region and beyond.

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Dubai Derma 2016

330 Million Dirhams Business Deals Sealed In Dubai Derma

"Scientific Committee Announces the Recommendations in Conclusion of Dubai Derma"

Dubai – United Arab Emirates, 14th of April 2016: The 16th edition of the Dubai Derma Conference and Exhibition concluded today after three days of tremendous success with a consensus from all its visitors, participants, and speakers that Dubai Derma has surpassed all expectations and witnessed a great success. The event has succeeded to attract over its 3 days 12,500 visitors and participants. Dr. Abdul Salam Al Madani, Executive Chairman of Dubai Derma said: "Dubai Derma succeeded over the past 16 years to successfully attract thousands of doctors, professors, specialists and technicians working in the field of dermatology and skincare to Dubai. We are proud that Dubai Derma today is the largest specialized event in this field in the MENASA region, and we will work diligently to acquire the number one in the world in the coming few years." Dr. Al Madani announced that the number of business deals sealed during the past three days surpassed 330 Million Dhs. He also said: "Exhibiting companies achieved a 10% increase in their business during Dubai Derma this year compared to last year. For this reason, companies are always looking forward to participate in Dubai Derma not only for the motivating revenue but also to achieve the maximum exposure for their products and machines in the regions markets." The scientific committee for Dubai Derma announced today the recommendations for the 16th edition of the Dubai Derma Conference. Dr. Ibrahim Galadari, Chairman of the Dubai Derma Conference and Professor of Dermatology at the UAE University announced:

• Due to the groundbreaking demand on the pre-conference courses witnessed this year, we decided to expand the halls and increase the number of speakers for next year. This comes to help doctors increase their knowledge and expertise, which eventually will benefit them in their practice and profession, as well as prepare them for the periodic exams.
• The scientific and organizing committees decided to organize the pre-conference courses bi-annually, and the workshops on a regular basis more than once a year in cooperation with the Arab Academy of Dermatology and Aesthetics.
• Allocating three halls for scientific sessions in parallel, due to the high demand on the scientific topics addressed at the conference, while adding a fourth hall next year.
• Holding exams to help prepare doctors wishing to apply for specific scientific certificates in collaboration with prestigious institutions and universities from around the world.
• Audit and control the cosmetic services, and confine it on dermatology specialties and cosmetic surgery under the supervision of accredited medical centers.
• Issuance of a medical journal titled "Dubai Derma" under the supervision of the Arab Academy of Dermatology and Aesthetics, which will be bi-annual in the beginning and then quarterly.
• Develop the accompanying exhibition and increase its space and work to gain the honor of organizing the World Dermatology Congress in 2023.

Form his side, Dr. Abdul Wahab Al Fouzan, Secretary General of the Pan Arab League of Dermatology, recounted the high praise he received from the participants for the high quality of the scientific lectures and sessions, which is due to the extreme efforts put by the scientific committee presided by Dr. Hassan Galadari, who worked hard to only pick the best and latest topics, papers, speakers, which led to the conference coming out on this level. On the sidelines of the conference & the exhibition, Dubai Derma Night along with the celebration of 25 years of success of INDEX Conference and Exhibitions took place yesterday at Al Meydan Hotel in Dubai. The night was attended by Dr Ahmed Al Banna, UAE Ambassador in INDIA and by His Excellency Abdullah bin Souqat, the Executive Director of the Sheikh Hamdan Bin Rashid Al Maktoum Award for Medical Sciences, and a number of international dignitaries and top-notch speakers from all around the world. Dubai Derma night included a number of recreational and cultural shows, gaining admiration of all the attendees who expressed their delight about all the presentations and accompanying entertainment shows. The ceremony also witnessed the handout of several awards by scientific committee, given to prominent personalities in the industry. Dubai Derma Personality of the Year Award was given to Dr. Ibrahim Galadari for his outstanding contributions to the dermatology and skincare profession. On the other hand, INDEX Special Award was awarded to Dr Ahmed Al Banna, UAE Ambassador in INDIA and to His Excellency Abdullah bin Souqat, the Executive Director of the Sheikh Hamdan Bin Rashid Al Maktoum Award for Medical Sciences, for their great support for INDEX over the years to deliver prestigious events that eventually adds value to the economy of the UAE.

In this context, Dr. Abdul Salam Al Madani Chairman of INDEX Holding said: "For the past 25 years, INDEX has had a pivotal role in the events industry in the UAE and the region and we are very proud that we are the only UAE national company that specializes in comprehensive events management which is recognized globally as a prime scientific, economic, technical and tourism, academic and cultural organization."
He added: "INDEX Conferences and Exhibitions is now at the forefront of the MICE industry globally. Over the past 25 years, we have contributed to 25% of the UAE's market share in the events industry, and attracted more than 1 million visitors from 133 countries to come to Dubai in order to participate, visit and benefit from the events organized by INDEX".
Dubai Derma is held under the patronage of H.H. Sheikh Hamdan Bin Rashid Al Maktoum, Deputy Ruler of Dubai, Minister of Finance and President of the Dubai Health Authority, and it is held in collaboration with the Arab Academy of Dermatology & Aesthetics, Pan Arab League of Dermatology and the GCC League of Dermatologists; and the event is supported by Government of Dubai and Dubai Health Authority. Dubai Derma is organized annually by INDEX Conferences and Exhibitions - member of INDEX Holding.

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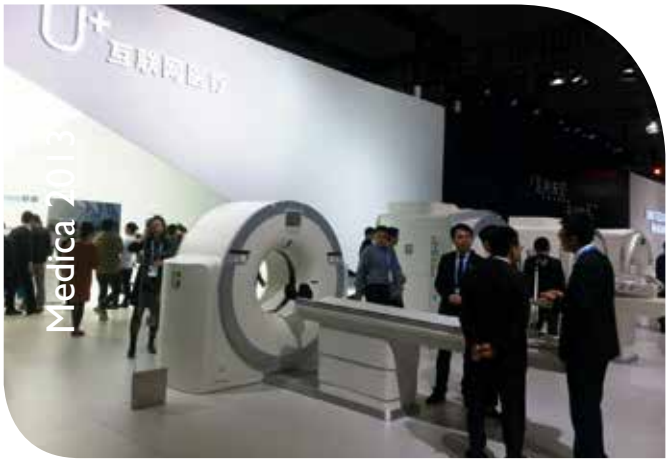

SHANGHAI, April 21, 2016 /PRNewswire/

The Health Industry Summit (tHIS) 2016 opened in Shanghai at the National Exhibition and Convention Center on April 17.

The organizer posted a record 380,000 entry scans, 216,784 professional visitors and more than 55,000 exhibiting staff to the venue over four days. In preparation of the large concentration of visitors, the city of Shanghai initiated its municipal level security mechanism and increased the frequency of the subway to divert the large crowds and dense traffic to the venue. Hotels were also fully booked in Shanghai during the event period.

Only in its second edition, tHIS has already been firmly established as the world's largest health industry event with over 330,000 square meters of exhibition space and 107 individual conferences.

Key events include China's three top medical equipment and pharmaceutical exhibitions (CMEF, PHARMCHINA and API China) and the leading healthcare investment forum - Healthcare China 2016. This year's investment forum was co-organised by Reed Sinopharm, JP Morgan Asset management, CICC and Sinopharm Capital and was attended by more than 700 selected investors and institutions.

The exhibition featured the entire industry value chain and presented some of the latest cutting edge technology including genetic diagnostics, rehabilitation robotics, wearable tech, 3D printing and more.

6,900 exhibiting companies from 30 countries were at the show presenting tens of thousands of products and services. Well-known healthcare equipment giants like GE, United Imaging, Siemens , Philips and Mindray as well as major pharmaceutical groups in China like Sinopharm, Shanghai Pharma and CR Pharmaceuticals were in attendance with major stand presence.

Natural Health and Nutrition Expo were among the fastest growing segments in the portfolio, helped by the expected population boom in light of the reversal of the single child policy as well as a growing health conscious middle class in China.

With the start of China's 13th Five-year plan in 2016, the "Health China 2020" program focusing on the co-development of healthcare, pharmaceutical production and health insurance has put the health industry among the top priorities for development in China and part of the national strategy.

Companies in China not traditionally associated with healthcare have also shifted major investment and resources into the sector, many renaming their company in the process to reflect this focus in industry coverage. International giants with the likes Alibaba, Lenovo, Fosun and Wanda Group have all taken a foothold into key segments of the industry in anticipation of major opportunities in the future.

The Health Industry Summit is organized by Reed Sinopharm, a joint venture between the world's leading event organizer Reed Exhibitions and China's leading state-owned pharmaceutical group Sinopharm.

Its next edition will be held in May 2017 in Shanghai.

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2016 / 2017

AZERBAIJAN

BIHE
22nd Azerbaijan International Healthcare Exhibition
19 – 21 September 2016 • Baku, Azerbaijan

Stomatology Azerbaijan
10th Azerbaijan International Stomatology Exhibition
19 – 21 September 2016 • Baku, Azerbaijan

KAZAKHSTAN

Astana Zdorovie
13th International Kazakhstan Exhibition on Healthcare
3 – 5 November 2016 • Astana, Kazakhstan

KIHE
24th Kazakhstan International Healthcare Exhibition
17 – 19 May 2017 • Almaty, Kazakhstan

POLAND

WIHE
4th Warsaw International Healthcare Exhibition
4 – 6 October 2016 • Warsaw, Poland

RUSSIA

4th International Healthcare Forum
14 – 16 October 2016 • St. Petersburg, Russia

Dental-Expo St.Petersburg
International Dental Exhibition
October 2016 • St. Petersburg, Russia

Pharmtech
18th International Exhibition for Equipment,
Raw Materials and Technologies
for Pharmaceutical Production
22 – 25 November 2016 • Moscow, Russia

Analitika Expo
15th International Exhibition for Laboratory
Technology, Chemical Analysis,
Biotechnology and Diagnostics
11 – 13 April 2017 • Moscow, Russia

Medima Siberia
28th International Specialised
Medical Exhibition Siberia
16 – 18 May 2017 • Novosibirsk, Russia

Dentima Siberia
9th International Dental Exhibition
16 – 18 May 2017 • Novosibirsk, Russia

Medima Krasnodar
16th International Specialised Medical Exhibition
24 – 26 May 2017 • Krasnodar, Russia

Dentima Krasnodar
17th International Dental Forum
24 – 26 May 2017 • Krasnodar, Russia

Stomatology
19th International Dental Exhibition and Conference
16 – 18 May 2017 • St. Petersburg, Russia

UKRAINE

Public Health
25th International Healthcare Exhibition
4 – 6 October 2016 • Kyiv, Ukraine

MTEC. Kyiv
4th Medical Travel Exhibition and Conference. Kyiv
4 – 6 October 2016 • Kyiv, Ukraine

MSF.Kiyv
4th Medical Specialized Forum
14 –16 March 2017 • Kyiv, Ukraine

UZBEKISTAN

Stomatology Uzbekistan
12th Uzbekistan International Dental
Exhibition and Conference
25 – 27 April 2017 • Tashkent, Uzbekistan

TIHE
22nd Uzbekistan International Healthcare Exhibition
25– 27 April 2017 • Tashkent, Uzbekistan

Apteka Expo Central Asia
12th Central Asian International
Exhibition for Medicines, Pharmaceuticals
and Pharmaceutical Technology
25 – 27 April 2017 • Tashkent, Uzbekistan

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The Exhibition in which Various Medical Experts Participate

KIMES offers a great opportunity for you to meet numerous buyers from Korea and overseas who have a strong purchasing power all in one place, including officials in medical institutions, academic industry, research institutions as well as hospitals such as oriental doctors, veterinarians, dentists, nurses, radiologists, physical therapists, medical laboratory technologists, pharmacists and emergency medical technicians.
The 33rd Korea International Medical & Hospital Show will take place at COEX in Seoul on March 16-19, 2017. Asia's premier medical event has been growing as the hub of attraction for all those involved in the medical and health care industries.With growingg demands from Korean consumers, the development of the medical industry in Korea is remarkably fast-growing. In the circumstances, KIMES's filling of the role of the platform where manufacturers and consumers can find their satisfactions.

The Exhibition in which Various Medical Experts Participate

KIMES offers a great opportunity for you to meet numerous domestic and overseas buyers who have a strong purchasing power all in one place including officials in medical institutions, academic industry, research institutions as well as hospitals such as Oriental medicine practitioners, veterinarians, dentists, nurses, radiologists, physical therapists, medical laboratory technologists, pharmacists and emergency medical technicians.

KIMES 2017 is...
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Contact:
Korea E & EX Inc. (KIMES 2017 organizer)
Tel: +82-2-551-0102
Contact : Mr. Sean Shin(sean@eandex.co.kr)

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Miami, USA

Show Opening Times: Tuesday – August 2, 2016 – 10:00am – 5:00pm
Wednesday – August 3, 2016 – 10:00am – 5:00pm
Thursday – August 4, 2016 – 10:00am – 4:00pm

Stand: C.E 32

Brazilian Health Devices

ABIMO
Brazilian Medical Devices Manufacturers Association

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Pre-register your visit now at www.medicalfair-asia to connect with key industry professionals from targeted segments and leading companies from the medical and healthcare industries!

Singapore will once again play host to MEDICAL FAIR ASIA, as it makes a much anticipated return from 31 August to 2 September 2016 at a new venue – the Marina Bay Sands Singapore. The 11th instalment of the international exhibition on Hospital, Diagnostic, Pharmaceutical, Medical & Rehabilitation Equipment & Supplies continues its proud tradition of show-on-show growth since its inception in 1997, with an anticipated participation of 1,000 exhibitors from 45 countries, 20 national pavilions and country groups from Austria, Canada, China, France, Hungary, Malaysia, Singapore, Taiwan and many more.
An event not to be missed, the 2016 edition will debut many new highlights, including a new Saudi Arabia national pavilion, special digital healthcare and rehabilitative care platforms and the inaugural staging of the MEDICAL FAIR ASIA MEDICINE + SPORTS CONFERENCE.

WHERE HEALTHCARE CONNECTS WITH TECHNOLOGY MEDICAL FAIR ASIA is well positioned to be the No.1 procurement stage for industry professionals to experience new and innovative technologies, solutions, products and services. At the 2016 edition, new disruptive digital healthcare solutions such as remote and wireless healthcare, IT platforms, wearable devices, smarter medicine and healthcare analytics are also expected to be showcased by participating exhibitors.
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classifieds

May

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• **11-13/05/2016**

KIHE 2016 - The 23rd Kazakhstan International Healthcare Exhibition

(Almaty – Kazakhstan)

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Phone: +7 727 2583434
Fax: +7 727 2583444
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Website: www.iteca.kz

Project Manager: Anastasia Balysheva
Email: Nastya.Balysheva@iteca.kz
Tel: +7 727 2583 439
Fax: +7 727 258 34 44

Venue: Atakent - International Exhibition Centre
Almaty - Kazakstanmedtec

www.kihe.kz/en/

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• **17-19/05/2016**

Bulmedica - Buldental 2016 50th International Specialized Exhibition for human and dental medicine

(Sofia – Bulgaria)

Organized by:
Inter Expo Center
Sofia, Bulgaria
Tel: +359 2 9655 220 // +359 2 9655 279
Fax: +359 2 9655 231
Email: iec@iec.bg
Website: http://bulmedica.bg/en

Project Manager: Gabriela Lubenova
Email: glubenova@iec.bg
Tel: +359 2 4013 279
Fax: +359 2 9655 231, +359 2 4013 231

Venue: Inter Expo Center
Add: 147, Tsarigradsko shose blvd
Sofia - Bulgaria

www.bulmedica.bg/en

Infomedix Booth: Hall 2 D10

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• **17-20/05/2016**

Hospitalar 2016 - 23rd International Fair of Products, Equipment, Services and Technology for Hospitals, Laboratories, Pharmacies, Health Clinics and Medical Offices

(Sao Paulo – Brazil)

Hospitalar Fair and Congress
Rua Padre Joao Manuel, 923 - 6Â° andar
01411-001 - Sao Paulo Brazil
Phone: +55 11 3897 6100
Fax: +55 11 3897 6161
Email: international@hospitalar.com.br

Venue: Expo Center Norte Exhibition Center - Add: Rua Jose Bernardo Pinto, 333, Vila Guilherme, Sao Paulo Brazil

www.hospitalar.com/english/index.html

Infomedix Booth: Booth L84

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• 17-19/05/2016

MedSib 2016 - Medima Siberia

(Novosibirsk – Russia)

ITE Siberia
633102 Novosibirsk
Russia, 104 Stancionnaya Street
Phone: +7 383 363 00 63
Fax: +7 383 363 79 01

Contact person: Yelena Knyazkova
Phone: +7 383 363 00 36 ext.355
E-mail: knyazkova.e@sibfair.ru

Venue: IEC Novosibirsk Expocentre
Novosibirsk
Russia

www.medimaexpo.ru/en-GB

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• 18-21/05/2016

EXPOSANITA' 2016 - 20th International Health Care Exhibition

(Bologna – Italy)

Organizers: SENAF Mestiere Fiere
Via Corticella, 181/3
40128 Bologna - Italia
Tel: +39 051 325511
Fax: +39 051 324647
Email: info.bo@senaf.it
Website: www.senaf.it

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Mrs Isabella Baricchi (International Exhibitiors)
Tel: +39 051 0560731
Fax: +39 051 5880078

(Italian Exhibitors)
Alessandra Bergonzoni
Antonella Denuntiis

Venue: BolognaFiere
Bologna - Italy

www.exposanita.it

Infomedix Booth:
Pavillion 22 Booth C60

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• 25-27/05/2016

Medima Krasnodar 2016

(Krasnodar – Russia)

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Fax: +7 861 200 12 54
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June

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• **28-30/06/2016**

Koreca 2016-
Korea Rehabilitation
& Senior Care Exhibition

(Busan - South Korea)

Organised by: Bexco
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612-704
South Korea
Tel: +82 51 740 7300
Fax: +82 51 740 7320
E-mail. bexco@bexco.co.kr
Website: www.bexco.co.kr

Venue: Bexco Exhibition Center 1

http://www.korecabusan.com/eng/intro/overview.php

July

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• **12-14/07/2016**

Myanmar Phar-Med Expo 2016 - The 4th International Exhibition and Conference on Pharmaceutical and Medical Industry for Myannar

(Yangon - Myanmar)

Organised by:
Minh Vi Exhibition and Advertisement Services Co., Ltd (VEAS CO., LTD)
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Phone: +84 8 3842 7755
Fax: +84 8 3948 1188
Website: www.veas.com.vn

Contacts

Ms Rosie
Email: rosie.tran@veas.com.vn

Ms Ann
Email: ann.ltb@veas.com.vn

Venue: Myanmar Convention Center (MCC) Yangon, Myanmar

http://pharmed-myanmar.com

2

• **22-24/07/2016**

Medicall Chennai 2016 - 15th edition Chennai, India

(Chennai - India)

Medexpert Business Consultants Pvt Ltd.
c-3 Shree Vidya Apartments 14 Balakrishna Street, west Mambalam
Chennai 600 300, Tamil Nadu, India
Email: info@medicall.in
Website: www.medicall.in
Phone: +91 44 2471 8987
Fax: +91 44 4266 3074

Project Director: Mr Sundararajan K
Phone: +91 98403 26020

Venue: Chennai Trade Centre
Nandambakkam,
Chennai 600 089
India.

www.medicall.in

calendar

August

1

• 02-04/08/2016

FIME 2016

(Miami Beach FL - USA)

Organised by:
FIME International Medical Exposition, Inc.
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Phone: +1 941 366 2554
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• 31/08 - 02/09/2016

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(Singapore - Singapore)

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Phone: +65 6332 9620
Fax: +65 6332 9655
E-Mail: mdafairs@singnet.com.sg
Website: mda.messe-dusseldorf.com

Venue: Sands Expo & Convention Centre
Marina Bay Sands Singapore

http://www.medicalfair-asia.com/

September

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• 04-05/08/2016

PharMed Cambodia 2016 - The 2nd International Exhibition and Conference on Pharmaceutical and Medical Industry for Cambodia

(Phnom Phen - Cambodia)

Organised by: Minh Vi Exhibition and Advertisement Services Co., Ltd (VEAS CO., LTD)
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Website: www.veas.com.vn

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Venue: Diamond Island Convention & Exhibition Center
Phnom Phem - Cambodia

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