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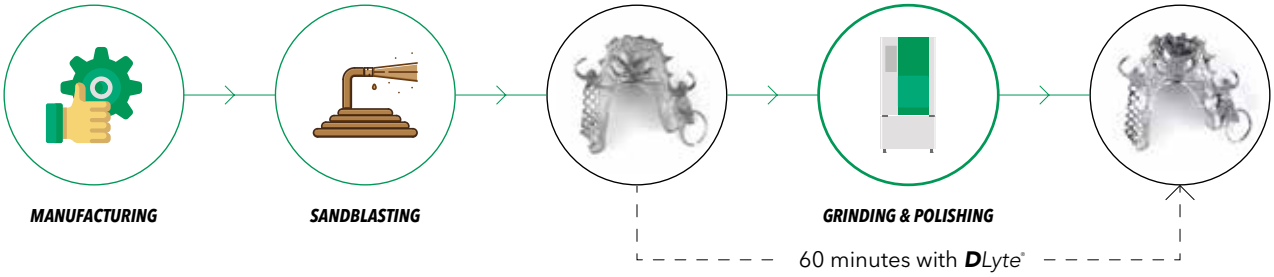

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We are excited to develop an innovation in our Infodent magazine. Starting from the upcoming issue our focuses are changing, nevertheless remaining loyal to our articles on the economic and medical markets as well as worldwide industry news.

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FOCUS ON THE TWO SIDES OF BRAZILIAN HEALTHCARE

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BOSNIA ERZEGOVINA ONE COUNTRY, TWO ENTITIES

Cover page
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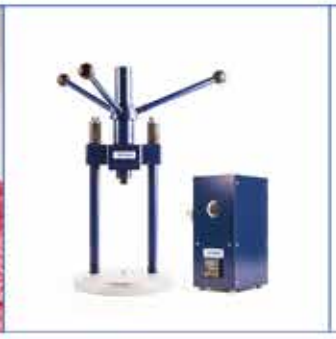

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THE "ABILITY" OF CONTENT MARKETING

You must have heard the phrase "content is king"; a statement that has never been more relevant. In a world where consumers are more savy, more demanding and more empowered than ever, brands and businesses need to increase their content marketing efforts to engage and inspire customers.

But what is content marketing? Content marketing is a strategic marketing approach focused on the implementation of creating, sharing and distributing quality content that is informative, entertaining and valuable to attract and retain a clearly-defined target audience. With digital technologies constantly evolving, there have never been more opportunities for brands and businesses to branch out to new prospects with innovative and inspirational niche content.

We've been hearing for decades now that print is dead. And the debate over whether this is true will probably continue for decades to come. However, there has never been a greater time of opportunity for brands in the printed channel than right now! **The key is to produce a highly niche, highly targeted publication that positions your business as a top expert on subject matter that your audience cares about.** Why is the print approach making such a rebound? In these days of 140-character tweets, instant messages and texts, print gives your customers something to sink their teeth into. You can discuss topics at greater length and give your readers something to hold onto for more than a few fleeting seconds. Since print is now considered "non-traditional," it's the perfect medium to use to capture — and hold — attention.

This is what Infodent International printed magazine is all about. We make all efforts in creating and sharing with our readers in-depth quality and valuable information on dental markets, social health issues and events. This time we are focusing on Brazil, and the government's commitment in reaching universal health coverage to eliminate social and health inequalities among citizens; while our outlook on Bosnia-Herzegovina tries to examine its far-reaching health reforms in an overall post-war context and transition from socialist to market economies. Our intent is to enhance awareness among our readers on the social and political aspects of the different markets to better approach the different business environments. How do we do all this? We have created long-standing connections and content-based synergies with scientific and trade dental associations, trade show organizers, chambers of commerce and health ministries in most countries around the world. We collect reliable and quality information, we search, double check and compare data from our sources and we travel the world to participate at congresses and trade exhibitions, round tables, press conferences and all sorts of industrial and scientific gatherings to get as much knowledge and know-how as possible, building a network of meaningful connections.

So, the path for content marketers is clear. Be it print, text, imagery, gifs or video – the importance of content marketing cannot be stressed enough and should be a vital part of every brands modern strategy. Nonetheless, writing great content is a choice. You can choose to put in the time and work required to create great content and build a prosperous brand. Or you can choose to take the easy path and write poor content – a path that ultimately will get you nowhere. It will only result in a waste of time, energy and resources. We, at Infodent International, have chosen quality and work.

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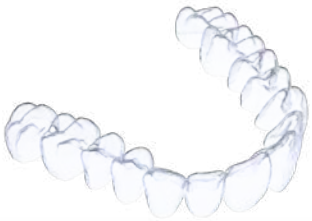

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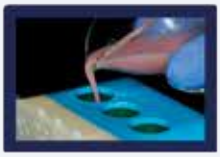

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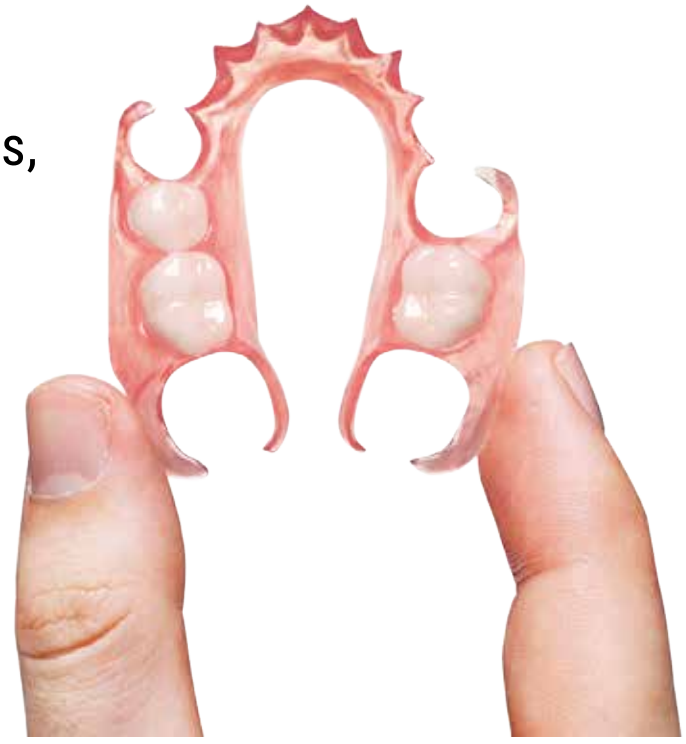

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- **TCS Unbreakable™** *nylon thermoplastic*
  Use for Flexible Partials

  Ideal degree of flexibility
  Lightweight yet durable
  Guaranteed unbreakable

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Built-in furnace. Requires connection to an air compressor.

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c) JP90 Handheld Injector
Used in conjunction with the TCS Digital Furnace. Injects clasps, repairs, and small cases without the traditional flasking method.

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e) TCS Digital Furnace
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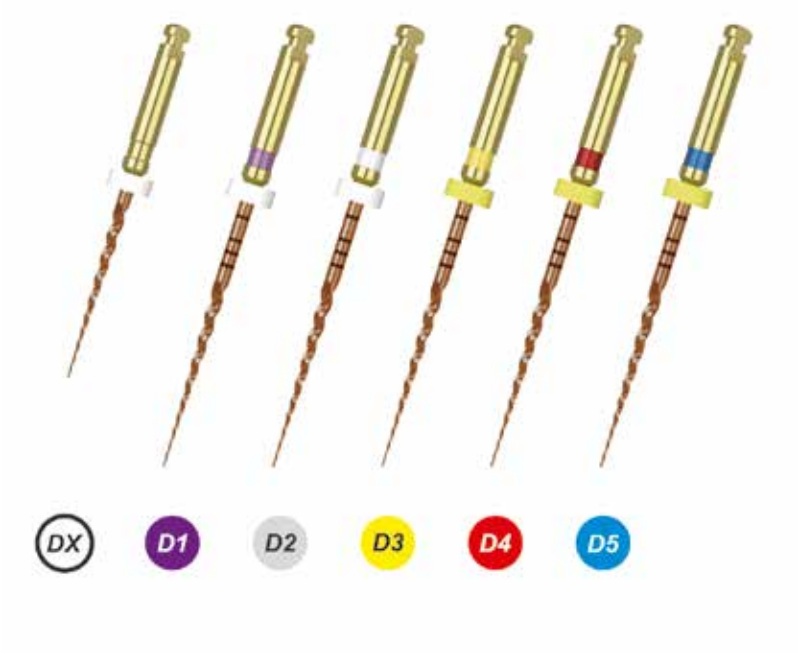

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MESTRA at Expodental and Dental Forum

Once again, the Talleres Mestraitua team (MESTRA) participated in the Expodental (Madrid) and the recently held Dental Forum (Paris). Definitely, the star of the stand was the new automatic polymerising pot (Geisser). It was released in the special product promotion a few months ago, with a very good reception.
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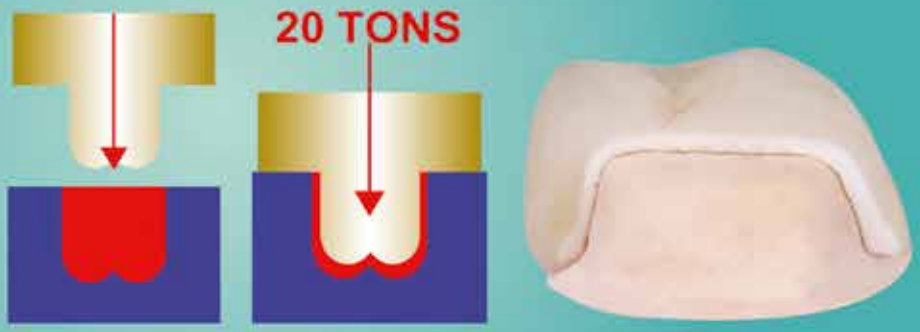

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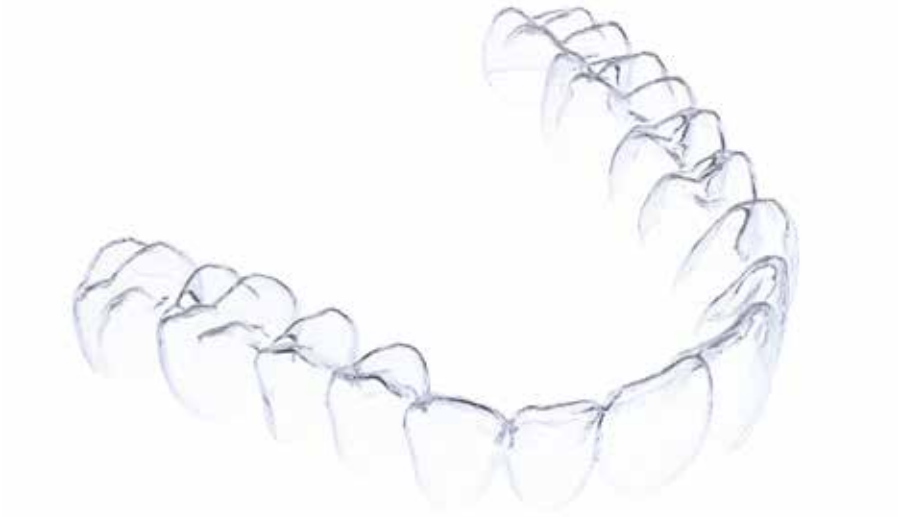

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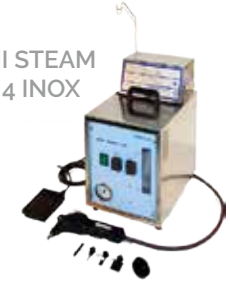

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BLAZIR is equipped with VIA™ system, a bridge to simple sintering option. The programming methodology is designed to assist the operator of the furnace by recommending the most adequate sintering program.

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• the liquid and the powder to make the whitening gel;

• the light cure gingival dam for the protection of the gingiva;

• the patient card to verify the teeth shade changes and to keep the patient information;

• Professional Oral Care NANO HAP for the immediate elimination of dental sensitivity post-treatment, if necessary;

Professional Oral Care Perfect White Liquid & Powder PLUS is a gel based on hydrogen peroxide (38%) for professional whitening treatments. Supplied in 2 separated containers, the gel is prepared directly at the dental office by mixing the liquid and the powder with an extreme simple and fast procedure. The special formula associated with the use of the powerful whitening lamp, Easy Lamp PLUS, accelerates the process of oxygen radicals liberation starting the molecules chromogenes oxidation process, giving the best results in reduced application time.

www.miromedgroup.ch // info@miromedgroup.ch

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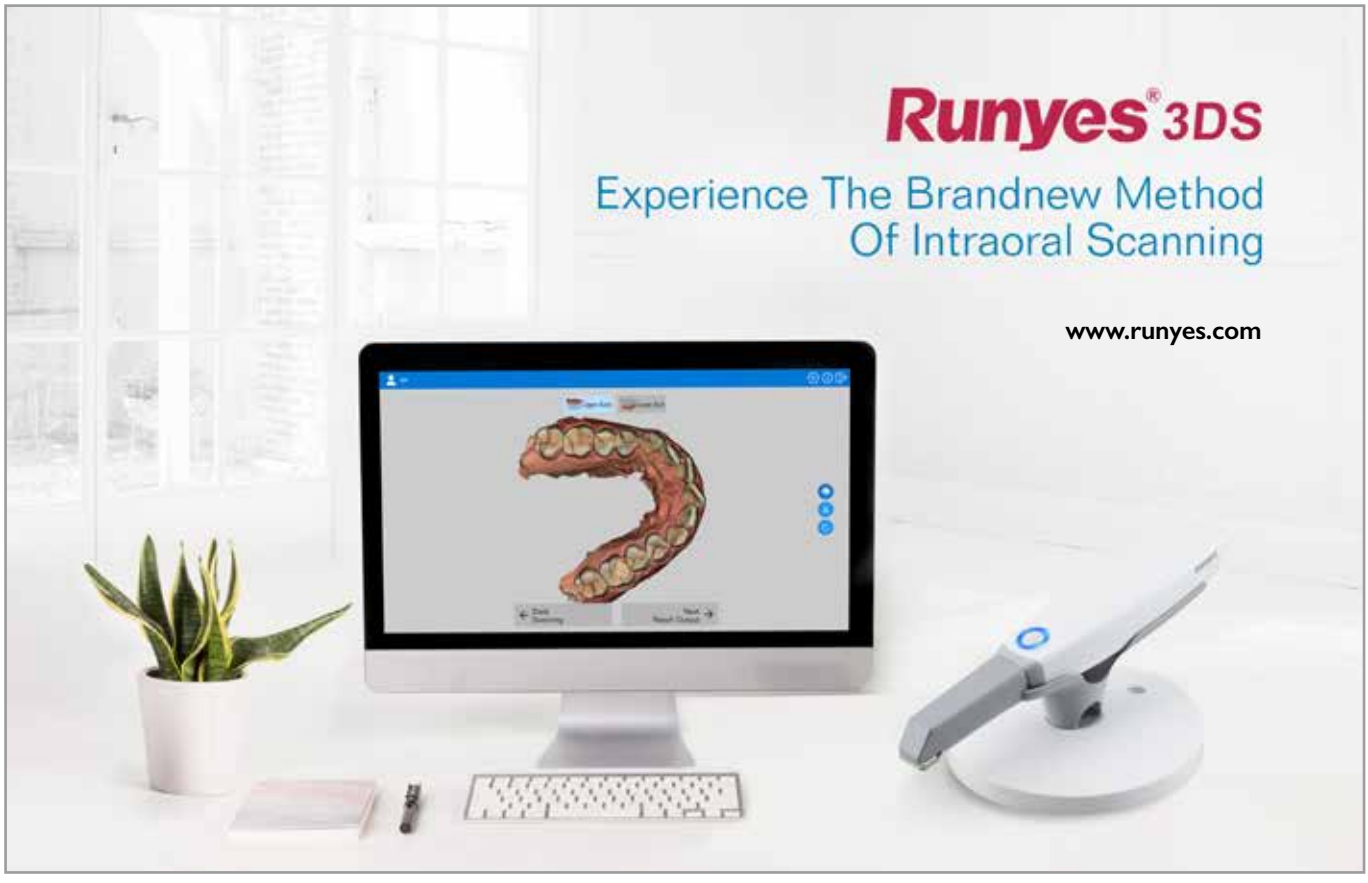

DMP presents NANOCERAM-BRIGHT

DMP, a European manufacturer of high quality dental materials with over 30 years of experience, exports worldwide to over 60 countries. DMP is defined by its commitment to clinical excellence, reliability, personalized customer service and competitive prices (DMP brand or OEM). Certified with ISO 9001 and ISO 13485 for the design, manufacture and distribution of dental materials, DMP's products carry the CE mark and have U.S. FDA clearance. Three main product groups cover its area of expertise – silicone impression materials, composites, amalgams. Leading the BRIGHT range of composites is NANOCERAM-BRIGHT, a radiopaque nanohybrid universal composite that allows clinicians to create exceptional aesthetic restorations in anterior and posterior areas. Its creamy consistency makes it easy to handle and its high filler loading results in low polymerization shrinkage yielding high marginal integrity and minimized post-operative sensitivity. The filler technology employed makes it easy to polish to the highest luster.

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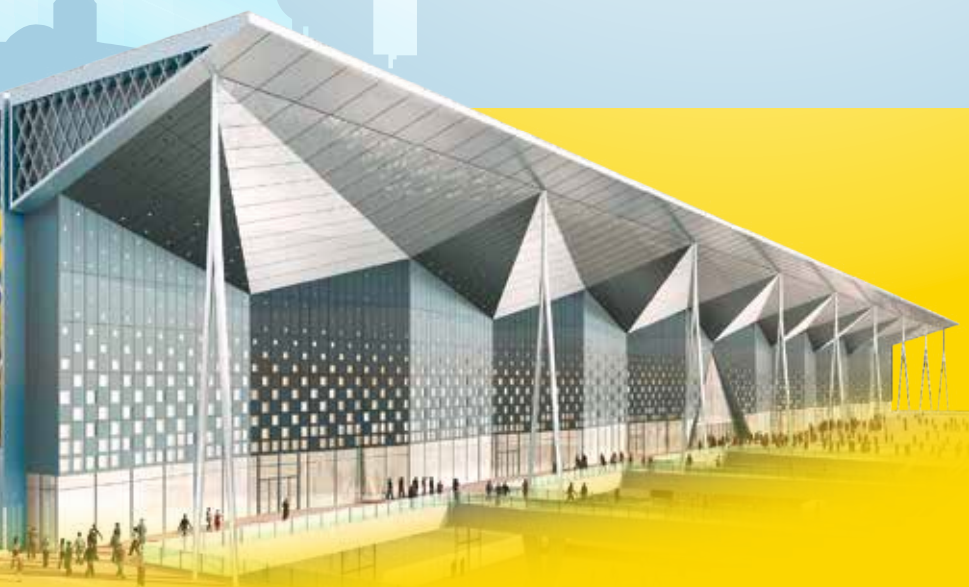

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A world first from Silfradent research team:

CGF Platelet-rich plasma in powder form.

An effective aid in the treatment of respiratory diseases

Katrin Rotter-Böttger – Independent medical Trainer for Meso-PRP/CGF and CGF denatured Plasma-Gel.
www.plasma-gel.de info@plasma-gel.de

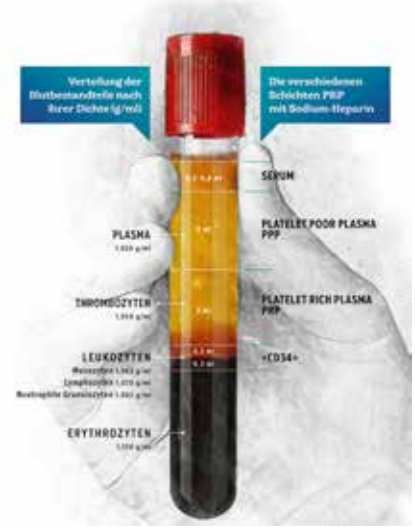
There are many application protocols in the field of plasma therapy.
One such protocol, used very successfully in many clinics and universities, is the CGF - approach (concentrated growth factors), which promises a high yield of thrombocytes from the plasma.

Autologous PRP/CGF Powder

The development of autologous plasma in powder form is attributed to the scientist Prof. Akhmerov. The powder is 20 times more concentrated than liquid plasma and allows application via inhalation, which can be of interest for many types of respiratory disease. So far, many observational values have given hints of great potential and these should be evaluated in further studies. At a temperature of -18° C the shelf life of the powder can be increased to 6 months, meaning it can be produced in larger quantities and stored for later applications. This eliminates the need for multiple blood samplings and preparation.
After centrifugation, in a separate work step, the plasma is immediately processed into a powder which contains particles of many sizes. This allows finer particles to penetrate deep into the lungs. Indications such as sinusitis, bronchitis and fibrosis can be positively influenced. The use of medication can thus be reduced or replaced. The thrombocyte, with its growth factors, can stimulate accelerated regeneration and healing, especially as mucous membrane (mucosa) shows rapid tissue response.

Before therapy

A blood test remains important and indispensable. The blood parameters should be within normal ranges, especially the platelet count.



CGF tubes

The use of high-quality borosilicate glass tubes is decisive for a high yield of platelets. Centrifugation exposes the tubes to high kinetic energies. Plastic tubes are not suitable here. Furthermore, we do not add citrate as an anticoagulant, but rather heparin; the thrombocyte requires calcium ions for degranulation, but these are bound by citrates. Heparin, on the other hand, inhibits antithrombin III, so it has no influence on CGF therapy. Safe systems work exclusively with vacuum tubes to ensure that no decantation of the blood is necessary after withdrawal.

Centrifugation

In centrifugation it is not the rotation as such that is important, but rather the relative centrifugal force (RCF). Low RCFs are advantageous here. Static centrifugation in the field of CGF production is also outdated. New application protocols fractionate - the centrifugation process is undergone at various intervals adjusted to the relative centrifugal force.
In the worst case, a too high centrifugal force can push the platelets into the erythrocyte phase, resulting in plasma that is largely ineffective (platelet-poor plasma). The aim is sedimentation corresponding to the density of the cells. Low RCFs show lower hemolysis and prevent premature degranulation of the platelets.

By now, plasma production has become a staple at many medical facilities. And with it, "Medifuge" - still the centrifuge of choice despite many competing products. It has a sterilization cycle to avoid cross-contamination and its programming is unique in fractionated centrifugation.

Katrin Rotter-Bottger organizes (English) courses. For registration and further information:
info@mesotherapie-ausbildung.de
www:plasma-gel.de

Focus

The Two Sides of Brazilian Healthcare

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Despite its many problems, Brazil's universal public health system represents an enormous achievement for Brazilian society. Brazil has not only managed to significantly improve access to healthcare, especially among the poorer inhabitants, but its system also represents a significant social and political commitment, by the government, and an effort to realize rights that are a key aspect of citizenship for millions of Brazilians. Nevertheless, health and social inequalities remain and more needs to be done.

AT A GLANCE

- **Population 207.681 million**
  fifth largest in the world, representing nearly 3 % of global consumers

- **Political System - Federal Republic.** The federal presidential constitutional republic of Brazil is a union of 27 Federative Units (Unidades Federativas, UF): 26 states (estados) and one federal district (distrito federal), where the federal capital, Brasília, is located.

- Brazil is composed of five major regions - the North, Northeast, Southeast, South and Central-West.

- Largest Economic City - **São Paulo** (represents 10.7% of the GDP)

- **GDP (PPP) - $3.219 trillion** (2017 est.)

- **GDP per capita (PPP) - $15,500** (2017 est.)

- **Revenues - $726.6 billion** (2017 est.)

- Expenditures - **$749 billion** (2017 est.)

- Exports (2017 est.) - **$215.4 billion**

- **Main export partners** (2016) -
  China 21.8%, E.U. 16%, U.S. 12.3%, Argentina 8%, Japan 2-4%, other 39%

- Imports (2016 est.) - **$139.4 billion**
  Main import partners: E.U. 21.2%, China 18.1%, U.S. 16.5%, Argentina 6.2%, South Korea 3.4%, Other 35%

- **Leader among emerging markets** - A BRICS member, many multi-national companies consider Brazil as an essential market for truly global businesses

- **E-Commerce in Brazil** - has grown by more than 20 % over the past three years

- **The government of Brazil** - investing heavily in the implementation of electronic medical records

Economic Profile - As of late 2010, Brazil's economy is the largest of Latin America, the second largest in the Americas (after the U.S.) and among the ten largest in the world. From 2000 to 2012, Brazil was one of the fastest-growing major economies in the world, with fast expanding business opportunities and an average annual GDP growth rate of over 5%, with its economy in 2012 surpassing that of the United Kingdom. However, its growth decelerated in 2013 and the country entered into a deep recession in 2014 . Per capita GDP decreased 4.4% in 2016 for a combined drop of almost 10% over two years. While unemployment stood at just 6.5% as recently as 2014, it ended 2017 above 13%. **From 2017, however, the economy started to recover again, with a 1% GDP growth in the first quarter. In the second quarter the economy grew 0.3% compared to the same period of the previous year, officially, but slowly, exiting the recession.** According to OECD forecasts, Brazil's GDP growth would pick up to 2.2% this year and 2. 4 % in 2019. Unemployment has also turned around falling by over a percentage point from its 14% peak earlier this year. Lower inflation and interest rates will further support a gradual economic recovery.

The long and deep recession seems to be over, but more needs to be done. **Brazil remains a highly unequal country, recent corruption allegations have revealed significant challenges in economic governance and the situation of its fiscal accounts is also challenging, with high and rising public debt.** Gross public debt has in fact increased by approximately 20 percentage points of GDP over the last 3 years and stands around 75% of GDP. In 2016, Brazil spent 16% of its budget on interest payments on government debt, which is held by investors, business and upper middle-class savers. This was more than on education and health (9%). According to the 2018 survey on Brazil, published by the OECD, interest payments were the second biggest outlay in the budget, beaten only by social benefits (35%), which were mostly pensions. Given that Brazil's pension system benefits disproportionately relatively better off public servants, Brazil's budget actively benefits the wealthy over the poor and leaves no money for investment. Without an urgent reform (expected by 2019), pension expenditure will more than double by 2060, leading to unsustainable fiscal dynamics. Improving the effectiveness of public spending, particularly public transfers, will be crucial for further social progress. At present, a large and rising share of social benefits is paid to households that are not poor, which reduces their impact on inequality and poverty. Public transfers to the corporate sector, which have increased markedly over recent years, also need adjustment. These transfers, often granted in the form of tax exemptions or subsidized lending, have not been associated with visible improvements in productivity or investment, but they benefitted primarily the more affluent, besides creating fertile ground for corruption and political kickbacks.

The OECD report looks at other distortions needing to be untangled. Among them, the high tax burden. Manufacturing companies in Brazil spend an average of nearly 2,000 hours a year preparing their taxes compared with 800 for Venezuela and less than 200 for the US. Furthermore, Brazil has the highest applied import tariffs of the countries listed in the report, about double the level of China and four times that of the US. Brazil has not gained new markets for its exports in recent years. In terms of imports and exports as a percentage of GDP Brazil is the least open country on the OECD's list, less even than Argentina. Lastly, a factor that increases inequality and costs in the economy is how much Brazilians overpay for consumer goods and services.

President Michel Temer, that took over from August 2016 as interim President after the impeachment of former President Dilma Rousseff, is now pursuing corrective macroeconomic, market-oriented policies to stabilize the economy; but the outcome of Brazil's October 2018 presidential election is uncertain, posing risks to its continuity. The proposed economic reforms aim to slow the growth of government spending and reduce barriers to foreign investment. Congress approved a landmark constitutional federal spending cap and is now debating complementary constitutional reforms to curb social security spending. Additional reforms to increase labor market flexibility and to rationalize Brazil's complex tax system are also on the agenda. International capital markets have recognized Temer administration efforts, lowering risk premiums significantly from 2015 peak levels and boosting the value of the *real*. Both portfolio and direct investors, however, remain sensitive to political uncertainties. Brazil has been taking steps to improve infrastructure and education, expand trade, and increase the presence of multinational businesses in the development of Brazil's huge oil reserves. Immense natural resources, a strong industrial base, a sizeable domestic market and a large and relatively diversified economy makes Brazil an attractive country for investors.

Health profile - With the creation of the National Health System (Sistema Único de Saúde – SUS) some 30 years ago, Brazil was one of the first and few countries outside the OECD

According to OECD forecasts, Brazil's GDP growth would pick up to 2.2% this year and 2. 4 % in 2019.

(Organization for Economic Cooperation and Development) to integrate the goal of universal health coverage in its legislation, recognizing health as a right of citizens and a responsibility of government. The 1988 constitution, in fact, enshrined health as a citizens' right, requiring the state to provide universal and equal access to health services. **Its National Health System is based on decentralized universal access, with municipalities providing comprehensive and free healthcare to each individual in need (citizen or anyone legally residing in Brazil), with a public sector covering almost 75% of the population and an expanding private sector offering health services to the rest of the population.** The public sector is funded through a variety of taxes and social contributions collected by the three levels of government (federal, state and municipal). The states receive money from the federal government, while the municipalities receive funding from both the federal and state governments.

SUS provides healthcare through a decentralized network of clinics, hospitals and other establishments, as well as through contracts with private providers (subsidized by the federal government via the Social Security budget). SUS is also responsible for the coordination of the public sector. The private sector includes a system of insurance schemes known as Supplementary Health which is financed by employment-based or individually purchased private insurance.

The public and private components are thus distinct but interconnected, as people can use both, depending on ease of access or their ability to pay. The law states that "health assistance is open to private enterprise", evidencing the existence of two health sub-systems within Brazil. The SUS is the public face of the system and is characterized by public financing and public/private delivery. It also serves a portion of those covered by private health insurance. The SUS aims to provide universal and free at the point of delivery healthcare services, through two main lines of action: the Family Health Program *(Programa Saúde da Família),* where family health teams provide primary care and act as gatekeepers to determine access to more specialized and hospital-based services; and a network of public and SUS-contracted private clinics and hospitals which delivers secondary and tertiary care nationwide. The private health sector offers duplicate coverage for most healthcare services.

Through the creation of the SUS, Brazil laid the foundations for a better health system and contributed to improving the quality of life of its population. The many measures have led to huge health gains, with an infant mortality rate of about 14 per 1,000 live births, down from about 27 in 2000. Maternal mortality has also been cut in half since 1990. The average Brazilian only lived to about 66 in 1990; today, life expectancy is at 75. The SUS is cherished, by rich and poor Brazilians alike, as a protection against steep medical bills with Brazil having the lowest rate of catastrophic health expenditures (2.2 %) of nearly any other country in the region, achieving higher level of financial protection than other countries such as Chile, Mexico and even the U.S..

Brazil health indicators, comparison with other countries

Health Indicators (2015)	Brazil	Argentina	Germany	USA
Maternal mortality ratio (per 100 000 live births)	44	52	6	14
Neonatal mortality rate (per 1000 live births)	8.9	6.3	2.1	3.5
Under-five mortality rate (probability of dying by age 5 per 1000 live births)	16.4	12.5	3.7	6.5
Life expectancy at birth (both sexes)	75	76.3	81	79.3
Healthy life expectancy at birth (years), both sexes	65.5	67.6	71.3	69.1

Source: WHO

The SUS triggered a fundamental restructuring of how the health system is governed; a process of decentralization and new arrangements for sharing of responsibilities across federal, state and municipal levels; as well as a gradual increase of public spending on health. **The increase in health spending was accompanied by an improved allocation of federal and state resources in favour of the poorest parts of the country and segments of the population.** This contributed to a significant improvement in access to primary healthcare services, which in turn has led to a reduction in avoidable mortality and hospital admissions from primary care sensitive conditions. Overall, in a twenty-year period, the number of primary care facilities increased from 2.2 per 10,000 inhabitants in 1990 to 3.6 in 2009, while the number of primary care consultations per person increased by 70 % during the same period. In large part, this reflected the introduction and expansion of the Family Health Program.

All three levels of government – federal, state and municipal – have worked to encourage the population to use and benefit from the health system through the Family Health Program and through the deployment of community health workers or *agentes de saúde* working with the poor. **Created in 1994, the Family Health Program – Brazil's main primary healthcare strategy – seeks to provide a full range of quality healthcare to families in their homes, at clinics and in hospitals.** Today, roughly 40,000 health centres are active in nearly all Brazil's 5,570 municipalities, covering well over 100 million people. A family health team includes a family physician, a nurse, a nurse assistant and five to seven community health workers; when expanded, it includes the oral healthcare team, with a dentist, a dental hygienist and a dental assistant. The Family Health Program has been an important factor in reducing child mortality and improving other health indicators, especially in the country's poorer North and Northeast regions. Even if long queues at hospital emergency departments, beds spilling into corridors, outdated and malfunctioning equipment and a scarcity of doctors and medicine in rural areas remain common complaints, Brazil's public health system has brought quality healthcare to millions of poorer inhabitants who were previously denied even basic care.

But several are the challenges. **First, notwithstanding heavy demand for healthcare services, the government has only modestly increased spending for SUS and federal healthcare spending is minimal at best, failing to meet ongoing needs.** Brazil spends on average 9 % of its GDP on healthcare (by comparison the U.S.'s 16-18 %) with less than 50% of health financing coming from public sources, one of the lowest shares in the OECD area. Competing with SUS, there is a vigorous market of private insurers and private providers, amounting to approximately 55 % of health financing: private health insurance covers more than 70 million people and generates revenues of more than 40% of the federal funding on healthcare, and direct out-of-pocket (OOP) expenses represent as much as one-third of total healthcare expenses. This mix of health financing makes the health system regressive: the lowest income decile, which accounts for 1% of the total country's income, is responsible for 1.8% of the total OOP expenditure, while the highest income, who have 46% of wealth, are responsible for only 37% of total OOP. Put differently, OOP represents 7% of family income for the poor, while only 3% for the richest, highlighting the difficulties of the public system to ensure quality access to underprivileged populations.

This quality gap between the public system and private providers also helps to explain a soaring market for private health insurance (an increase of more than 50% in the last decade). On top of this, public health policies have helped the development and maintenance of this parallel private market: federal government tax exemptions to private expenses with healthcare have doubled in the last decade and now account to as much as a quarter of total public financing with healthcare, depriving the public system from important financing that could be directed towards a higher investment in the public system around the country.

Second, SUS hospitals and the Family Health Program have often had a difficult time treating individuals in hard to reach areas, such as the Amazonian region while individuals often have to wait a long period of time for prevention and treatment services. Government-funded hospitals and clinics offer quality medical services but often time there is shortage of essential infrastructure, such as beds (only about 2 hospital beds for every 1,000 people), X-ray machines. **On the contrary, the private system comes with shorter wait times, high quality and well-equipped facilities and, even if high-earners tend to visit private doctors, they also turn to the public system to get costly procedures.** On this regard, people with private insurance report having better access to preventive and curative services through their insurance, but often receive vaccines, high-cost services and complex procedures such as transplants through the SUS, crowding out people who have no choice but to use the SUS.

There are some 6,761 hospitals in Brazil. Of these hospitals, 70 % are private/not for profit hospitals and over 50% of hospitals are found in 5 states: São Paulo, Minas Gerais, Bahia, Rio de Janeiro and Parana. The public hospital infrastructure

Brazil's public health system has brought quality healthcare to millions of poorer inhabitants who were previously denied even basic care.

required hospitals to be spread over a territory of 8,516 million square kilometers, as such the public hospital infrastructure relies on a vast network of small hospitals where over 55% of public hospitals have less than 50 beds. Brazil is one of the leading medical tourism destinations in South America and has some of the highest quality hospitals in Latin America, attracting patients from neighbouring countries, mostly for plastic surgery, cancer and cardiovascular treatment.

What's more, there is a high level of inequality in medical technology and infrastructure, with larger, more affluent municipalities able to provide better technological equipment and medical care. SUS funding is split between the federal, state and municipal governments, creating disparities and misuse of public funds in the system. Brazilians in the south tend to live better, healthier lives than their poorer northern countrymen. Infant mortality rate of the north is twice as high as that of the south. The richest fifth of Brazil's population is twice as likely to receive prenatal care as the poorest fifth.

And finally, there is a chronic shortage of doctors and nurses, especially in rural areas. Many hospitals are also poorly managed, lacking autonomy from state governing boards.

Over the years, within the *"Mais Medicos" (More Doctors) program,* the government imported doctors from abroad, primarily Cuba, to serve the poor and those in inadequately served rural areas. Mais Medicos participants provide primary care and are expected to serve for three years, while Brazil expands long-term plans to put more students in medical school. Brazil has between 360,000 – 475,000 active doctors (numbers vary according to different sources), of which over half are specialists. Most doctors are concentrated in the richest areas: the state of Rio de Janeiro has 3.44 doctors per 1,000 residents, compared with less than one per 1,000 people in Acre, far away on the Bolivian and Peruvian borders or 0.58 in the poor north-eastern area of Maranhao.

Put differently, OOP represents 7% of family income for the poor, while only 3% for the richest, highlighting the difficulties of the public system to ensure quality access to underprivileged populations.

	Brazil	Germany	USA
Skilled health professionals density (per 10 000 population), 2005–2015:	93.0	176.0	117.8
Physicians density (per 10 000 population), 2007-2013:	18.9	38.9	24.5
Radiotherapy units per million population (public sector only), 2013:	1.74	6.4	12.37 (not specified if data are delivered for public or private sector)

Sources: WHO, World Health Statistics

The public health system will need to continue to develop – improving the quality and coordination of care, continuing the expansion of primary care coverage, addressing the significant barriers to accessing specialized and high-complexity care and reducing the relatively high level of dependence on private spending to finance the health system. These challenges are expected to become more pressing in the future, as the Brazilian population ages and the national health system needs to face the double burden of infectious diseases and the increased risk of non-communicable diseases such as cancer, cardiovascular disease as well as

trauma resulting from violence and accidents, obesity and diabetes. Nearly half of Brazilians are overweight (46.6 % in 2013 up from 42.7 % in 2006, according to figures released by the Ministry of Health) and about 15 % are obese. Among the reasons for the rapid shift from malnutrition to obesity is Brazil's newish middle class—36 million people who climbed out of extreme poverty in the past few decades, now struggling with non-communicable diseases, being junk food the first thing that comes with economic development.

	Brazil	Argentina	Germany	USA
Mortality due to non-communicable diseases (Probability of dying from any of cardiovascular disease, cancer, diabetes, chronic respiratory disease between age 30 and exact age 70 (%), 2015)	16.9	17.1	12.0	13.6
Road traffic mortality rate (per 100 000 population), 2013	23.4	16.3	4.3	10.6

Sources: WHO

Industry Profile - In spite of political uncertainty, the healthcare industry is expected to grow. To create a more dynamic business environment, Brazil would need to streamline public sector governance, both at the federal and sub-federal levels, with a view to reforming the notoriously complex tax system, ending fiscal competition among federative states; modernizing the outdated labour regime; cutting red tape and delays (e.g. for starting a business and for processing intellectual property rights applications); and increasing transparency, including in the operations of enterprises with public participation. **The Government of Brazil is in fact the nation's largest buyer of healthcare goods and services but navigating the government procurement process is challenging.** Exporters may find themselves at a competitive disadvantage if they do not have a significant in-country presence – whether via established partnerships with Brazilian entities or some type of Brazilian subsidiary.

There are around 4,000 manufacturers of medical and dental products in Brazil and over 10,000 distributors. Many of the largest multinational companies have set up manufacturing facilities in Brazil to reduce costs and to be more competitive within the public system. **For most small and medium-sized exporters, it is essential to work through a qualified representative or distributor when developing new business.** Brazil's business culture relies heavily upon the development of strong personal relationships and requires intimate knowledge of the local business environment. In addition to high tariffs, there is a complex legal system and customs procedures. In 2016, imports of medical products and devices have suffered a 16 % reduction from previous year but are expected to grow in the near future. The value added tax on sales and services (ICMS) exemption is expected to continue for a few products until September 2019. A few notable growth areas were in dental products, where imports increased 10.6 % and in imaging diagnostics, where imports increased by 32.4 %.

ANVISA, the Brazilian Health Regulatory Agency, monitors the price of medical products and pharmaceuticals and regulates commercialization and registration. Foreign companies must have a Brazilian representative or establish a local office to submit the registration of products to ANVISA. Other government bodies involved in the introduction of new medical products are the National Institute of Metrology, Quality and Technology (INMETRO), certifying electromedical devices and implants and the National Commission for Incorporation of Technologies in the Brazilian public healthcare system (CONITEC) which incorporates new medical technologies in the public health system.

For most small and medium-sized exporters, it is essential to work through a qualified representative or distributor when developing new business.

Brazil is ranked among the top ten largest pharmaceutical markets in the world, accounting for 3.5 % share of the world market. While Brazil hosts manufacturing plants of some of the largest international pharmaceutical companies, local industries are mostly focused on the production of generic and similar brand medicines. Generics comprise 29 % of Brazilian's pharmaceutical market and to expand the access of the population to drugs, incentives have been offered for marketing generic products, which cost an average of 40% less than brand-name products. Also, public laboratories supply chronic disease medicines that are distributed for free or at discounted prices to the public. Brazil aggressively negotiates drug prices to help keep prescriptions cheap and available.

More info on registration of medical products at ANVISA: *http://portal.anvisa.gov.br/registros-e-autorizacoes/produtos-para-a-saude/produtos/registro and http://portal.anvisa.gov.br/exporting-to-brazil*

Oral health profile - Oral healthcare follows the trend of general health. It is incorporated within the Public Health System (SUS) with the aim of universal coverage but with lower priority in public policies and public financing. A gap exists between what is officially covered and what is in fact available in practice.

Public oral health coverage reaches less than 40% of the population with a substantial proportion of the population covered neither by public sources nor by private dental insurance. The national policy on oral health, also known as Smiling Brazil ("Brasil Sorridente"), was implemented in 2004 with the aim to reorganize public oral health and provide primary oral healthcare within the Family Health Program (Programa Saúde da Família) and specialized dental procedures through the creation of the Dental Specialty Centers (Centros de Especialidades Odontológicas – CEOs). Oral health was designated as 1 of the 4 priority areas of the SUS, with the objective to achieve the integrality of care envisaged at its creation. "Smiling Brazil" increased federal funds to states and municipalities to provide comprehensive and universal access; furthermore, its financial support also increased the number of municipalities with a fluoridated water system, however, despite its efforts, the magnitude of inequality in Brazil remains and public investment in oral health remains low and not sufficient to address social inequalities in access to oral healthcare.

The Brazilian population covered by oral healthcare teams, within primary care, rose from 15.2% to 37% between 2002 and 2012 with roughly 22,000 teams in 4,900 municipalities. As for the CEOs

there are more than 900 centers all over the country. To access them, people must first be assessed by an oral healthcare team, which will provide primary oral healthcare and if necessary will refer the patient to the nearest center. Services covered by public sources include all procedures considered as primary oral healthcare (examination, diagnosis, preventive care, sealants, scale and polish, fillings, extractions and urgent care) and also some specialized procedures delivered at the CEOs, such as periodontal surgery, endodontic treatment, minor oral surgeries, diagnosis and treatment of oral lesions, dentures and treatment to disabled patients. Crowns and bridges are not covered.

As in general healthcare, coverage for oral healthcare in Brazil is duplicated as people who have private insurance are not excluded from public coverage. Private dental insurance covers around 9.5% of the population and insurance companies must cover a set of dental benefits mandated by the regulatory agency ANS, including primary and specialized procedures. They can also offer optional benefits, which they have no obligation to cover. Many companies have cost-control mechanisms for some procedures, such as preauthorization of benefits and cost sharing. **In consideration of what said, the Brazilian oral healthcare system is mainly privately financed, even after the implementation of "Smiling Brazil". 2010 estimates suggest that private dental insurance finances around 25.7% of total oral healthcare expenditures, out-of-pocket payments account for about 63.9% and the SUS finances only 10.4% of total oral healthcare expenditures.** Individual characteristics (low levels of education) and regional differences (low levels of economic development) maybe associated with poorer access to oral healthcare services. While the supply of oral healthcare services by the SUS has increased, it appears to be still largely targeted to younger and school-age populations.

As in general healthcare, coverage for oral healthcare in Brazil is duplicated as people who have private insurance are not excluded from public coverage.

There are five recognized oral healthcare professions in Brazil: dentist, dental hygienist, dental assistant, dental technician and dental technician assistant. **As roughly 9,000 students graduate each year, the number of dentists becomes comparable to 12% of all dental professionals in the world. The Brazilian oversupply of dentists is associated with an excess of dental schools and graduates but it has not resulted in better access to oral healthcare, given the unequal geographic distribution of professionals.** Such an unequal distribution is related to differences between the more and less developed regions of the nation. For example, in the northern region there are 0.27 dentists per 1,000 population and in the south-eastern region this number increases to 1.25 dentists per 1,000 population.

Comparative framework of the oral healthcare systems, Brazil and selected countries, latest data available

INDICATOR	Brazil	Canada	France	U.K.	USA
Coverage for oral healthcare					
% of population covered by public sources	37.0	5.5	100.0	100.0	5.0
% of population covered by private dental insurance	9.5	62.6	95.0	11.8	59.5
Financing					
Total oral healthcare expenditure (TOHCE), 2010 (billion US$)	3.96	10.55	11.39	8.73	108.44
TOHCE as % of GDP, 2010	0.17	0.80	0.50	0.60	0.70
Per capita TOHCE at average exchange rate, 2010 (US$)	20.75	309.40	175.70	141.23	349.00
TOHCE as % of total healthcare expenditure	1.8	7.4	4.6	4.1	4.0
Public oral healthcare expenditure as % of TOHCE, 2010	10.4	5.3	35.6	46.0	9.3
Private dental insurance as % of TOHCE, 2010	25.7	52.1	38.5	13.4	48.6
Out-of-pocket payments as % of TOHCE, 2010	63.9	42.6	25.5	40.6	41.6

Source: http://ncohr-rcrsb.ca/knowledge-sharing/working-paper series/content/garbinneumann.pdf

Public oral healthcare is usually provided in local community settings and all oral healthcare providers working in the public sector are part-time or full-time salaried employees of the municipality where they are working. On the other hand, private oral healthcare is delivered in independent private dental offices, where dentists can work on their own or in a group practice. These practitioners can earn their living entirely through fees paid directly by their patients and/or by dental plans. They can also work as part-time employees in the public sector.

In the 2010 Brazil National Oral Health Survey, the most significant results include an important reduction in dental caries compared to the 2003 survey. At 12 years, the mean DMFT (mean number of decayed, missing or filled teeth) was 2.1 compared to 2.8 in 2003. For the component of untreated (decayed) teeth, the decrease was 29% (from 1.7 to 1.2) and the proportion of "caries-free" children (DMFT = 0) increased from 31% to 44% in 2010. In adults aged 35-44 years, the mean DMFT in 2003 was 20.1, decreasing to 16.3. **However, the survey identified persistent issues including large regional differences in the prevalence of dental diseases; 80% of decayed deciduous (primary) teeth are still untreated; and despite the decreasing need for dental prostheses in adolescents and adults, there are still significant needs in the elderly, as only 7.3% of them do not need prostheses.**

In terms of access to and utilization of oral health care services, a 2008 survey showed a decrease in the proportion of subjects that had never visited a dentist, from 18.7% (1998) to 11.9% of the population. Nearly 40% of Brazilians made a dental visit in the previous 12 months, but the number increases significantly among the higher income group (67.2%) comparing to the lower income group (28.5%). **The main reason for not obtaining dental care was the waiting times to get an appointment within the SUS due to a shortage of dentists, which can reflect cost barriers to access private dental services.** Data also showed that the SUS was responsible for delivering 29.3% of all oral healthcare services at that time.

Self-reported access to and utilization of oral healthcare services was also explored in 2009. Data were collected from a sample of the Brazilian adult population in Brazil's state capitals and showed that 15.4% of Brazilians who felt they needed oral health care services in the 12 months before the survey did not receive them. Lack of access to oral healthcare was more frequent among women, young adults, less educated individuals and blacks.

Dentistry personnel in Brazil, latest data available.

	Brazil
Number of practicing dentists	Between 256,889 - 290,000
Dentist/1000 population ratio	1.4
Number of dental hygienists	16,033
Number of dental assistants	96,143
Number of dental technicians	20,405
Number of dental technician assistants	4,818
Regulation level for oral healthcare providers	Federal

Sources: http://ncohr-rcrsb.ca/knowledge-sharing/working-paper-series/content/garbinneumann.pdf /

Oral Health Outcomes

Average number of DMFT at age 12	2.1
% of individuals who visited a dentist within the previous 12 months	40.2
% of individuals who felt they needed oral health care services but did not receive them in the previous 12 months.	15.2

Source: http://ncohr-rcrsb.ca/knowledge-sharing/working-paper-series/content/garbinneumann.pdf

ORAL HEALTH, COMPARATIVE DATA

SEVERE CHRONIC PERIODONTITIS
Estimates of average prevalence among those 15 years or older (2010)
Brazil - more than 15.0%
Germany -10.1%-15.0%
US, Canada, France, UK - 10% or less

ORAL CANCER
Incidence per 100,000 population of oral and lip cancer among those 15 years or older (2012 estimates)
US, France, Germany - 5.0-6.9
Brazil, Canada, UK - 2.5-4.9

DENTAL SCOOLS PER COUNTRY
Brazil, U.S. - 50 or more
Canada, France, Germany, UK - 10-49

PUBLICATIONS
Papers published on dental research per country
US - 8,661
Brazil - 4,527
England - 2,900
Germany 2,769

Source: FDI World Health Atlas, 2015

Largest Medical and Dental Latin America international trade exhibitions, both held in Sao Paulo:

• Hospitalar
22-25 May 2018
www.hospitalar.com/en/the-fair/general-information-eng
(Medical)

• Congresso Internacional de Odontologia
30 Jan. – 2 Feb. 2019
Organized by the Sao Paulo Association of Dental Surgeons
www.ciosp.com.br/ (Dental)

Among main sources:

-Extracts from "The hallmark of the Brazilian National Health System (SUS)", Magnus Lindelow, Sector Leader for Human Development for the World Bank. For full article: Brazil.http://www.worldbank.org/en/news/opinion/2013/12/20/brazil-sus-unified-public-healthcare-system-new-study
-Extract from "Exporting to Brazil – Market Overview" by Export.gov.The U.S. Department of Commerce's International Trade Administration collaborates with 19 U.S. Government agencies to bring Export.gov. For full overview on Brazil: https://www.export.gov/article?series=a0pt0000000PAtOAAW&type=Country_Commercial__kav
*-Extract from "A comparative analysis of oral health care systems in the United States, United Kingdom, France, Canada and Brazil" By Daniela Garbin Neumann*1 and and Carlos Quiñonez2. Garbin Neumann NCOHR Working Papers Series 2014, 1:2. http://ncohr-rcrsb.ca/knowledge-sharing/working-paper-series/content/garbinneumann.pdf*
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** Correspondence: danigneumann@hotmail.com*
1 CAPES Foundation, Ministry of Education of Brazil, Brasília, DF, Brazil.
2 Discipline of Dental Public Health, Faculty of Dentistry, University of Toronto, Toronto, Canada
- Extract from "The Brazilian Health System: A tale of two countries", by Pedro Ramos, a medical doctor and holds a Master in Health Management and Economics from Porto University, Portugal. He is currently working as Assistant Director at the Physician-in-Chief Office in a Brazilian hospital. For full report: http://ghnetwork.org/article/the-brazilian-health-system-a-tale-of-two-countries/
- "Flawed but fair: Brazil's health system reaches out to the poor" by WHO (World Health Organization). For full text: http://www.who.int/bulletin/volumes/86/4/08-030408/en/
-Extract from "In Brazil, health care is a right" by Eduardo J. Gomez, special to CNN. Full article at: https://edition.cnn.com/2012/07/13/opinion/gomez-brazil-health-care/index.html
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-"The Health System of Brazil" https://www.ncbi.nlm.nih.gov/pubmed/21877078
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-WHO data from: http://apps.who.int/gho/data/node.country.country-BRA?lang=en http://apps.who.int/gho/data/node.main.688?lang=en
-WHO, World Health Statistics 2017 and World Health Statistics 2015
- Financial Times, March 2018 https://www.ft.com/content/f3d2cd90-1e46-11e8-aaca-4574d7dabfb6
-Extracts from "Towards a more prosperous and inclusive Brazil" by Jens Arnold and Alberto Gonzalez Pandiella, OECD, for full article: https://oecdecoscope.wordpress.com/2018/02/28/towards-a-more-prosperous-and-inclusive-brazil/
-Central Intelligence Unit: https://www.cia.gov/library/publications/resources/the-world-factbook/geos/br.html https://www.cia.gov/library/publications/resources/the-world-factbook/geos/br.html

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ABIMO

BRAZILIAN MEDICAL AND DENTAL DEVICES MANUFACTURERS ASSOCIATION

Brazil is Proud of its Odontology

The success of Brazilian odontology goes overseas and brings recognition in all market branches. It is the most competitive of all branches represented by ABIMO. In addition to that, the scholar network of national odontology is leader in scientific papers production in Latin America and occupies an honourable second place on a worldwide scale, back-seating only to United States of America.

It takes credit for the best scientific performance among all areas of knowledge. **Brazilian odontology has evolved over the decades upon the following formula: high demands and a great ability to make deals and to invest in constant innovation.**

World leader in the amount of dental surgeons, having more than 290 thousand working professionals, Brazil trains about 9 thousand new professionals each year. With so many dentists always searching for more effective and efficient solutions, along with a middle class eager to spend on dental and aesthetic products, this industry keeps up with the development pace, increasing internal production to meet the needs of its own market and elsewhere.

Such devotion to the industrial chain of dental products is reflected on the increasing volume of exports and on the export maturity level found on companies. Each day more suited to the international scenario, Brazilian companies reach a significant amount of world markets. **Nowadays, about 130 countries buy dental products from Brazil, including countries which pose great demands like United States, good buyers of national output.** In 2017, a US$ 87.3 million figure was exported by Brazilian odontology. From this amount, US$ 6.5 were purchases made by North Americans.

> The success of Brazilian odontology goes overseas and brings recognition in all market branches.

A look on the odontology market in Latin America shows that Brazil and Mexico lead the market. The US$ 87.3 million worth in exports has a top ten buyers list of national dental products, including United States, Germany, Switzerland and even Mexico, which bought more than US$ 8.6 million worth in dental products from Brazilian dental industry this year.

Such positive scenario, allying scholarship and productive chain, leads to a national production able to join two great market advantages: quality and competitive pricing. It is a common occurrence for Brazil to sell products that have better performance against products from competitors, and a markedly more attractive price.

Such cost/benefit ratio places more and more the dental sector of Brazilian industry within international settings. That includes active participation on main segment fairs, both to showcase its internal production and to capture world ideas, trends and news.

Massive presence on world events reassures the impressive national odontology stamina and is a contribution to bring the country due attention, and the recognition of the nation as a vast technical mastery reservoir.

Further demonstration of the quality found in country, some events sponsor the Hands On Area, a space created by national industry to teach-by-showing and to demonstrate the applicability of products and solutions. On such space Brazil shows its expertise, both on manufacturing technologies and on dynamic use of such technologies thanks to demonstrations performed by renowned dental surgeons.

Simultaneously to this stepping out the Brazilian borders to see what the world has to show as the most interesting features of the dental sector, it opens its doors to welcome the same professionals during **CIOSP, an annually held congress said to be the biggest in the sec-**

Further demonstration of the quality found in country, some events sponsor the Hands On Area, a space created by national industry to teach-by-showing and to demonstrate the applicability of products and solutions.

tor on Latin America, and one of the largest in number of visitors. It has an expositor's area about 20 thousand square meters large and 250 brands as expositors, both Brazilian and from abroad. This congress also offers a scientific schedule taught by the best professional of each specialty addressed.

Such interchange between Brazil and the world, a point of high interest to Brazilian business men, also contributes to the high quality of national production. Besides the participation in fairs and events, and the carrying out of many commercial missions to gather specific information on each of world markets, the exchange of information among sector professionals also finds no geographical boundaries. Many Brazilian professionals devote themselves to international experiences. They build bridges that increase the quality of internal research, turning themselves into lighthouses to dental surgeons and also to industry. Such intercontinental relationships often work as the basis for partnerships between Brazilian industry and universities and industries of prominent centers of reference on worldwide odontology.

Cutting-edge technology

Brazilian dental innovations are recognized worldwide. Embracing all branches of the segment, from consumables to instruments, through equipment, endodontics and to implants, Brazilian industry makes and markets very high-quality products, oriented by what is most advanced in the world.

One highlight is the sector of bioceramic cements. Because of investment on research and development, Brazilian companies were able to produce chemical processes that turned into a market revolution. **With the rise of nanotechnology, bioceramic started to become popular on endodontics, bringing numerous advantages both to dental surgeons and patients.** Chemically stable, this material has been widely used on the repair of punctures and as restoration cement.

Other segments of Brazilian odontology also keep fostering technological advances. **On orthodontics, new technologies for brackets, supports for the orthodontic tooth brace fixed in each tooth that needs correction, became a worldwide success on more than a hundred countries, including patent rights claimed on United States.** Mixing passive and interactive techniques in a single system, these new bracket models save time on consultations and are beneficial at all points in the chain.

Distinction also on dental implant area, Brazilian manufacturers are celebrating partnerships with renowned research institutes like Chalmers University, on Sweden, a country thought of as the birth place of worldwide implantdontics. As a result of such successful interchange and of almost a decade of intensive studies, a new generation of Brazilian implants was created to fill in the blanks of the segment. The synergy between macrogeometry and the most advanced surface nanoactivation, capable of speeding up significantly osseointegration, drew attention from the best professionals in the world.

This article will also be available in the Sector Book realised by ABIMO, which will be launched during Hospitalar (22-25 May 2018; São Paulo – Brazil). Besides the dental sector, other topics of the book will be: medical hospital sector, laboratory sector and rehabilitation sector.

ABIMO - Brazilian Medical Devices Manufactures Association was founded in 1962, in order to represent its members before governmental and civil bodies, also supporting them with technical and normative services.
ABIMO has 350 members and offers a special exports program (Brazilian Health Devices) in partnership with APEX- Brazil (Brazilian Trade and Investment Promotion Agency). The project aims to increase Brazilian exports in the area of healthcare products by promoting training to companies, marketing actions, exhibitions, trade missions and business intelligence.

Countries that have bought Brazilian dental products

Rank	Countries	2017
TOTAL	**TOTAL**	**87.391.902 in US Dollars**
1	Mexico	8.617.778
2	Argentina	7.679.792
3	Chile	7.121.016
4	United States	6.594.691
5	Germany	6.438.505
6	Colombia	5.141.779
7	Switzerland	4.874.949
8	Peru	4.227.336
9	Bolivia	3.459.815
10	Paraguay	3.262.700
11	Ecuador	2.668.684
12	India	2.281.466
13	Indonesia	2.277.816
14	Costa Rica	2.054.219
15	Portugal	2.012.802
16	Guatemala	1.738.466
17	Dominican Republic	1.180.450
18	Uruguay	1.122.319
19	Turkey	1.103.355
20	Panama	875.491
21	Spain	858.281
22	South Korea	759.108
23	United Arab Emirates	598.834
24	Japan	560.963
25	Algeria	560.951
26	Iran	532.367
27	Nicaragua	382.959
28	Venezuela	381.437
29	United Kingdom	373.197
30	Italy	372.015

Rank	Countries	2017
31	Morocco	338.757
32	Saudi Arabia	330.333
33	France	320.556
34	China	312.130
35	Philippines	311.969
36	Poland	297.356
37	Honduras	263.713
38	Lebanon	254.118
39	Myanmar	252.575
40	El Salvador	247.147
41	Egypt	245.188
42	Vietnam	244.347
43	Hong Kong	215.887
44	Romania	185.088
45	Australia	183.221
46	Russia	167.332
47	Kenya	149.312
48	Serbia	146.192
49	Sweden	141.316
50	Angola	139.331
51	Kuwait	134.146
52	Iraq	122.567
53	Malaysia	117.410
54	Nigeria	114.749
55	Israel	113.009
56	Pakistan	108.070
57	South Africa	94.865
58	Luxembourg	93.734
59	Tunisia	91.658
60	Qatar	85.126
61	Thailand	75.673
62	Singapore	74.092
63	Finland	72.136
64	Lithuania	71.271

Rank	Countries	2017
65	Azerbaijan	70.787
66	Netherlands (Holland)	66.340
67	Canada	64.257
68	Bulgaria	58.404
69	Greece	56.359
70	Tanzania	54.432
71	Ghana	48.647
72	Slovenia	43.422
73	Ukraine	40.094
74	Kazakhstan	39.169
75	Albania	38.898
76	Bhutan	38.084
77	Jordan	35.284
78	Rwanda	33.982
79	Belgium	32.001
80	Czech Republic	27.120
81	Libya	26.353
82	Hungary	25.726
83	Croatia	25.207
84	Taiwan (Formosa)	21.603
85	Afghanistan	21.406
86	Armenia	20.338
87	Sudan	17.866
88	Macedonia	17.838
89	Madagascar	16.168
90	Bangladesh	14.827
91	Syria	14.500
92	Austria	13.818
93	Sri Lanka	12.289
94	Gambia	12.049
95	Slovakia	11.699
96	Puerto Rico	11.300
97	Mauritius	10.908
98	Haiti	9.830

Rank	Countries	2017
99	Bahrain	9.204
100	Oman	8.414
101	Nepal	8.181
102	Malawi	8.166
103	Cyprus	7.704
104	Moldova	7.541
105	Cabo Verde	7.030
106	Zimbabwe	6.850
107	Niue	6.809
108	Trinidad and Tobago	6.401
109	Papua New Guinea	4.119
110	Georgia	3.915
111	North Korea	3.597
112	Curacao	3.224
113	New Zealand	2.791
114	Senegal	2.747
115	Belarus	2.536
116	Jamaica	2.302
117	Ireland	2.197
118	Norway	1.882
119	Mozambique	1.266
120	Latvia	1.169
121	Denmark	1.034
122	Palestine	894
123	Suriname	714
124	Mongolia	673
125	Equatorial Guinea	489
126	Cambodia	372
127	Gibraltar	305
128	Guyana	205
129	Ivory Coast	140
130	Zambia	69
131	Monaco	24
132	Uganda	18

At a Glance

• Capital and largest city – Sarajevo

• National languages - Bosnian, Croatian and Serbian

• Population - 3,856,181 (July 2017 est.)

• Area - 51,129 sq km (19,741 sq miles)

• Major religions – Islam (47%), Orthodox Christianity (36.9%) and Roman Catholics (15%)

• Currency - Bosnian convertible Mark (1,96 KM = 1 Euro)

• In February 2016 the country formally requested to join the European Union

• Nearly 70% of Bosnians are online. Facebook is the top social media resource

• Administrative divisions - 3 first-order administrative divisions - Brcko District (Brcko Distrikt) (ethnically mixed), the Federation of Bosnia and Herzegovina (Federacija Bosne i Hercegovine) (predominantly Bosniak-Croat), the Republic of Srpska (Republika Srpska) (predominantly Serb)

• Government - Federal parliamentary constitutional republic

• The presidency in Bosnia-Herzegovina rotates every eight months between a Serb, a Bosniak (Bosnian Muslim) and a Croat. The responsibilities of the presidency lie largely in international affairs. In addition, the Federation of Bosnia and Herzegovina, and Republika Srpska each have their own presidents

• Bosnia-Herzegovina prime minister - Denis Zvizdic, of the Muslim Party of Democratic Action, became federal prime minister in February 2015, after the party won the most votes in the October 2014 elections

GDP (PPP, purchasing power parity):
$43.85 billion (2017 est.)
$42.78 billion (2016 est.)
$41.94 billion (2015 est.)

GDP per capita (PPP, purchasing power parity)
$11,400 (2017 est.)
$11,100 (2016 est.)
$10,900 (2015 est.)

GDP- real growth rate:
2.5% (2017 est.)
2% (2016 est.)
3% (2015 est.)

One Country, Two Entities

Bosnia and Herzegovina is a country in south-eastern Europe located on the Balkan Peninsula. The country (often known informally as Bosnia), still recovering from the devastating three-year war (1992-1995) which accompanied the break-up of Yugoslavia in the early 1990s, is now an independent state and home to three main ethnic groups or, officially, constituent peoples, as specified in the constitution: Bosniaks, the largest group of the three, Serbs, the second largest and Croats.

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The war destroyed much of Bosnia's infrastructure and economy. Around two million people - about half the population - were displaced. **Bosnia and Herzegovina is made up of two separate subnational entities: The Federation of Bosnia and Herzegovina and the Republika Srpska, each with its own president, government, parliament, police and other bodies. Overarching these entities is a central Bosnian government and rotating presidency.** The main cities in the Federation are the capital Sarajevo, and the cities of Mostar, Tuzla, Bihac and Zenica, while in the Republika Srpska entity the main cities are Banja Luka, Bijeljina, Prijedor and Trebinje. Formally part of both entities is the Brčko District, a multi-ethnic self-governing administrative unit, over which neither the Republika Srpska nor the Federation of Bosnia and Herzegovina have jurisdiction. As well as its own education system, the city of Brčko has free-standing courts and separate health and police services. It is, practically, a free city in Europe. The political system in Bosnia-Herzegovina is complex, making governance extremely difficult, but reflecting the provisions of the country's constitution developed to end ethnic conflict. A highly decentralized government hampers economic policy coordination and reform, while excessive bureaucracy and a segmented market discourage foreign investment. The economy is among the least competitive in the region.

In July 2015, the Council of Ministers of Bosnia-Herzegovina, the Government of Republika Srpska and the Government of the Federation of Bosnia and Herzegovina adopted a joint program of structural reforms known as the reform agenda, aiming to promote a unified economy in such a highly decentralized country. In 2016, Bosnia also began a three-year IMF loan program, but it has struggled to meet the economic reform benchmarks required to receive all funding instalments. Since 2013, Bosnia-Herzegovina has witnessed positive economic growth, though severe flooding hampered recovery in 2014. It became a full member of the Central European Free Trade Agreement in September 2007. High unemployment remains the most serious macroeconomic problem.

Key economic challenge is the imbalance of its economic model: public policies and incentives are skewed toward the public rather than the private sector, consumption rather than investment and imports rather than exports. The country needs to shift to a business environment conducive to private investment that supports both vibrant small and medium-sized enterprises and the growth of larger companies, facilitates export performance and productivity improvements, and generates much-needed private sector employment. At the same time as addressing these imbalances in the economic model, the country must also ensure the sustainability and inclusiveness of future growth. Top economic priorities are: acceleration of integration into the EU; strengthening the fiscal system; public administration reform; World Trade Organization membership and securing economic growth by fostering a dynamic, competitive private sector.

Administratively and legally, the two governmental entities of Bosnia-Herzegovina are divided further into 10 cantons in the Federation of Bosnia and Herzegovina, 7 regions in Republika Srpska and 156 municipalities overall, plus Brcko District.

Consequently, healthcare finance, management, organization and provision in Bosnia and Herzegovina are the responsibility of each entity, while Brcko District runs a healthcare system over which neither entity has authority. In this context, the health system in the Federation of Bosnia and Herzegovina is arranged on the principle of decentralization, with a high degree of autonomy of cantons, while in the Republika Srpska the healthcare system is centralized. Brcko District has its own healthcare system.

Bosnia and Herzegovina, therefore, has 13 ministries of health and health systems for its 3.8 million population: one for Republika Srpska, one for Brcko District, one for the Federation level and ten cantonal ministries in the Federation of Bosnia and Herzegovina (one for each canton). Despite the huge administrative apparatus and complex legal divisions, there is no national mandate for healthcare financing and provision and no regulation exists to rule over inter-entity issues in healthcare utilization. Such an organization raises insurmountable operational difficulties.

The country healthcare system is based on compulsory social health insurance. Under the Dayton peace agreement, the Serb entity, Republika Srpska, established its own centralized health insurance fund while in the Federation of Bosnia Herzegovina, a Law on Health Care and a Law on Health Insurance, adopted in 1997, stipulated that each of the ten cantos would have their own insurance fund.

The revenues are raised through a payroll tax on a compulsory basis, as well as government contributions. Furthermore, patients pay for part (or the total) of the cost of their treatment and drugs. Supplementary contributions may also be made. **Nonetheless, the breadth of coverage by social health insurance has been low, with many population groups falling through the gaps, including refugees, some pensioners and people working in the large informal sector.** Despite a wide option for the people to get healthcare it is estimated that 15 % of population in general are not covered by health insurance.

Comparing with western European countries, where most dental clinics are equipped with the latest technical facilities and supported by health professionals from various specialties, public dental health services in Bosnia-Herzegovina are mostly directed to provide emergency care or interventions towards certain age group population (pregnant women, pre-schoolchildren, school children etc.), neglecting the rest of the population. Public dental services offer basic oral care coverage and intervention procedures mostly consist of treating exist-

ing problems and restoring teeth and related structure to normal function. As such the need to work on disease prevention and health promotion policies to improve oral health conditions, in general, is evident.
Public dentistry very much reflects general health and Bosnia-Herzegovina's national capacity and human, financial and material resources are still insufficient to ensure availability and open access to essential oral health services of high quality for individuals and population, especially in deprived communities.
Accessibility to public oral healthcare facilities differs between administrative units, varying by cantons and regions and even more by municipalities. Furthermore, access to dental care depends on financing and socioeconomic factors, creating inequalities.
The number of oral health personnel, and specifically dentists, appears irrelevant, as well as undertrained, to the actual oral health needs and demand. The entire oral health organization (public and private) is amongst the less developed in Europe. To improve oral health, an adjustment of existing oral health manpower structures with the training programmes for types of personnel which would match the oral health needs are needed in Bosnia-Herzegovina.

In recent years however, the biggest change has been the wide scale privatization of the previously public dental services and the exceptional growth of private practices. According to the Federation of Bosnia-Herzegovina chamber of dentists, there are some 400 dental practices in the Federation and some 260 are estimated in the Republika Srpska. Furthermore, dental tourism is gaining momentum, mainly in Sarajevo, in the Herzegovina region and in the north-west area of the country, bordering with Croatia. Dental implants are a very common procedure among European and international tourists because of remarkably low prices and fairly good quality. Orthodontic procedure on the country are not much requested and only few dental practices offer them. On such a perspective, the dental sector has good potential for development and growth. There are some 7-8 dental importers and distributor in the country.

A study conducted in the Federation of Bosnia-Herzegovina, in a time period of six years (2005-2011), gives us a deeper understanding on public dental healthcare in the Federation.

The number of dentists employed in the public sector slightly increased from 529 in the year 2005 to 587 in 2011. In such a time period, the study also shows an increased number of graduate dentists. An estimated total number of dentists, including dentists employed in the private sector, is given by the WHO in 2014, amounting to 825 (787 in 2000).

Number of graduated doctors of dental medicine (DDM) during the period from 2005 to 2011 and number of doctors of dental medicine/ number of DDM per 100,000 populations employed in public sector during the same time period.

Year	Number of graduated Doctors of Dental Medicine	Number of Doctors of Dental Medicine/ number of DDM per 100,000 populations*
2005	57	529/23
2006	107	573/25
2007	108	547/23
2008	66	514/22
2009	78	515/22
2010	55	595/25
2011	68	587/25

* The data of number of doctors of dental medicine employed in the private sector is missing.

Number of visits and performed treatments per doctor of dental medicine in public dental service during the time period year 2005 to 2010

Treatments	2005	2006	2007	2008	2009	2010
Filled primary teeth	34.0	29.0	28.0	34.0	38.0	30.0
Filled permanenth teeth	439.0	436.0	433.0	563.0	548.2	479.5
Extracted primary teeth	163.0	163.0	143.7	152.0	141.3	118.6
Extracted permanenth teeth	412.0	421.0	411.3	473.4	445.3	370.6
Complete dentures	8.0	8.1	7.7	10.4	9.5	8.1
Partial dentures	8.0	6.8	6.3	8.2	6.9	5.9
Single crowns	5.0	3.6	4.5	3.2	3.6	2.9
Removable orthodontic appliances	9.4	9.7	11	21.2	11.9	10.7
Periodontal treatment	200.6	172.2	197.6	260.5	267.0	251.5
All visits, total	**1775.1**	**1716.8**	**1696.0**	**2063.2**	**2032.2**	**1840.6**

Dental caries and periodontal diseases are among the most common oral diseases in the Federation. In 2011 there were 1,352 caries per 10,000 population (against 1,256 in 2005), for pulp and periapical tissues diseases the rate was 948 per 10,000 population and gingivitis and periodontal diseases, 219 per 10,000 population.

Year	Dental Caries per 10,000 population
2005	1,256
2006	1,540
2009	1,303
2010	1,322
2011	1,352

In the table above, which measures number of visits and dental treatments performed, it is interesting to note the small number of filled deciduous (primary) teeth in 2010 (30 per dentist) compared to the number of extracted deciduous

HEALTH STRUCTURE

Health Centres (Dom zdravljas) - owned by the municipal governments, each one covering a population of 30,000 to 50,000 residents. They provide outpatient care but they do offer a wide variety of specialist services. Medical services provided include, general practice, maternity care, child healthcare, healthcare for lung diseases and dental care. They also provide emergency medical aid as well as laboratory, radiology and other diagnostic services.
Health centres provide general practice medicine and are staffed with doctors and nurses; some have small maternity hospitals attached, temporary accommodations for patients and centres for rehabilitation.

Health Stations (ambulantas) – are field posts for the health centres. They are outpatient clinics, which employ general practitioners, dentists and community health nurses. They are sometimes attached to a health centre; otherwise, they are run as private practices. The high number of specialist doctors has made the ambulanta services more expensive and unequal. They tend to be used by people in the cities and urban areas and they often overuse the services, whilst those living in rural areas have little access to any form of medical care.

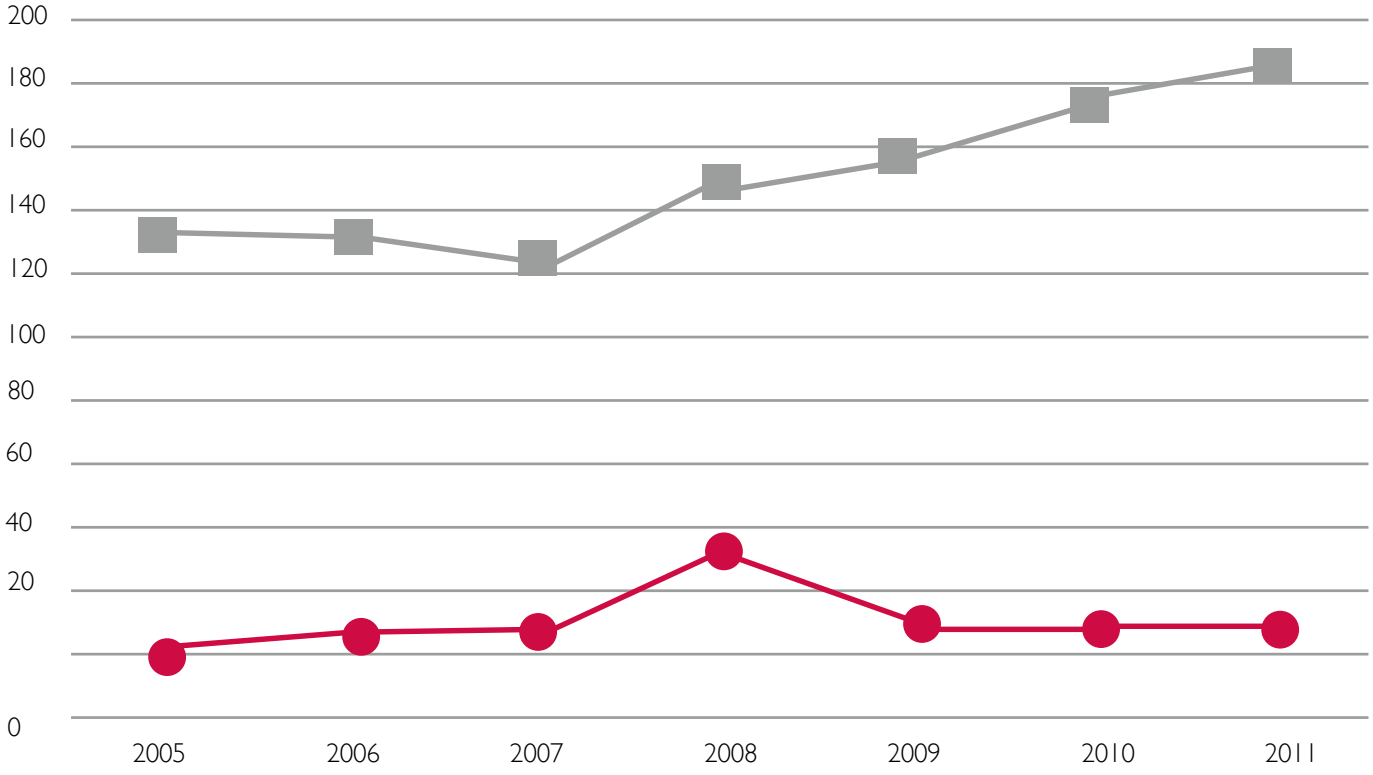
Hospitals - Hospital management is poor because there is a low level of trained hospital managers and poor technical systems to aid hospital administration. Hospitals provide care, emergency care and treatment for both inpatients and outpatients once a patient is referred by a doctor. There are four types of hospitals: clinical centres, general acute hospitals, specialised hospitals and small district hospitals. General hospitals usually have four departments: internal medicine, surgery, paediatric care, and gynaecology/midwifery. Apart from caring for inpatients, hospital doctors also provide consultancies to outpatients who are referred to them by a general practitioner.

Pharmacies - State pharmacies are reimbursed for drugs on the Essential Drugs List. Private pharmacies, however, are excluded from reimbursement by the state fund. WHO and UNICEF helped the Bosnia-Herzegovina government to put together an Essential Drugs List. Private pharmacies abound, but there is a lack of hospital pharmacists. Drugs are expensive and prices vary tremendously making it inconvenient for patients, who are forced to search retail pharmacies for cheaper drugs.

teeth in the same time period (119 per dentists). **Limited access to oral health services can be considered as one of the reasons for such a big number of extracted primary teeth as well as permanent teeth.** Because of limited access to oral health services, teeth are often left untreated and later extracted because of pain or discomfort. The study also reports an almost equal number of fillings in permanent dentition and extracted permanent teeth, which certainly increases the number of patients who needs partial dentures or even total prosthesis as a treatment.

Having in mind that early extraction of deciduous teeth usually leads to loss of space, many extractions of primary teeth can be partly considered as the cause of increased number of dentofacial anomalies. A strong positive correlation has been seen between the increased number of dentofacial anomalies and increased usage of removable orthodontic

appliances. The figure below shows the increased number of dentofacial anomalies (grey line) during the time period from 2005 to 2011. This trend can be considered one of the reasons for the increased number of removable orthodontic appliances (red line) recorded in the same period.



The results of this study found that the extraction of permanent teeth is the most common treatment in dental offices in the Federation of Bosnia-Herzegovina. These results correspond with the results registered by WHO where 78 % of edentulous adults in Bosnia and Herzegovina, aged 65 years and more, present the biggest percentage of edentulous people in the world. Although losing teeth is a natural consequence of aging, those results indicate the need to reorient oral health services in Bosnia and Herzegovina towards prevention and oral health promotion. Incidence rates of malignant neoplasms found in this study coincide with the incidence rates in most countries worldwide. Those incidence rates relate directly to risk behaviours such as smoking and alcohol consumption. It seems, while oral and pharyngeal cancers are both preventable, in Bosnia-Herzegovina, like in most countries, they remain a major challenge to oral health programmes. **Severity of oral health burdens registered in this study partially can be considered as the result of changing of socio-demographic factors.** Reform of oral health services in the Federation of Bosnia-Herzegovina should lead to increased interest in basic preventive oral health interventions (especially in high-risk populations) as an easy and reliable approach to reduce systemic load of curative dental treatments with the aim to improve not only oral health but the health in general.

Among main sources:

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Šejla & Selimovic, Mediha (2013). For full report:
https://www.researchgate.net/publication/276347494_Efficiency_of_dental_health_care_in_Federation_of_Bosnia_and_Herzegovina
Corresponding author: Šejla Ciloviæ-Lagarija, Institute for Public Health of Federation of Bosnia and Herze-govina, Maršala Tita 9. 71000 Sarajevo, Bosnia and Herzegovina E-mail: seila.cilovic@gmail.com, s.cilovic@zzjzfbih.ba
- Italian Trade Agency (I.C.E.), Ul. Cekalusa 39, 71000 Sarajevo, Bosnia Erzegovina http://www.ice.gov.it/it/mercati/bosnia-erzegovina
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- Extract from: http://www.europe-cities.com/destinations/bosnia-herzegovina/health/
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- Central Intelligence Agency (CIA), https://www.cia.gov/library/publications/the-world-factbook/geos/bk.html
-BBC News, http://www.bbc.com/news/world-europe-17211415

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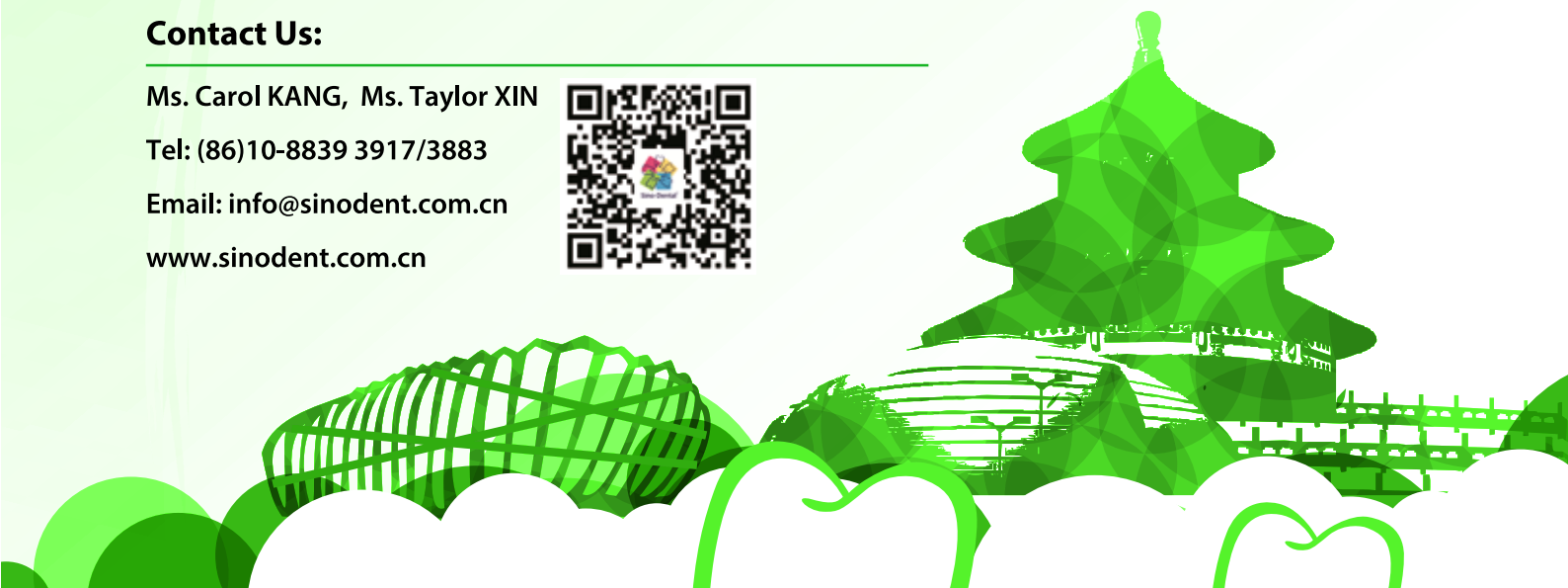

23rd Dental South China International Expo 2018

The Dental South China International Expo 2018 came to a successful end on April 7th in the Area C of China Import and Export Fair Complex in Guangzhou. The four-day expo covered a total area of 54000 square meters, attracting five pavilions 942 exhibitors and 54936 visitors from over 90 countries and regions. Meanwhile, 189 symposiums were held successfully sharing advanced treatment techniques and exchanging advancement of the industry.

• Greater Platform Brings New Millstone

Dental South China International Expo, as a trend vane of the dental industry, is a full –range presentation and communication platform for exhibitors and visitors to exchange information and experience.Exhibitors bring high quality products and cutting-edge technologies, varying from dental equipment to general medication and tools. Pavilions from Germany, America, Korea, Taiwan and Nanhai, Foshan continue to strike the stage with their elaborate exhibits. By means of diversified and multi-media promotion, the whole expo extremely demonstrates the unique characteristics of each brand and further enhances the overall image of the regional development of dental industry.

• Cutting-edge Conferences Cover Every Filed

The Dental South China is also a diversified stage for continue education and cutting-edge achievement sharing. 189 high-quality symposiums concerning managerial skills, comprehensive training, advanced technology, case sharing and experience sharing were held here. Experts and professors shared the latest medical research achievements, practical clinical techniques, and their experience in advanced equipment operation and efficient strategies on clinic management.

• International Buyer delegations bring business opportunities

The attendance and active interaction of International buyer delegations from Indonesia, Malaysia, Thailand, Bangladesh, Pakistan and Philippines not only brought business opportunities for exhibitors but also increased event atmosphere.This complied with the industry appeal for exploiting new markets and contributed to the cultivation of advantages in the field of foreign trade. With the background of the "One Belt One Road" initiation, it is foreseeable that more related countries would be involved in the course of overseas expansionof domestic dental industry. Dental South China International Expo, known for its large scale, high prestige and great services, builds up a good public image and at the same time, makes contribution to the international promotion and experience exchange for the whole trade.

The next Dental South China International Expo will be help on 3rd-6th March 2019. Do not miss this great event!

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IDEM 2018 Takes Clinical Excellence to the Next Level

19 April 2018 – SINGAPORE – The 10th edition of the International Dental Exhibition and Meeting (IDEM) successfully concluded after three days of exhibition, meetings, conference and insightful discussions on the latest breakthroughs in dental innovation and practices.

Co-organised by Koelnmesse and the Singapore Dental Association, Asia Pacific's cornerstone event in dentistry drew 8,571 attendees from 71 countries. The exhibition floor hosted 13 national pavilions and a total of 506 exhibitors from 41 countries. "We are proud of how IDEM has developed since its inauguration 18 years ago. The 10th edition of IDEM once again focused on integrating breakthrough technologies into dental and biomaterial sciences, as well as better care for patients. Looking ahead, we will continue to provide our audience with a world-class event that is cutting-edge and contemporary. This includes the further blending of education, trade, and networking, and full use of digital technologies to facilitate maximum interactions between exhibitors and visitors," said Mr. Mathias Kuepper, Managing Director, Koelnmesse Pte Ltd.

The exhibition floor featured the latest innovations, including 3D printing, an integrated blade that minimizes the risk of injuries during surgeries as well as the latest range of intraoral scanners that are ergonomic, portable and able to provide real-time scanning with no ongoing calibration requirements, which are designed for patient comfort.

"The IDEM exhibition is the perfect event to meet all the Asian customers at a central location," said Stefan Leben, A. Schweickhardt GmbH & Co. KG, an exhibitor who participated at IDEM 2018.

Highlights from the conference floor included key sessions by Dr Christopher Ho, who shared concepts of additive dentistry and went into detail on how to select the techniques and materials of choice for various clinical scenarios; Dr Sergio Piano, who proposed a simplified approach for minimising both the surgical impact and the treatment time; and Dr Anthony Mak who discussed restorative treatment planning and how to choose the correct preventive or restorative materials and techniques for the older dentition.

"IDEM provides dental professionals with the best opportunities to further their professional education and development as well as strengthen their practices and industry knowledge," said Dr Kuan Chee Keong, Chairperson, IDEM 2018 Committee. "We are working closely with the Koelnmesse team to deliver an even more attractive programme for dental professionals and will look for opportunities to showcase the latest technological advances as well as increase the engagement between speakers and the audience at the next edition of IDEM."

The next edition of IDEM will take place on 24 – 26 April 2020 at Suntec Singapore Convention and Exhibition Centre. Attendees will be able to look forward to re-energizing their business with more intensive educational sessions, interactive presentations, engaging meetings, and learning about new advancements in dentistry.

About IDEM Singapore

IDEM Singapore, a specialised dental trade fair accompanied by a professional congress, has developed since its premiere in 2000 into the leading dental event in the Asia-Pacific region. At IDEM 2020, participants will meet key decision-makers, strengthen valuable contacts with customers and partners, and explore the potential of an exciting growth market.

About Koelnmesse

Koelnmesse is one of the world's largest trade fair companies. Its more than 70 trade fairs and exhibitions have the broadest international scope in the industry, as 60 percent of the exhibitors and 40 percent of the visitors come from outside Germany. Koelnmesse events include the leading global trade fairs from 25 sectors, such as Imm Cologne, Anuga, Interzum Cologne, Photokina, Gamescom, and the International Hardware Fair Cologne. The Singapore subsidiary, Koelnmesse Pte Ltd also organizes the dental events DAMA, AOSC and IDEC.

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CEDE in Poznań – the quintessence of an exhibition and learning combined

Preparations are underway for one of the most prestigious dental exhibitions in Central and Eastern Europe – CEDE 2018 (20-22 September). For the second time the exhibition of equipment, materials and instruments will be held concurrently with the Polish Dentistry Union Congress.

CEDE 2018 will mark the 27th occasion when devotees of modern dentistry will come together for this marquee exhibition. For the needs of the exhibitors, the organisers have reserved four pavilions at the Poznan International Fair, which will provide approximately 7 000 m2 of net exhibition space. In 2017 a total of 220, firms including 41 from outside Poland, showcased their products at CEDE. Last year, many of the leading market players made an appearance in Poznań. Over the course of three days more than 11,000 people visited CEDE, including guests from, among other places, Ukraine, Germany, Russia, Great Britain and Lithuania, Austria, Italy, Norway, Sweden.

CEDE 2018 will focus on the inseparable connection that exists between science and business, as is evident, among other things, in the programme of the Congress and the Speaker Corners agenda.

CEDE 2018 will feature many lecturers whose names will already be familiar to those who frequent international congresses. Among speakers who have already confirmed participation are Jan B. Ahlqvist, Diego Lops, Miguel Roig, Carlos Fernandez Villares, Ezio Gheno, Angelo Troedhan, Gian Battista Greco, Hande Şar Sancaklı, Joseph Shapira, Hal Stewart.

The Congress Scientific Committee is chaired by Professor Marzena Dominiak, the President of the Polish Dental Association and a member of the FDI Education Committee.

The slogan adopted for this year's CEDE is "More than an exhibition". Over the years the organisers have managed to put together an exhibition that includes more and more elements with a real impact on the development of Polish dentistry and an increasingly integrated environment.

During this year exhibition free oral cancer screening tests will be offered to Poznań residents, workshops on how to deal with patients with disabilities for dental practitioners and even a pool championship for CEDE participants. For the second time this year dental professionals will also have the chance to vote via internet for their favourite products in the "Stars of CEDE" competition.

Read more at **www.cede.pl**

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EuroPerio 2018

Amsterdam - Netherlands

Organized by: EFP - European Federation of Periodontology C/ Antonio Lopez Aguado N° 4, bajo dcha.
Madrid 28029, Spain
Phone: +34 91 3142715
Fax: +34 91 3235745
Contact person: Mrs. Mónica Guinea
Venue: RAI Amsterdam
Europaplein 1078 GZ Amsterdam
The Netherlands

www.efp.org/europerio

16-18 05 2018
Bulmedica Buldental 2018

June

22-24 06 2018

SIDEX 2018 - The 15th Seoul International Dental Exhibition & Scientific Congress

Seoul - Korea, South

Organized by:
Seoul Dental Association (SDA)
Managed by: SIDEX Organizing Committee
81-7 Songjeong-dong
Seongdong-gu
Seoul 133-837, Korea
Phone: +82 2 498 9146
Fax: +82 2 498 9147
E-mail: sda@sda.or.kr
Website: www.sidex.or.kr
Exhibition Venue: COEX
(Seoul Convertion and Exhibition Center)

eng.sidex.or.kr/#

28-30 06 2018

International Congress on Implant Prosthodontics - 18th Premium Day

Valencia - Spain

Organized by: Sweden & Martina SpA
Via Veneto 10
35020 Due Carrare, (PADOVA) Italia
Phone: +39 049 91 24.300
Fax: +39 049 91 24 290
Email: info@sweden-martina.com

Venue: Congress Palace
Valencia, Spain

www.sweden-martina.com/it_it/events/premium_day-1617.html

July

20-21 07 2018

World Dental and Oral Health Congress 2018

London - United Kingdom

Organized by: Graviton International
Email: info@gravitonevents.org
Phone: +44 203 371 8514

Venue: Holiday Inn London Kensington UK

www.worlddentalcongress.co.uk

20-22 07 2018

MIDEC 2018 - Malaysia International Dental Exhibition and Conference

Kuala Lumpur - Malaysia

MALAYSIAN DENTAL ASSOCIATION
Address: 54-2, Medan Setia 2,
Plaza Damansara, Bukit Damansara,
50490, Kuala Lumpur
Malaysia
Phone: +60 3 20951532 // 20951495
Fax:+ 60 3 20944670
Email: mdaassoca@mda.org.my
Website: www.mda.org.my

Venue: Kuala Lumpur Convention Center
Kuala Lumpur, Malaysia

www.mda.org.my/midec/2018/index.html

September

27-30 09 2018

Sofia Dental Meeting 2018 - 11th International Forum on Dental Medicine

Sofia - Bulgaria

Sofia Dental Meeting
str. Stoyan Zaimov 12
Sofia 1421, Bulgaria
Phone: +359 2 866 2257 //
+359 884 27 84 83

sofiadentalmeeting@gmail.com
sofiadentalmeeting@dir.bg
office@sdm.bg

Venue: Hotel Ramada
Maria Luiza 131 Blvd
1202 Sofia
Bulgaria

www.sofiadentalmeeting.com

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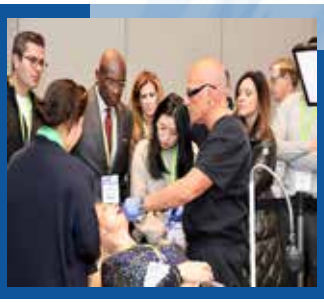


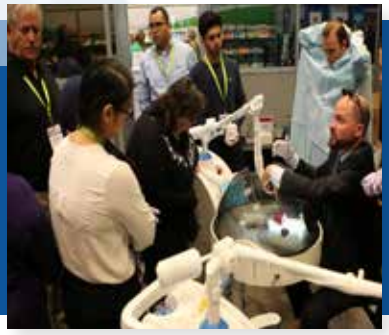

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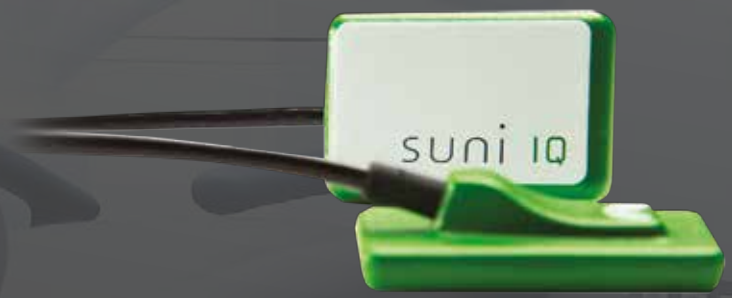

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