“Most dental practices will encounter fraud”

An interview with expert David Harris, United States

The potential for embezzlement and theft is a problem no business is immune to. And research shows that smaller businesses are more likely to experience problems than larger ones. For dental practice owners, it’s not just being small that increases risk. The typical dental office management structure is inherently vulnerable to fraud. Adding to the challenge, detection can be trickier in a dental practice compared with other small businesses. And the bad news continues. David Harris, who has 20 years of experience in dental-practice fraud investigation, puts little stock in deterrence. Instead, he emphasizes early detection as the only viable defense. Recently, he shared those thoughts and more with Dental Tribune US editor Robert Selleck.

Robert Selleck: What is the like­lihood of a dental office experienc­ing fraud?

David Harris: There have been sev­eral studies by the American Dental Association and others. Collectively they suggest that the probability of a dentist being a fraud victim in his or her career is between 50 and 60 percent. However, such statistics are necessarily low because there is an un­quantifiable amount of fraud that is never detected or is detected but not disclosed.

Are there any reasons why dental practices would be more likely or less likely than other types of small businesses to experience fraud?

Two main points influence the pre­valence of fraud in dentistry. First, the clinical responsibilities carried by dentists effectively reduce them to being absentee owners in their own businesses. Second, the fact that so much of dentistry is paid for by third parties removes one of the most basic controls that businesses depend on.

Is there a difference in potential for fraud in a three- or four-person office compared with a practice with 20 or more?

Intuitively, one would think that a larger practice should be able to have tighter controls through increased se­paration of duties. But many group

practices are essentially several solo practices sharing space, thus offering no particular administrative synergy. When a group practice is run as a sin­gle unit, the dentists owning the clinic tend to delegate oversight of the admi­nistrative functions to a single dentist. Given that there are many thefts per­petrated against a solo dentist, ima­gine the fraud possibilities when one dentist is overseeing a much larger business activity.

Do you have statistics for average or median losses to fraud based on various sized dental practices?

Unfortunately, there isn’t any published data specific to practi­ce size. Bill Hitz, who heads our investigation department, has a hypo­thesis that frauds typically range between 4 and 7 percent of monthly revenue while the fraud is going on. In its 2007 Survey of Current Losses in Dentistry, the ADA surveyed den­tists who had been fraud victims. The average estimated loss was US$18,174. Based on our own experi­ence, this number is tremendously low. That’s not surprising because in the same survey only 51.3 percent of the dentists who were fraud victims completed a fraud investigation, rais­ing questions on how the remainder determined their losses. We normal­ly find that the amount of fraud that dentists are able to identify without the benefit of professional assistance is far less than the true fraud.

We surveyed our own files several years ago and found an average theft of more than US$150,000. This is super­ficially consistent with the As­sociation of Certified Fraud Exami­ners’ numbers of US$200,000 for the average small business loss, but many of its “small businesses” are much bigger than most dental practices. We have seen a number of dental frauds of more than US$500,000 and a few exceeding US$1 million.

What are the most typical types of fraud cases seen in dental practices?

Most of the fraud that we see is “re­venue fraud.” Some examples are writ­ing off amounts that were actually collected, deleting treatment that was done so that collections are “off the books” and hiding the full amount to two insurance companies when some­one has dual coverage.

So what are the dangers? First, the behaviour of embezzlers is remarkably consistent. With the right deterrence of opportunity or where thieves can manipulate their payroll or create a phony supplier, very few will commit expense fraud while concurrently resisting stealing some of the cash that patients hand them daily.

What about fraud that’s more indirect, such as questionable wor­kers’ compensation claims?

We have seen an astonishingly wide variety of unconventional thefts, everything from stealing the gold that is recovered from old restorations to misappropriating dental supplies and instruments and selling them online.

Method of stealing: very few stick to a single methodology. Also, we are continually seeing new variants. For example, we recently saw a thief take advantage of a server crash to decrea­se some accounts receivable balances. When patients paid the correct balan­ces, they were paying more than the “official” balance in the practice management software, with the thief pocketing the difference.

Is there a type of fraud more pre­valent in a dental practice compared with other small or similarly sized businesses?

Since we investigate only dental embezzlement, my knowledge of fraud patterns in other small busi­nesses is limited to what I read. My perception is that much of the fraud committed against other businesses involves expenses: payroll, paying non­existent suppliers, padding ex­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­…”

Because shoplifting is a crime of opportunity, control systems such as video cameras and radio-frequency identification tags on merchandise are effective at helping to prevent pilfera­ge; however, such deterrence is unli­ke­ly to work in a dental practice.

The other point I will make is that fear of punishment seems to be vir­tually ineffective in deterrence. Em­bezzlers we see are well aware of the consequences of their actions, which include loss of livelihood and poten­tially, loss of liberty. Because of the needs of each group, we should not expect punishment to deter either the dishonest or the desperate fraudsters.

Are there any effective deterrents?

My suggestion is that deterrence strategies that provide no collateral benefit (i.e., are done only to discou­rage fraud) are a waste of resources; instead dentists should focus on early detection of fraud.

I will again disagree with much of the collective “wisdom” that exists on dental embezzlement when I say that for a dentist or advisors to try to con­firm fraud by some form of audit or analysis is unproductive and possibly dangerous. Because there are many possible ways to steal from a dentist, without considerable knowledge and some specialized software, this ac­tivity is looking for a needle in a field of haystacks. Fortunately for dentists, even though there are myriad ways to steal, the behaviour of embezzlers is remarkably consistent. With the right knowledge, identifying embezzle­ment through behavioural analysis is painless and reliable.
We have a behavioural assessment questionnaire requiring less than five minutes to complete, which dentists can request from our website.

How does an economic downturn affect dental-practice fraud?

Difficult economic times create more of these desperate people I mentioned earlier, which creates more fraud. We did notice a much larger incidence of fraud in the Detroit area after the auto industry downsizing a few years ago.

What are the first critical steps a dental practice owner should take if he or she suspects internal fraud is occurring?

Unfortunately, intuitive steps are not always the right ones at this point. Dentists try to conduct their own investigation, bring their CPA into the office, or call the police. Doing any of these will likely alert a perceptive thief to your suspicions.

The overarching objective is not to telegraph your suspicion to the suspect. When fraudsters think they are about to be discovered, their strong urge is to destroy evidence. This invariably causes collateral damage. Destruction might consist of wiping the computer's hard drive and destroying all backup media.

In one spectacular case, the victims did not engage us but began their own (clumsy) investigation. The thief, once alerted, burned down the office!

This is really the point where expert guidance is needed. We have an “instantaneous checklist” for dentists who suspect fraud in their office. They can request the checklist from our website.

Our investigative process is completely stealthy. I promise never to send a nerdy-looking investigator to your office. This helps ensure that evidence is protected, and also that working relationships are not destroyed in the event that suspicions are groundless.

What is the most unusual fraud case you have encountered?

About once a month we see something innovative. The alteration of receive balances after the server crash is one I think of—we suspect that the thief caused the server to crash. By placing a magnet inside one of our lab computers, we could replicate the crash quite easily.

Is there specific insurance owners can buy to protect their business against loss to fraud? Is such insurance worth getting?

This insurance is either included in the basic insurance package that offices already have or an “employee dishonesty” rider can be added. I don’t have cost details, but understand that it is quite inexpensive. Based on what I said about the probability of fraud in offices, I think everyone should have this coverage.

How much of a problem is external fraud involving customers, vendors, suppliers or other business relationships compared with internal fraud?

It certainly happens. We see a fair amount of identity theft from people trying to make use of someone else’s insurance coverage or to obtain prescription medication. However, the financial and other damage that this type of activity normally causes pales in comparison to the damage caused by embezzlement.

Thank you very much for this interview.

DTI

TOKYO, Japan: A team of Japanese researchers has demonstrated that hydrogen sulphide, one of the main causes of bad breath, could be a key component in developing future dental therapies. In a recent study conducted at the Nippon Dental University in Tokyo, they reported that stem cells isolated from dental pulp transformed into liver cells after being incubated with the characteristically foul-smelling gas for at least three days.

While dental pulp stem cells have been found to have the ability to transform into a number of different cells, including muscle and blood cells, this is the first time that researchers have claimed to have produced a huge number of cells that were able to store glycogen and collect urea—the two main functions of the liver. They said that although more research might be needed on the possible carcinogenic effects of the method, results indicate that it produced cells with little potential to differentiate, hence limiting the risk of developing tumours after transplantation.

“Hydrogen sulphide did not cause apoptotic changes in the cells,” they stated in the report.

Common methods of producing hepatic cells for human transplantation include the use of foetal bovine serum, which is heavily regulated worldwide. The researchers however extracted stem cells for their study from patients undergoing regular tooth extractions. These were then divided into two groups, of which one was incubated with hydrogen sulphide and the other with a different medium.

Commonly associated with the smell of rotten eggs, hydrogen sulphide is produced in small amounts by the human body for signalling and other biological functions. In the oral cavity, where it is considered highly toxic to tissue, it is produced by forms of bacteria that do not require oxygen to grow.

It is estimated that between 20 and 50 percent of people in developed countries suffer from halitosis, the main side-effect of this process.

Traditional imaging will not disappear with CBCT

An interview with Prof. Stefan Haßfeld, Germany

The ability to examine the cranio-maxillofacial region in three-dimensional images obtained through Cone Beam Computed Tomography (CBCT) has been praised as the new gold standard in oral surgery. Dental Tribune recently had the opportunity to speak with Prof. Stefan Haßfeld from the University of Dortmund’s Department of Oral and Cranio-Maxillofacial Surgery in Germany about the technology and its future potential at the FDI Annual World Dental Congress in Hong Kong.

Dental Tribune: Prof. Haßfeld, in your opinion, has CBCT become a standard in dentistry?

Prof. Stefan Haßfeld: CBCT has been available in dentistry for over a decade and since then has been established as a standard for many indications. Despite this development, I doubt that the technology will make traditional imaging obsolete any time soon. Instead, it will be used as an aid in more complex treatments.

One of the areas in which CBCT is already in implant treatment planning. What are the other main areas of application?

Nowadays, the technology is widely used in complex oral and maxillofacial surgery procedures. For example, we regularly examine large cysts and deeply impacted third molars with CBCT.

Its use can also be of benefit for the diagnosis of maxillary sinus diseases, as well as in traumatology or the correction of anomalies and dysmorphias.

What potential does the technology offer regarding the improvement of treatment outcomes?

In contrast to traditional imaging, CBCT allows the human anatomy and pathology to be assessed in detail in 3D space. This can be extremely helpful for treatment planning and the assessment of regions that present a surgical risk, like adjacent nerves, teeth or blood vessels. In many cases, we expect a significant reduction in operative risks and an improvement in surgical planning.

According to the industry, the radiation dose for patients is significantly lower with CBCT. Do you agree with this statement?

I would have to disagree, since compared with traditional imaging, CBCT usually has a higher radiation dose. However, it also yields completely different information. By taking a high number of single images from different angles, CBCT can provide lower radiation doses only in a few exceptional cases.

Is this the only drawback compared with traditional imaging techniques?

CBCT has another field of indications, comparison with traditional imaging techniques is not appropriate. However, there are indeed some shortcomings, like higher radiation doses and costs, as well as a lower resolution compared with dental film.

What role will CBCT play in dental practices in the future?

CBCT will take root in dental practices, particularly in those with emphasis on surgery, when it comes to certain complex treatment issues. For all the mentioned reasons, traditional imaging methods will not disappear.

A panoramic X-ray image, for example, provides an excellent overview of the entire jaw arch for clinically oriented examinations, with only little effort and at a small radiation dose. Dental film still offers the highest resolution for viewing details. Rather, the establishment of CBCT for dental imaging offers us additional options for daily practice.

Thank you very much for this interview.
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Dutch supplier acquired by SomnoMed

Daniel Zimmermann

SYDNEY, Australia/ZURICH, Switzerland: SomnoMed has expanded its own distribution network in Europe through a new acquisition. According to the terms of an agreement closed between the Australian-based company and Goedegebuure Slaaptechniek BV (GS) in Lommen aan de Vecht near Amsterdam, GS will market and distribute SomnoMed’s range of dental solutions for the treatment of sleep breathing disorders exclusively in the Netherlands.

Currently, GS is one of the leading Dutch suppliers of mandibular reposi­tioning appliances. With the take­over, SomnoMed intends to boost its presence and business development in Europe, particularly in important Central European markets, CEO Ralf Barschow said. He told Dental Tribune Asia Pacific that sales have jumped­star­ted in the Netherlands because devices for the treatment of conditions like ob­structive sleep apnoea syndrome have been reimbursed by the country’s he­alth insurance companies since 2010.

The acquisition will be paid half in cash and half in shares and is expected to be completed by 2019. SomnoMed stocks listed on the Australian Securi­ties Exchange reacted positively to the announcement.

According to Barschow, sales in Europe contribute approximately 25 per cent to SomnoMed’s global busi­ness results. Last year, revenues in the region grew by over 30 percent.

He confirmed that the company is also in talks with other suppliers in Eu­rope. Since 2008, the company has been operating actively in Europe through its subsidiary in Zurich in Switzerland.

US study suggests dentists cause implant failure

LOMA LINDA, Calif., USA: The indi­cations and versatility of dental im­plants have increased, and so have com­plications. Researchers from the Loma Linda University School of Dentistry in the US have suggested that, regardless of patient risk factors like bruxism, successful long­term outcomes signifi­cantly depend on the experience of the clinician performing the procedure.

By reviewing the records of eden­tulous patients who had received full­arch maxillary and/or mandib­ular supported fixed complete den­tures over a period of ten years, the researchers found that 12 percent of implants failed when clinicians had less than five years of experience in the field. Implants were also twice as likely to fail if the surgeon had performed less than 50 implantations in his career, they report.

Other contributors to implant fai­lure were identified as being related to the patient rather than the implant. Almost every third patient with diabe­tes or a history of bruxism had expe­rienced implant failure.

Other risk factors commonly as­sociated with implant failure like the type of prosthesis used, smoking or implant location were found to have less impact on long­term success, ac­cording to the researchers. They sta­ted that the absolute rate of success was found to be 90 percent.

Overall, the records of 50 patients treated with 297 implants at the scho­ol were reviewed.

20 Years Luxatemp—a successful material celebrates its anniversary

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Find out more about Luxatemp from your official DMG dealer or see www.dmg­dental.com/20­years.

* The Dental Advisor, Vol. 28, No. 01 Jan/Feb 2011, Pg. 9
*REALITY now, Oct 2011, No. 228, Pg. 1
Luxatemp Star is sold in the USA as “Luxatemp Ultra” and was also tested under this name.

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At last year’s IDEM, Dr Nigel Pitts from the UK presented a lecture focusing on dental caries as a public-health issue, as well as the epidemiology and importance of understanding the science behind primary and secondary caries prevention. Dental Tribune Asia Pacific spoke with him about evidence-based approaches to planning care that can be utilised in dental practice.

**Dental Tribune Asia Pacific:** Caries is increasingly considered a serious public-health issue. Has the perception of the disease changed during the last few years and if so, what are the indications of this development?

Dr Nigel Pitts: Yes, the perception has changed, but in what way, very much depends on which country one is considering. There is a growing awareness in many “developed” countries, where caries has been declining dramatically for decades, but there are still vulnerable groups, particularly young children, with a very high burden of preventable disease.

In other countries, caries in young children is thought to be increasing. In yet other traditionally low-caries “developing” countries, there are real concerns that changes in diet and lifestyle may be accompanied by an increasing caries problem for society and for individuals.

**An interview with IDEM presenter Dr Nigel Pitts, UK**

You are one of the developers of a caries classification and management system endorsed by dental organisations like the FDI World Dental Federation. What is the concept behind it and what is its potential for decreasing the burden of tooth decay in the world today?

ICDAS (International Caries De­tection and Assessment System) is a simple, logical, evidence-based, detection and assessment system that provides a common language for all stakeholders to communicate about caries, and facilitates valid, consistent comparisons of lesions at single and multiple time points. ICDAS has evolved to comprise a number of approved, compatible formats for different needs and applications, including simplified forms for those wanting to work with fewer stages of caries. The potential for decreasing the burden of caries ranges from helping the transition to a more preventive approach to caries, helping in assessing health needs more realistically for populations and individuals, helping evaluate preventive programmes and helping to deliver more preventive caries control and better future products through research.

Apart from classification, what other advantages does such a system offer?

ICDAS leads to better quality information, derived from the assessment of caries severity and activity, to support decisions about diagnosis, prognosis and clinical management at both individual and public-health levels. As we know more about the complexities of the caries process, informing sound clinical decisions is increasingly important for providing appropriate and high-quality caries care.

**How can these concepts be applied to dental practices?**

ICDAS has created the International Caries Classification and Management System (ICCMS), an open system developed specifically to meet the needs of those seeking a preventively oriented framework to support and enable comprehensive clinical caries management in the dental practice situation. This framework will help the dental team secure improved long-term outcomes for their patients.

There are improved means of detecting and assessing risks for early carious lesions. Has technology changed how we look at them?

The clinical visual detection and assessment of early lesions (using ICDAS-style approaches) is the foundation for planning care, but there is a continuing need for detection aids to help identify lesions that are difficult to detect visually and for effective risk assessment tools.

Examples of some of the newer approaches on the market for detection of caries include direct visual approaches enhanced with digital photography and imaging. These should be considered prudently as aids to preventive caries care, not just finding more cavities to fill.

There are also developments in risk assessment systems, such as CAM-TRA, to accompany older established systems, such as cariogram. All of the information derived from these useful detection and risk assessment tools needs to be integrated into a holistic and personalised preventive treatment plan for each patient.

**Concerning the management of early carious lesions, you promoted a study in 2010 on the best way to manage decay in children’s teeth called FICTION (Filling Children’s Teeth, Indicated or Not?). The study to be finished in 2018 is examining the different approaches (conventional restoration, preventive method and the Hall technique) to children of ages three to seven. Is there a tendency towards any of these approaches so far? As you indicated, this exciting study will not be completed for some years. What approaches to primary and secondary caries prevention are the most promising and what evidence do we have with regard to their clinical effectiveness?**

The strongest evidence on caries prevention comes from high-quality systematic reviews of fluoride, whether in water, salt, toothpaste, varnish or other forms. In addition, there is strong evidence of the efficacy of sealants.

There are also some promising new developments with remineralisation, but it will inevitably take time to accrue further evidence of clinical effectiveness.

There is evidence that a purely restorative approach is not efficient but preventive caries control has been adopted rather slowly in many countries. Do you see a move from an operative towards a more preventive approach?

I do see this move from a purely operative towards a more preventive-based approach gathering pace. It has been a very slow change in some countries, despite the profession talking about it for decades. However, there are a number of countries that have been controlling caries in this way for years and an increasing number of countries that are in transition. Reform of payment systems and changes in patient expectations are important components of this change.

Thank you very much for this interview.

“Do you see this move from a purely operative towards a more preventive-based approach?”

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Dr Nigel Pitts at IDEM 2012. (DTI/Photo Claudia Duschek, DTI)

“**A common language for all stakeholders to communicate about caries**”

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**An interview with IDEM presenter Dr Nigel Pitts, UK**

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