COMMENTARY

Enlightened self-interest and public/private partnerships

Harold C. Slavkin, DDS

Center for Craniofacial Molecular Biology, Herman Ostrow School of Dentistry, University of Southern California, Los Angeles, CA

Keywords
oral health; oral health disparities; public/private partnerships.

Correspondence
Dr. Harold C. Slavkin, Center for Craniofacial Molecular Biology, Herman Ostrow School of Dentistry, University of Southern California, 2250 Alcazar Street CSA-103, Los Angeles, CA 90033. Tel.: 323-442-2216; Fax: 323-442-2981; e-mail: slavkin@usc.edu.

Received: 11/28/2011; accepted 12/2/2011.

doi: 10.1111/j.1752-7325.2011.00302.x

I have always been fascinated by Benjamin Franklin and his advocacy for enlightened self-interest in the public good. During his era in American history, he designed community-sponsored utilities or services that were in the public's self-interest – health, education, welfare, and a host of services to support the larger community. He generously adopted the term "social contract" from a large class of theories whose subjects are implied agreements by which people form communities, states, or nations maintain a social order based upon self-interest. Franklin's assertions are apparent in nation or state summits designed to address social, health, and economic inequities. The design, organization, and implementation of the Maryland Oral Health Summit held October 20 and 21 in Columbia, Maryland clearly demonstrated and celebrated many of the ideas found in John Locke's "social contract; and Franklin's legacy of "the enlightened self-interest."

The symbolism of holding this Summit in Columbia, Maryland did not escape this participant. Columbia was designed by developer James W. Rouse as a new community in terms of human values. It was first opened in 1967. Rouse's goal, shared by the early adopters to this lovely planned community, was to eliminate racial, religious, and income segregation. Social, economic, and educational inequities were considered through the self-interest of the Columbia community.

With purpose and foresight, the Maryland Oral Health Summit brought stakeholders together from around the State of Maryland (and beyond) to address oral health inequities as profoundly demonstrated by the untimely and tragic death in 2007 of a 12-year-old boy, Diamonte Driver, from an untreated bacterial infection that spread from his teeth to his brain. Tooth decay is the #1 chronic disease of children. And tooth decay is a preventable infectious microbial disease.

We know that tooth decay is caused by bacteria that are vertically transmitted from caregiver to infant. We know that diet provides the carbohydrates that enrich or enhance the success of bacteria to produce acids that dissolve the outer tooth structure, enamel. We know that fluoride in drinking water significantly reduces tooth decay. We further realize that eradicating tooth decay requires more than an immunization, it requires preventive measures plus major behavioral changes in caregivers and their children, starting during the last trimester of pregnancy.

Since 2007, the response in Maryland has been significant. The Maryland Dental Action Coalition was created. A Maryland Strategic Plan was drafted, analyzed, and implemented, and the Summit provided the venue to highlight what has been planned, implemented, and also provided an appreciation of how progress will and can be measured. Further, the Summit enabled each of us as participants to garner a number of "best practices" that reflected six critically important factors: a) the importance of partnering; b) simplifying administration; c) leveraging funding; d) the need for case managers and community health workers; e) motivational interviewing; and f) the imperative to foster health literacy throughout the State.

Public/private partnerships have already made appreciable progress toward reducing oral health disparities throughout Maryland. Key federal and state health agencies along with health professional organizations, universities, foundations, and industry are learning the values from open communication, collaboration, and cooperation. The Summit proceedings gave every indication that oral health disparities in Maryland will be reduced if not eliminated. I suggest that even more stakeholders be invited to join the coalition – patient advocacy groups, preschool and K-12 educators, the communities of dental and non-dental health professionals, and major corporations located within Maryland. Of course, as the Strategic Plan advances, resources need to be identified to evaluate efforts and progress ("what is working?" "what adjustments need to be made?"), monitor access, define and measure comprehensive quality care, and publish and communicate progress, problems, and gaps toward reducing oral health disparities in Maryland. Ben Franklin would be very proud.

Conflict of interest

The author is a board member of Patterson Companies.