University of Pennsylvania

From the SelectedWorks of Amy J. Sepinwall

2002

Regulation of the Global Marketplace for the Sake of Health

Marion Danis, *National Institutes of Health*
Amy J. Sepinwall

Available at: https://works.bepress.com/amysepinwall/4/

bepress™

Regulation of the Global Marketplace for the Sake of Health

Marion Danis and Amy Sepinwall

Mounting evidence suggests that socioeconomic status is a determinant of health. As nations around the globe increasingly rely on market-based economies, the corporate sector has come to have a powerful influence on the socioeconomic gradient in most nations and hence upon the health status of their populations. At the same time, it has become more difficult for any one nation to influence corporate activities, given the increasing ease with which corporations relocate their operations from country to country. As a result of all of these factors, nations wishing to assure the health of their populations will need to both involve the corporate sector and cooperate with other nations.

In this article, we review the business ethics literature and consider what justification it might provide for requiring multinational corporations to attend to concerns about population health. We adopt Thomas Donaldson and Thomas Dunfee's Integrative Social Contracts Theory and Donaldson's ethics of international business to provide a basis for arguing that norms derived from a hypothetical social contract impose some ethical obligations on corporations. We modify their theories to suggest the possibility that emerging recognition of the relationship of economic gradient to health status may provide both new grounds for a duty of corporations to avoid depriving health, as well as a mechanism for having groups of nations as the parties to the contract with the corporation. This ethical analysis justifies the regulation of corporations that operate in the global marketplace and lends grounds for a global economy that aims to promote not only free trade, but population health as well.

To be healthy is an interest of all individuals and it is an interest that individuals cannot address entirely on their own. The usual strategies for maintaining health have been found in the domains of public health and medical care. But those with a commitment to assuring population health will have to contend with a surprising finding — one that defies the usual strategies of these traditional domains: A growing body of scientific evidence indicates that socioeconomic factors are powerful determinants of health. Specifically, both economic status and socioeconomic gradient influence health status, a circumstance that is true even when health care is universally available.

This finding emerges at a time when a growing fraction of national economies lay in the hands of corporations that function beyond national borders. If multinational enterprises comprise a large fraction of most national economies, then any expectations we have of nations to attend to the economic determinants of health may ignore the reality that national governments cannot dictate entirely the way the distribution of income and wealth affects the health of their residents.

The finding about the effects of socioeconomic status and income inequality thus catches us offguard for at least two reasons. First, it implies that the economic sector has a very significant role to play in assuring health, despite the fact that we have not generally expected or demanded of the economic sector that it function in a manner that serves this goal. Second, it suggests that, in order to ensure that corporations do play a role in assuring health, nations will need to work together, even though the need to meet the health requirements of the public has traditionally been seen as an obligation that each country owes only to its own citizens.

It is the following question, then, that we wish to address in this paper: Are there moral grounds for requiring multinational corporations to attend to the concern that economic arrangements have a substantial impact upon population health? We argue that there are, and we locate

Journal of Law, Medicine & Ethics, 30 (2002): XX–XX.
© 2002 by the American Society of Law, Medicine & Ethics.

these grounds in an obligation of the corporation not to deprive individuals of health. Since perpetuation or exacerbation of income inequality does deprive people of health, we conclude that corporations have an obligation to forebear from aggravating, or even perpetuating, existing inequalities in wealth. We suggest, as well, that this obligation can and will be enforced if nations work together to constrain the activities of multinational corporations.

Our reasoning is organized in five parts. First, we present evidence that socioeconomic status and income gradients are indeed strong determinants of health. Second, we argue that the global shift to market-based economies involving multinational entities diminishes the capacity of national governments to assure the health of their populations on their own. Instead, they will need the international cooperation and participation of multinational enterprises to address the interplay between socioeconomic gradient and health. Third, we identify ethical arguments derived from the business ethics literature, particularly Integrative Social Contracts Theory, as a potential basis for justifying an expectation one might impose on multinational enterprises. Fourth, we extend Integrative Social Contracts Theory to specifically justify requiring these enterprises to avoid depriving the public of health. Finally, we conclude that our argument provides justification for international agreements requiring multinational enterprises to bear responsibility both directly and indirectly for population health, and we allude to the policy implications of these arguments.

The Socioeconomic Determinants of Health

It has long been clear that poverty is associated with poor health. In nations where the gross national product per capita (GNPpc) is below $5,000, there is a tight positive relationship between GNPpc and life expectancy.[1] But a growing body of evidence indicates that absolute income affects life expectancy all along the income spectrum and not merely for the very poor.[2] Furthermore, some evidence indicates that it is not merely absolute income that determines health outcomes, but the steepness of the income distribution gradient as well.[3] Perhaps the first hint of the relationship of the impact of income on health came from the link between occupational class and mortality rates among civil servants in England and Wales, all of whom had access to the same quality of health care.[4] Death rates for unskilled workers were 9.9 per 1,000 and dropped gradually as class rose to 4.0 per 1,000 for professionals. Similarly, data from the Multiple Risk Factor Intervention Trail (MRFIT) demonstrated the inverse relationship between income and mortality for white men in the U.S. population.[5]

In the literature examining the relationship between income and health, debate rages between proponents of the absolute income hypothesis[6] and proponents of the relative income hypothesis.[7] While the policy recommendations that we advance below (see "Policy Implications") would address the causal mechanisms in either of these accounts, it is nonetheless useful to survey each account here, since each furthers our understanding of the way that income and health are related.

Research explaining the relationship of absolute income to physical and mental health has focused on general categories of explanation, such as health-related social selection, behavioral and cultural factors, and material circumstances.[8] The effect of specific factors or the impact of absolute poverty on particular diseases has also been studied. Mental illnesses, for example, are both more prevalent and associated with higher mortality among lower social classes than in higher social classes, and this finding holds in both developed and developing countries.[9] Some of the most revealing work in this vein has explored the impact of socioeconomic position across the life course in relation to lung ailments.[10] The findings from this work indicate that the poor are likely to suffer more from poor nutrition, air pollution, first- and secondhand exposure to smoke, and occupational hazards. The early effects of these are poor lung development, frequent childhood respiratory infections, reduced school attendance and accomplishment, while the cumulative effects are ultimately reduced lung function and strikingly higher mortality rates from bronchitis and pneumonia.[11]

Relative income, or income distribution, is thought to influence health via three mechanisms: (1) by affecting access to life opportunities and resources, including education, housing, education, and employment; (2) by impeding social processes involving social cohesion, such as mutual support, cooperation, and communication; and (3) by harming psychosocial processes related to social relations.[12]

The first mechanism suggests that the more significant the disparities in income distribution, the more access to life opportunities and resources are diminished among those with lower incomes. These opportunities and resources include access to affordable housing, education, and, particularly in the United States, health care, all of which are important for health. Income disparity may contribute to making these resources less abundantly available to those with lower incomes by increasing the concentration of the poor in poor neighborhoods and the wealthy in affluent neighborhoods, with the attendant disparities in services in these poor and affluent neighborhoods.[13] This is thought to be the case because affluent individuals who relocate from municipalities to suburban residences take the tax base needed for services with them. For instance, George Kaplan and colleagues have shown that states with more income disparity have less investment in education.[14]

The second postulated mechanism relates to social conflict: Several studies can be interpreted as consistent with the possibility that the greater the disparity in income, the less social cohesion and, concomitantly, the lower the life expectancy. When Britain, for example, underwent a

compression of income distribution during World War II, it experienced a contemporaneous growth in social solidarity and a substantial improvement in life expectancy.[15] More systematic evidence comes from study of the connection among social cohesion, or measures of civic trust, perceptions of reciprocity and membership in associations, and lower mortality rates in U.S. states.[16] Social capital may lessen mortality — namely, through the help that neighborhood residents provide each other, through greater access to community services, and through the reduction of individual social isolation.[17]

The third postulated mechanism by which income inequality influences health is by affecting psychosocial processes related to mortality.[18] Biological responses to the stress of low social status have been shown to involve the immune and cardiovascular systems in both animal[19] and human studies.[20] For example, low social status causes a chronic elevation of cortisol levels, which results in other hormonal and biochemical changes that contribute to cardiovascular disease, including elevation of glucose, insulin, cholesterol, and fibrinogen.[21]

In the literature that adopts a comparative geographical perspective, greater emphasis is placed on the causal role of inequality than absolute poverty in explaining disparities in health outcomes. For example, looking across nations, there is a very weak correlation (in 1993, $r = 0.008$) between life expectancy in the twenty-three wealthiest countries in the Organization for Economic Co-operation and Development (OECD) and gross domestic product, while there is a very close relationship between income and mortality rates when using grouped data within countries, with some of these correlations in the range of 0.8 or 0.9.[22] This suggests that relative deprivation is more causally responsible for disparities in health than absolute deprivation. The relationship between inequality and health is highlighted by several striking cross-national comparisons. Life expectancy in Costa Rica, for example, where the income gradient is small, is similar to that of the United States even though the gross domestic product per capita (GDPpc) differs between the two countries by $21,000.[23] Even more remarkably, while Cuba and Iran both have a GDPpc of about $3,100, Cuba, with the narrower socioeconomic gradient, boasts a life expectancy that exceeds that in Iran by 17 years.

If the relative income hypothesis is correct, then there is mounting cause for concern because the steepness of the socioeconomic gradient (or the polarization of assets, as Kawachi and colleagues refer to it) has been increasing both within and among countries. When the U.S. Census Bureau began to record household income in 1968, the ratio in incomes between the highest 20 percent of households and the lowest 20 percent of households was 10 to 1. Three decades later, in 1996, this ratio was 13 to 1.[24]

The growing gap in wealth is also among countries, specifically between developed and developing countries. The average per capita income of the poorest and middle thirds of all countries has lost ground steadily over the last several decades compared with the average income of the richest third.[25] The poorest nations have made few strides, while the richest nations have accumulated increasing assets. According to the World Bank's *World Development Report 1999/2000*, the percentage of the population living on less than $1 a day in Latin America was 22 percent in 1987 and 23.5 percent in 1993, and in Sub-Saharan Africa, it was 38.5 percent and 39.1 percent in these same years. Today, three-fifths of the 4.4 billion people living in developing countries lack basic sanitation; a third have no access to clean water; a quarter lack adequate housing; and a fifth have no access to modern health services.[26] At the same time, the Group of Seven nations, which constitute 11 percent of the world's population, account for two-thirds of the planet's GNP.[27]

Growing Market Power and Globalization

We have just reviewed the evidence that income and economic inequality are determinants of health, and that income disparity has widened over the last two to three decades. The global economy has shifted in another way as well, as multinational enterprises have begun to account for a remarkable proportion of the world's revenue. Multinational corporations, or multinational enterprises, are defined as those corporations that divide their resource extraction, production, marketing, and distribution among several different countries. The last 25 years has seen an explosion of these enterprises, as their numbers grew, for example, from 7,000 in 1970 to 54,000 in 2000.[28] By 1991, the budget of these corporations exceeded the value of all of the world's exports of goods and services, and by 1996, multinational enterprises controlled, either directly or indirectly, a third of the world's revenue.[29] We need only consider that, among the 100 largest economic organizations, fifty-two are corporations and forty-eight are nations in order to appreciate the power of the multinational enterprise.[30]

In this section, we focus on the potentially harmful consequences of the expansion of multinational enterprises. Nonetheless, we believe that, if properly regulated, globalization carries with it great promise for improving the standard of living of people everywhere. As such, we briefly review the potential benefits of the expanding global economy before explicating the reasons we believe this expansion must proceed more carefully than it has to date.

Globalization has the potential to greatly improve the economic situation of individuals everywhere, for globalization brings with it new opportunities, such as access to markets and new technological knowledge. These benefits will be even more pronounced in developing countries than in developed ones, for the former generally have poorer natural resources and a workforce more in need of skills training. Globalization mitigates these weaknesses by allowing devel-

oping countries to specialize their spheres of production, and thereby make the most efficient use of the resources they do possess while importing the products or services that other nations are able to provide more cheaply. Moreover, the prospect of globalization encourages developing countries to stabilize their financial and legal institutions in order to attract foreign investors, who typically look for sites of operation where sound macroeconomic fundamentals are operative, investors' rights and regulations are made transparent, and foreign and domestic investors are treated as equals before the law.[31]

These benefits are a welcome feature of an expanding global market, but they can only be enjoyed if the expansion of the global economy proceeds with care, for rampant globalization has the potential to worsen the economic situation of many. Indeed, the opening up of markets to foreign goods has been credited with increasing inequality both within and among societies, and we turn now to a consideration of the relationship between globalization and inequality.

Globalization has increased income inequality *within* countries by decreasing both wages and job availability for low-skilled workers. More specifically, prior to the entry of foreign competition, unskilled laborers in concentrated industries (i.e., those producing a great proportion of the total output of that industry, such as U.S. auto manufacturers) tended to earn higher wages than their counterparts in less concentrated industries. Yet it is concentrated industries that are mostly likely to be affected by foreign imports. As their profits have decreased, these industries have been forced to lower their employees' wages, thereby pushing more people into the lower earnings portion of the income gradient. Some companies within these industries have also been forced to downsize. Employees laid off as a result must then compete with their counterparts in the lower paying, nonconcentrated sectors of the economy. And with more individuals competing in the same job market, there is little incentive for employers to increase incomes.[32]

While this serves to explain some of the growing income disparity within a given country, there has also been a growing disparity *among* countries. It is useful here to distinguish between the impact of globalization on poorer and poorest countries. Multinational enterprises are not likely to set up their operations in the poorest countries, where the infrastructure is weak or where individuals are too ravaged by famine or illness to serve as employees. As such, the poorest countries have been completely left out of the globalization process and have not experienced the gains of more stable developing countries.

Poor, but more stable developing countries have been able to effectively offer corporations of the developed world relatively cheap sources of labor and have thus witnessed the opening of corporate production plants in their midst. Three worries arise from these arrangements, however. First, multinational enterprises may overwhelm banks, and even overhaul entire economies, by creating an overabundant influx of foreign capital. Second, globalization induces nations to relax their safety standards in order to be more attractive to foreign investors. This entails that the multinational corporation need not internalize all of the costs of production into its prices. And because the corporation does not have to pay for pollution clean-up efforts or safe working conditions, for example, it can lower prices on its products, thereby conferring on the corporation even more of a competitive advantage in international trade. Finally, while foreign investment may help to improve average income in some countries, it has also been shown to heighten income disparity, thus posing a troubling trade-off. Indeed, systematic measurement of the degree of openness of regulation of international financial transactions indicates a widespread pattern among many nations: Those with greater permissiveness of international financial regulations experience greater economic growth, but increased income inequality.[33] This is because economic liberalization favors those with assets or skills that are in high demand/low supply in international markets, like capital or managerial skills, and disfavors those with assets or skills in low demand/high supply, like unskilled labor.[34]

We have seen so far that income disparity has widened during a time when the multinational corporate sector has been responsible for a growing fraction of the world economy. How can nations with an interest in assuring the health of their populations do so at a time when this portion of the private sector accounts for an ever-expanding fraction of their economies and when corporations carry out much of their operations beyond any one nation's boundaries? What demands can nations legitimately impose on multinational enterprises in an effort to attend to the health concerns of their populations?

These questions present themselves with special urgency once we recognize that most nations do not have the power to regulate or negotiate with corporations on their own. Corporations will choose to establish their operations in nations where the laws are best conducive to maximizing profit. In a "race to the bottom," nations eager for this investment will undermine the regulatory attempts of other nations in the absence of any supranational code of corporate conduct. This allows corporations to evade the regulations of countries that attempt to impose greater control over their operations. Instead, corporations will choose to set up their operations in poor countries that are eager to attract foreign business. These countries will make great efforts to accommodate the corporations' interests, sometimes even to the point of exposing their inhabitants to grave dangers in the process.[35]

It is clear, then, that the unscrupulous corporation can take advantage of the members of its host country. To bolster the bargaining power of individual countries, we propose that nations are justified in collectively regulating corpora-

tions. We turn now to a development of this proposal. Before moving on, though, we wish to comment on the reality that income inequality is considered acceptable and even desirable in a capitalist society. It is considered a powerful motivator or incentive. Hence, any suggestion to reduce economic inequality, as we will make here, might be considered anathema. While we cannot address this issue in full, we would suggest that one might counter with a Rawlsian argument — that in a society where inequality exists, we would choose arrangements such that the worst off are least disadvantaged.[36]

Adopting the Integrative Social Contracts Theory

We have thus far argued for two claims: first, that individuals have an interest in securing their health through limiting income inequality; and second, that this will require regulatory oversight of the market pursued through international cooperation. In this section, we adopt a framework within which an international agreement between the multinational enterprise and potential host countries could take place. There are at least three desiderata for the agreement in question. First, it should be binding in all corners of the globe so that the multinational enterprise cannot escape its terms by locating its operations in a country where the agreement is not in force. Second, if the agreement is to achieve the first goal, there must be latitude built into it, so that cultural differences can be accommodated within its terms. Finally, the agreement must not impose constraints so great that globalization, with its attendant benefits, is hindered or thwarted altogether. In this section, we attempt to determine the terms of an agreement that would satisfy these desiderata through appeal to the device of a hypothetical social contract. To this end, we first describe the social contract we wish to adopt and then argue for the advantages unique to this sort of approach.

Originally, the idea of a social contract was invoked to establish the legitimacy of the state. Recently, however, Thomas Donaldson[37] and Thomas Dunfee[38] extended this idea in order to assess the legitimacy of corporations. Following their work, we propose to use the social contract to determine the conditions under which it would be both justifiable for a corporation to establish itself in one or more societies and rational for those societies to grant the corporation permission to do so. The conditions become the justificatory clauses for the corporation — its existence and its operations are permissible so long as they are in accordance with these conditions.

From Donaldson and Dunfee's social contract approach, we can begin to determine the conditions for the legitimacy of corporations by imagining a preindustrial society — that is, one without any productive organizations. We then consider the conditions or terms under which members of that society would agree to the establishment of a corporation. Donaldson and Dunfee's hypothetical device is intended to allow us to formulate the reciprocal obligations of productive organizations and the societies in which these organizations desire to establish themselves.[39]

For example, the productive organization, or corporation, would receive benefits from the society in which it was to establish itself in the form of recognition of the organization as a single agent, especially in the eyes of the law, and permission to hire employees and own or use land and natural resources. In exchange, the corporation would confer benefits on members of that society, such as an increased capacity to use or acquire expensive technology and resources, and increased stability in levels of output and channels of distribution. In addition, the corporation would have an obligation to avoid harming members of that society. As such, it would be required to refrain from polluting, depleting natural resources, misusing political power, and so on. Finally, potential employees of the corporation would no doubt want the hypothetical agreement to contain terms that protect them specifically. In particular, they would seek to increase income potential and avoid worker alienation, lack of worker control over work conditions, and monotonous or dehumanizing work.

Given that the agreement we envision is one that would hold between the multinational corporation and many nations, rather than just one, we can extend the heuristic just described by appealing to Donaldson and Dunfee's conception of the international social contract. This conception is captured in their Integrative Social Contracts Theory, which they describe as a "communitarian conception of economic morality that defines correct ethical behavior through the device of a hypothetical social contract."[40] The theory is communitarian insofar as it affords communities the opportunity to arrive at what the authors call "micro-social contracts," and integrative insofar as it assimilates these within a "macro-social contract" that holds everywhere. The basic idea behind the structure of these contracts is that the delegates to a hypothetical convention to author a macrosocial contract would want to preserve for their communities a moral and economic free space — that is, they would want to leave room for their communities to implement and act upon local norms, within the boundaries set by the terms of the macrosocial contract. The more localized agreements that are established in this way are the microsocial contracts.

Given that the macrosocial contract would both hold internationally and constrain local microsocial contracts, its terms are of import for us. What should these terms be? At a minimum, according to Donaldson, the macrosocial contract should abide by the dictates of justice.[41] His elaboration of what justice requires in the realm of international business provides us with a better sense of the corporation's responsibilities in diminishing poverty and inequality. More specifically, in setting up a "minimal floor of responsibility," Donaldson arrives at a list of human rights that includes not

only rights of noninterference (such as a right to self-determination or bodily integrity), but also positive or welfare rights — those rights that require that some act be performed in order to achieve their fulfillment (for example, the right to education).[42] Yet, even while it includes rights of this kind, Donaldson's account does not require that the obligation of fulfilling these rights befall the corporation. So, for example, while all individuals have the right to minimal education, this imposes only a correlative duty on the corporation to avoid depriving individuals of this right; the corporation is not charged with ensuring the right's fulfillment by, say, providing the funds for education.[43]

This part of Donaldson's account is significant for our purposes. One might have thought that the goals we set out — namely, the reduction of inequality and poverty — would have to be met by appropriating some of the corporation's profits (in addition to those already levied in the form of taxes) and then redistributing them to those in need. Yet Donaldson and Dunfee would argue that, as a matter of justice, it would be impermissible to proceed in this way — for if the corporation's profits served this purpose, this would effectively require the corporation to shoulder at least part of the burden of fulfilling individuals' welfare rights. If this requirement is not imposed on others, however, it would be unjust to impose it on the corporation.

Of course, if the corporation does not bear positive duties (or at least if it does not bear them any more than anyone else does), then we are left with the question of who does. We posit that the state is the legitimate executor of these duties on behalf of the individuals whom it represents. And, the state, in conjunction with other countries, fulfills these duties through its efforts to regulate the corporation. In the next section, we work out the details of this international regulatory effort. Before undertaking this task, however, it will be useful to step back and appraise the value of a social contractarian approach, both in and of itself as well as in relation to other theories of business ethics.

The social contract affords advantages not found in other accounts. Especially important among these is the ability of implicit or explicit social contracts to influence our conduct so that it conforms to their terms. Diana Robertson and William Ross, Jr., have demonstrated empirically that "judgment of an act as a breach of a social contract is significantly linked to reduction in likelihood of engaging in the act."[44] This finding indicates that the social contract has normative force — we use it to determine what we ought or ought not to do. A second attraction of the contractual device, as Donaldson and Dunfee note, is that it can accommodate the artifactual nature of organizations, since the contract itself is an artifact.[45] Relatedly, the social contract employs language familiar to the business realm, given its reliance on contracts. As such, managers and shareholders will more easily assimilate the ethical precepts flowing from a social contract. The social contract also effectively captures the role that corporations play in societies: They provide us with benefits in exchange for our allowing them to operate. A contractual device is structured to reflect this exchange.

A final benefit of a social contractarian approach is that it makes plausible the notion that it is both justifiable to hold the corporation to a set of obligations and rational for the corporation to accept these obligations. This is an especially important point, for it represents a break from the conventional position in the business ethics literature.[46] That literature has expressed wide support for the proposition that we cannot legitimately expect the corporation to improve social welfare. Some theorists argue that the corporation is not an appropriate institution for the promotion of social goods because the corporation is not democratically governed.[47] As such, even if corporations were competent to effect social improvements, the intended beneficiaries of these improvements would have no say in what sort of improvements would be sought, how they would be carried out, who would benefit, and so on.[48] Staunch advocates of *laissez faire* economics argue that it would actually be wrong for corporations to seek to improve social welfare.[49] Accordingly, corporations could pursue this end only by violating their obligations to shareholders, for it is shareholders' money that would be spent on these efforts.[50]

We find these arguments of conventional business ethics unpersuasive. Obligations arise for corporations in exchange for the benefits that they receive from the societies in which they operate and so are imposed on corporations only with their consent. In short, for all of the reasons just cited, we believe that the social contract is a more faithful representation of corporate ethical obligations than are its competitors,[51] which renders it more likely to garner our adherence.

A Modified International Business Ethics Theory for the Sake of Health

We have marshaled evidence so far to build the case that health is determined to an important extent by economic status and socioeconomic gradient; that in virtually all nations today corporations and, in particular, multinational corporations significantly affect economic status and wealth distribution; and that corporations are thus in a position to affect health by their influence on the distribution of wealth. However, it is traditionally states, and not corporations, that are under an obligation to provide for the health of their residents. In this section, we set ourselves the task of resolving this disconnect of responsibility and power to act — namely, that corporations have had no obligation to ensure that individuals' health needs are met and yet have a significant effect on their health, while states do have this obligation but are hard pressed to fulfill it, given the market sector's effect on the economic determinants of health.

The broad strokes of our argument are as follows: As we have seen, Donaldson argues that international businesses

have an obligation to avoid depriving individuals of certain rights. Yet the right to health is not one of the rights he explicitly mentions. We argue that deprivation of health can be construed as the sort of rights violation that Donaldson is intent on opposing. With the recognition that health is determined by socioeconomic factors, it becomes a matter of concern to individuals that society assure that socioeconomic factors are arranged in a manner that does not deprive them of health. If societies relegate many of their economic functions to the marketplace, then individuals will have an interest in establishing the social contract so that socioeconomic arrangements will be compatible with health.

We wish to point out two precedents that support shifting our conceptions of the necessary tasks and responsibilities for maintaining health: first, that the use of societies' resources for the sake of health is not new; and second, that responsibility for the health and well-being of a society's residents is not and has not always been located exclusively in the hands of government.

The fact that a population's health requires socially organized efforts is certainly not new. Prior to our more recent understanding of the economic determinants of health, societal attention to health took the form of public health measures and the delivery of medical services. When we appreciate the contribution of socioeconomic factors to health, citizens begin to have an interest in arranging socioeconomic factors in a way that is compatible with their health. After all, why bother carrying out public health and medical measures without addressing other major mediators of health if, in so doing, these measures are insufficient in achieving the goal of assuring health?

Efforts to assure the health of populations in different periods of history have been a function of various societal organizational elements in society.[52] As Dorothy Porter writes, "In pre-modern societies this means paying attention to a wide variety of different theatres of power including city states, fiefdoms and dukedoms, monarchical realms and large social organizations such as the Church. In the modern period, the study of the operation of power in relation to population health necessarily involves an examination of the rise of the modern state as an autonomous political sphere."[53] Interestingly, Porter focuses on "different interpretations, made in different periods, of the rights and obligations of citizens within the 'social contract' of health between the state and civil society in modern democracies."[54] Appreciation of the historical shifts in the locus of responsibility for health should help us adjust to the possibility that with the expanding economic role of the global market place, it may be expected that those operating this economic power now share in this responsibility.

We might argue that if the marketplace dictates the economic factors that are preconditions for health, then individuals should collectively negotiate with multinational enterprises. Using this line of reasoning (call this the direct approach), one concludes that individuals would want to arrange the social contract with corporations in such a way as to guarantee their health. Alternatively, one might argue that individuals have traditionally relied on governmental functions to attend to their health and, in recognizing the extent to which the marketplace has a bearing on health, government should mediate on behalf of individuals to guarantee that organizational entities in the marketplace act so as to avoid depriving individuals of their health (call this the indirect approach).

It seems to us there are reasons to endorse both the direct and the indirect approaches. The direct approach sets up a straightforward justification for arguing that corporations should not deprive individuals of their health.

On the other hand, the indirect approach — that government should mediate on behalf of individuals to guarantee that organizational entities in the marketplace act in such a way as to avoid depriving individuals of their health — also has its advantages. It recognizes the reality that attention to health may be a function that governments have much more experience and interest in attending to than financial corporations do. It recognizes that the employer-employee relationships that exist between individuals and corporations are likely to be too short-lived to address the lifelong concerns that individuals have about their health. Individuals move from job to job, and face periods of unemployment and retirement. Children, whose health is particularly susceptible to socioeconomic determinants, have no direct relationship to corporations while they are growing up. And beyond the fact that individuals have discontinuous relationships with corporations, we face the reality that business cycles make it likely that during periods of recession large numbers of individuals may be unemployed, at which time there exists no ongoing contractual relationship for substantial numbers of individuals. Hence, it may be more useful to take the indirect route and argue that governments should mediate on behalf of its citizens. States need to partner with the private corporate sector to attend to the socioeconomic determinants of health where they have a clear direct role to play. They need to regulate the function of multinational enterprises in the marketplace.

What becomes apparent here is that if we argue for the indirect route for the various reasons we have outlined, then we return to the reality that national governments are not able to individually oversee multinational corporations. It becomes necessary then to justify multinational attention to the health-related consequences of socioeconomic status and socioeconomic gradient.

In sum, given the role of multinational enterprises in the growth of international markets and economic inequality, we ought to amend Donaldson's list of obligations for international business to include the duty to avoid depriving individuals of their right to health. It should be noted that in justifying such an obligation of multinational enterprises, we

have ignored the likelihood that corporations have a self-interest in guaranteeing the health of their employees for the sake of greater productivity. To the extent that this is the case, the moral justification and self-interest fortunately coincide.

Policy Implications

Having now justified calling multinational enterprises to account for their role in influencing population health, we have established a universal norm that serves as a basis for nations to jointly assert that these enterprises should function not only to efficiently promote trade, but to promote the health and well-being of populations as well. What do the contractual expectations that we have argued for mean in concrete terms?

Certainly, identifying concrete solutions for modifying the socioeconomic determinants of health and the growing inequality in income in today's global economy poses an enormous policy challenge that is only beginning to be addressed. Here, we survey only a handful of the more promising strategies that have been proposed.

While a variety of evidence suggests that nations can adopt domestic policies that influence the financial well-being of their populations, some economists are skeptical about the ability of governments to successfully influence the distribution of income and wealth. For example, Yehojachin Brenner and colleagues argue that efforts to redistribute wealth through policies like minimum wage regulations are generally unsuccessful.[55] But those such as Amartya Sen and James Galbraith have argued that the quality of life in societies depends largely on social policies and public actions,[56] and that both income distribution and its impact are related to actions taken by governments. High rates of employment, less private capital, less debt, and higher taxes for social insurance, for example, have been shown to create societies that are more equal.[57]

Among the most responsive governments, recognition of the relationship between socioeconomic status and health has led to policy recommendations aimed at addressing the economic determinants of health directly. Examples include developing countries as well as developed ones. In Bangladesh, for instance, a program called the Bangladesh Rural Advancement Committee was instituted to create an enabling environment that attends to deficiencies in health by ensuring employment and minimum income, entitlements to land, access to housing, and mechanisms for saving and credit.[58] In England, the Acheson report recommends both efforts to ameliorate the downstream effects of economic and health inequalities, as well as policies to reduce absolute poverty.[59]

Some of the strategies that are likely to be effective in reducing the socioeconomic gradient involve corporations even more directly. These include on-the-job training; increases in the level of control that employees have over their work; management practices to increase the variety of skills in the workforce; participation of the workforce in planning and implementation; enhancement of management skill; and offers of continuing education through the worksite to enhance job mobility.[60]

Given that multinational enterprises lie beyond the boundaries of individual nations, most effective are likely to be strategies that attempt to regulate the global market economy in cooperation with other nations, all of whom agree to uphold the terms of market regulation. Of course, this set of strategies is bound to be controversial since it raises the specter of an ongoing debate about the shape that the global market economy should take. On one side of this debate are those who argue that a seamless unregulated free market should prevail, and on the other are those who contend that the global economy should be arranged to take into account the needs of nations to attend to the welfare concerns of their residents. This debate is likely misguided, however, since it presumes that the two conceptions of the global economy are mutually exclusive. In fact, history teaches us that attention to welfare concerns can be compatible with a free market economy.

At the end of World War II, for example, the World Bank and International Monetary Fund were created in order to foster free trade and promote economic revival as the Cold War began. Yet, as David Korten has written, the success of the Western economy after the war was not due entirely to a free market economy. Rather, "it was due to the practice of democratic pluralism built on institutional arrangements that sought to maintain balance between the state and the market and to protect the right of an active citizenry to hold both accountable to the public interest."[61]

The International Monetary Fund and World Bank have increasingly recognized that policies exclusively focused on promoting global trade may contribute to growing income inequality and reduced health status.[62] Pressured by these concerns, they have adopted policies aimed at reducing poverty and building capacity in developing countries. The World Trade Organization has developed a consensus among its 134 member nations that it should promote growth and development.[63] These measures are the sort of efforts that conform to the norms we have spoken of and begin to address the concerns we have articulated here. Given the importance of the social determinants to health, these organizational policies will increasingly need to address the impact of the social determinants on populations in nonpoor nations as well. Perhaps most promisingly, the World Health Organization's Commission on Macroeconomics and Health has developed a model for understanding the consequences of globalization for health and has endorsed policies that explicitly consider the distributional effects of decisions at the global level.[64]

In sum, we have argued here that multinational enterprises have a duty grounded in social contractarian terms to

avoid depriving individuals of health by refraining from perpetuating inequalities in wealth. States working in concert with one another can enforce this duty, and thereby fulfill their own obligations to their citizens, by structuring economic arrangements so that they are responsive to the way that socioeconomic factors affect health. Taken together, these considerations demonstrate that a socially structured marketplace that imposes obligations and regulations on multinational enterprises is a justifiable way of improving health.

Acknowledgments

Part of this work was presented at Health, Law and Human Rights: Exploring the Connections, the annual meeting of the American Society of Law, Medicine & Ethics in Philadelphia on October 1, 2001. The opinions expressed here are those of the authors and are not the policies of the National Institutes of Health or the Department of Health and Human Services. We wish to thank Avi Astor, Dan Brock, and Gopal Sreenivasan for their comments and suggestions.

References

1. R.G. Wilkinson, *Unhealthy Societies: The Affliction of Inequality* (New York: Routledge, 1996): at 35.

2. D. Black et al., *The Black Report* (London: Crown, 1980); R.G. Evans, M.L. Barer, and T.R. Marmor, eds., *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations* (London: Aldine de Gruyter, 1994); M. Marmot and R. Wilkinson, *Social Determinants of Health* (Oxford: Oxford University Press, 1999); N.E. Adler et al., *Socioeconomic Status and Health in Industrial Nations: Social, Psychological, and Biological Pathways* (New York: New York Academy of Science, 1999); D. Leon and G. Walt, eds., *Poverty, Inequality, and Health: An International Perspective* (Oxford: Oxford University Press, 2001).

3. I.K. Kawachi, B.P. Kennedy, and R.G. Wilkinson, *The Society and Population Health Reader: Income Inequality and Health*, vol. 1 (New York: The New Press, 1999): *xxii–xxiv*.

4. P. Townsend and N. Davidson, eds., "The Black Report," in P. Townsend, N. Davidson, and M. Whitehead, eds., *Inequalities in Health*, 2d ed. (London: Penguin Books, 1992): 43–56.

5. G. Davey Smith, J.D. Neaton, and J. Stamler, "Socioeconomic Differentials in Mortality Risk Among Men Screened for the Multiple Risk Factor Intervention Trial: I. White Men," *American Journal of Public Health*, 86 (1996): 486–96.

6. J.M. Mellor and J. Milyo, "Reexamining the Evidence of an Ecological Association Between Income Inequality and Health," *Journal of Health Politics, Policy and Law*, 26 (2001): 487–522; J.S. House, "Commentary: Relating Social Inequalities in Health and Income," *Journal of Health Politics, Policy and Law*, 26 (2001): 523–32.

7. I. Kawachi and T.A. Blakely, "When Economists and Epidemiologists Disagree," *Journal of Health Politics, Policy and Law*, 26 (2001): 533–42.

8. G. Davey Smith, D. Gunnell, and Y. Ben-Shlomo, "Life-Course Approaches to Socio-Economic Differentials in Cause-Specific Adult Mortality," in Leon and Walt, eds., *supra* note 2, at 88–124.

9. C. Woodroffe et al., eds. *Children, Teenagers and Health* (Philadelphia: Open University Press, 1993); V. Patel, "Poverty, Inequality, and Mental Illness in Developing Countries," in Leon, *supra* note 2, at 247–62.

10. Davey Smith, Gunnell, and Ben-Shlomo, *supra* note 8.

11. *Id.*

12. Kawachi, Kennedy, and Wilkinson, *supra* note 3.

13. D. Massey, "The Age of Extremes: Concentrated Affluence and Poverty in the Twenty-First Century," *Demography*, 33 (1996): 395–412.

14. G.A. Kaplan et al., "Inequality in Income and Mortality in the United States: Analysis of Mortality and Potential Pathways," *British Medical Journal*, 312 (1996): 999–1003.

15. R. Wilkinson, *Unhealthy Societies. The Affliction of Inequality* (London: Routledge, 1966).

16. I. Kawachi et al., "Social Capital, Income Inequality, and Mortality," *American Journal of Public Health*, 87 (1997): 1491–98.

17. *Id.*

18. *Id.*

19. C. Shively and T. Clark, "Social Status and Coronary Artery Atherosclerosis in Female Monkeys," *Atherosclerosis and Thrombosis*, 14 (1994): 721–26.

20. E. Brunner, "Stress and the Biology of Inequality," *British Medical Journal*, 314 (1997): 1472–76; M. Kristenson et al., "Attenuated Cortisol Level Response to a Standardized Stress Test in Lithuanian Versus Swedish Men: The LiVicordia Study," *International Journal of Behavioral Medicine*, 5(1998): 17–30.

21. See Brunner, *supra* note 20.

22. R.G. Wilkinson, "Income Distribution and Life Expectancy," *British Medical Journal*, 304 (1992): 165–68.

23. N. Daniels, B. Kennedy, and R. Wilkinson, "Why Justice Is Good for Our Health: The Social Determinants of Health Inequalities," *Daedalus*, 128 (1999): 215–51.

24. L. Brown, M. Renner, and C. Flavin, *Vital Signs 1997: The Environmental Trends That Are Shaping Our Future* (New York: W.W. Norton and Company, 1997).

25. World Bank, *World Development Report 1999/2000* (New York: World Bank, 1999), *available at* <http://www.worldbank.org/wdr/2000/fullreport.html>.

26. *Id.*

27. A. Benoist, "Confronting Globalization," *Telos*, 108 (1996): 395–412.

28. M. Velasquez, "Globalization and the Failure of Ethics," *Business Ethics Quarterly*, 10 (2000): 343–52.

29. Benoist, *supra* note 27.

30. H. Daly, "Globalization and Its Discontents," *Philosophy and Public Policy Quarterly*, 21 (2001): 17–21, at 20.

31. World Bank, *supra* note 25, at 7.

32. G. Borjas and V. Ramsey, "Foreign Competition, Market Power, and Wage Inequality," *Quarterly Journal of Economics*, 110 (1995): 1075–110.

33. D. Quinn, "The Correlates of Change in International Finance," *American Political Finance Review*, 91 (1997): 531–51.

34. *Id.* at 541.

35. T. Donaldson, "Values in Tension," *Harvard Business Review*, 74 (1996): 48–58.

36. J. Rawls, *A Theory of Justice* (Cambridge: Harvard University Press, 1971).

37. T. Donaldson, *Corporations and Morality* (Englewood, New Jersey: Prentice-Hall, 1982); T. Donaldson, *The Ethics of International Business* (New York: Oxford University Press, 1989).

38. T. Dunfee, "Business Ethics and Extant Social Contracts," *Business Ethics Quarterly*, 1(1991): 23–51.

39. Donaldson, *Corporations and Morality*, *supra* note 37.

40. T. Donaldson and T. Dunfee, "Integrative Social Contracts Theory: A Communitarian Conception of Economic Ethics," *Economics and Philosophy*, 11(1995): 85–112, at 87.

41. *Id.* at 93–97.

42. Donaldson, *The Ethics of International Business*, *supra* note 37, at 82.

43. *Id.* at 84–87.

44. D.C. Robertson and W.T. Ross, "Decision-Making Processes on Ethical Issues," *Business Ethics Quarterly*, 5 (1995): 213–37, at 231.

45. T. Dunfee and T. Donaldson, "Contractarian Business Ethics: Current Status and Next Steps," *Business Ethics Quarterly*, 5(1995):173–85, at 182–83.

46. M. Friedman, "The Social Responsibility of Business Is to Increase Profits," in W.M. Hoffman and J.M. Moore, eds., *Business Ethics: Readings and Cases in Corporate Morality* (New York: McGraw Hill, 1994); J.R. Danley, "Corporate Moral Agency: The Case for Anthropological Bigotry," in W.M. Hoffman and J.M. Moore, eds., *Business Ethics: Readings and Cases in Corporate Morality* (New York: McGraw Hill, 1994).

47. G.V. Brenkert, "Private Corporations and Public Welfare," *Public Affairs Quarterly*, 6(1992): 155–68.

48. *Id.* at 160.

49. Friedman, *supra* note 46.

50. *Id.* at 138.

51. Friedman, *supra* note 46.

52. D. Porter, *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (London: Routledge, 1999).

53. *Id.* at 5.

54. *Id.*

55. Y. Brenner, J. Reijnders, and A. Spithoven, *The Theory of Income and Wealth Distribution* (New York: St. Martins Press, 1988).

56. A. Sen, *Inequality Re-examined* (Cambridge: Harvard University Press, 1992); A. Sen, "The Economics of Life and Death," *Scientific American* (May 1993): 40–47; J. Galbraith, *Created Unequal: The Crisis in American Pay* (New York: Free Press, 1998).

57. See Galbraith, *supra* note 56.

58. A.A.M.R. Chowdhury and A Bhuiya, "Do Poverty Alleviation Programmes Reduce Inequalities in Health?," in Leon and Walt, eds., *supra* note 2, at 312–32.

59. D. Acheson, *Independent Inquiry into Inequalities in Health Report* (London: The Stationary Office, 1998).

60. *Id.*

61. D. Korten, "The Failures of Breton Woods," in J. Mander et al., eds., *The Case Against the Global Economy* (San Francisco: Sierra Club Books, 1996): 20–30, at 25.

62. Policy Development and Review and Fiscal Affairs Department, International Monetary Fund, *Review of the Poverty Reduction and Growth Facility: Issues and Options* (February 14, 2002), *available at* <http://www.imf.org/External/NP/prgf/2002/021402.pdf>; World Bank, *supra* note 25.

63. The Fourth WTO Ministerial Conference, "Ministerial Declaration," adopted by the World Trade Organization, in Doha, Qatar, November 14, 2001, *available at* <http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_e.htm>.

64. D. Woodward et al., "Globalisation and Health: A Framework for Analysis and Action," WHO-CMH Working Paper No. WG4, May 1, 2001, *available at* <http://www.cmhealth.org/docs/wg4_paper10.pdf>.