Introduction and Forward to the Special Issue on Business and Public Health Partnerships: Practice, Policy, and Ethics

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Every generation has its defining moments. Dramatic and mundane events converge and serve as a tipping point where "business as usual" and "life as we know it" are reexamined. How we choose to respond to these events becomes the measure of our character — as persons and as a society. New models emerge and, in the parlance of sustainability, these models demand an ethical response that ensures a better quality of life for everyone — now and for future generations.

We find ourselves in one such moment today. The global issues of poverty, access and rights to water, pollution, the HIV/AIDS pandemic, new and emerging infectious diseases, and bioterrorism each involve the public and the public's health. In fact, in the globalized world of the twenty-first century, one could say that all health is public health. These issues are not confined to one place; they are global in nature and have a global impact. These issues expose our vulnerability as individuals and as a global society. Finally, these issues illuminate the need for a coordinated and integrated response among stakeholders. That business has a unique contribution to make was not lost on two recent issues in the *Harvard Business Review:* one on the need for coordinated efforts in preparing for a pandemic;[1] the other on "Making a Real Difference" linking strategy and society in effecting social change[2] and the role of catalytic innovation in addressing social-sector problems.[3] "It is becoming more and more apparent that treating broader social issues and corporate strategy as separate and distinct has long been unwise, never more so than today . . . we are learning that the most effective way to address many of the world's most pressing problems is to mobilize the corporate sector in a context of rules, incentives and partner-

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ships where both companies and society can benefit."[4]

Public-private partnerships are not new phenomena. Many were created during the late 1990s in response to specific public health concerns such as malaria, tuberculosis, and HIV/AIDS.[5] In 2000, the W.K. Kellogg Foundation provided funding to the Washington Business Group on Health to investigate the role of business in improving community health so that healthcare and public health activities could be directed more effectively. Historically, public health agencies have had few formal partnerships with private business, yet both share an interest in having a healthy population. Simply put, "businesses have a financial interest in supporting organized public health efforts; in turn, business partnerships can increase the reach and effectiveness of public health."[6]

One of the many challenges for public health is to collaborate across a broad range of stakeholders, which includes business. One of the many challenges for business is to focus on their interdependence with society rather than the tension between the two. Forward movement is evident, however. KLD Research and Analytics Inc. are now in their seventh year of identifying the 100 best corporate citizens utilizing social performance data.[7] The rise of the citizen sector organization created by social entrepreneurs, the "pioneers working in business, finance and social activism" effects change by forging partnerships with business, academic institutions, and governments moving beyond stop-gap solutions to systemic approaches to problems.[8]

The business community, in partnering with public health, can shape the cross-sector dialogue necessary to address today's complexities in healthcare while at the same time informing policy and ethical decision making.[9] This partnering does not supplant the values of business with public health goals and objectives but rather reminds "what is most important is that management realize that it must consider the impact of every business policy and business action upon society. It has to consider whether the action is likely to promote the public good, to advance the basic beliefs of our society, to contribute to its stability, strength and harmony."[10] The values of public health are not supplanted by a profit motive but rather serve to inspire and guide innovative ways to further community enhancement through newly created models of microlending and microcredit.

The Institute of Medicine defines the mission of public health as "fulfillment of society's interest in assuring the conditions in which people can be healthy"[11] and that improving health in the twenty-first century requires adopting new approaches that engage the public, the business community, and public policy makers.[12] A recent lead article in the journal *Foreign Affairs* calls for new "systems and sustainability" to effectively deal with the ever-growing challenges of global health.[13] We believe business-public health partnerships provide one such approach.

In a world of increasing competition for scarce resources, there is a strong economic and social imperative for partnerships that are both measurably effective and sustainable. Although there are several examples of public health-private partnerships, many efforts are episodic or transitory. We are grateful to the editors of *Organizational Ethics: Healthcare, Business, and Policy* for dedicating an issue to exploring those models that identify the challenges, initiatives, factors, and trends of business and public health partnerships that influence practice, policy, and ethics. The invited authors are leaders in their respective fields. The authors bring to this issue their expertise and insights that provide a foundation for readers and practitioners to better understand the many issues, challenges, and opportunities within this area of study and practice.

We begin with the article by Donna J. Wood and Jeanne M. Logsdon on "Global Business Citizenship in Action: Business Re-

sponses to Healthcare Crises" because it provides a provocative perspective on the role of business as a global citizen and the corresponding responsibilities that ensue. They pose necessary questions to create the context for our dialogue on business-public health partnerships: What are "the pros and cons of globalization"? "Can and should corporations be thought of as citizens?" "Who will lead the way?" Wood and Logsdon provide a much-needed conceptual and practical approach to these questions in their global business citizenship (GBC) model: a set of policies and practices that allow a business organization to identify principles of ethical management using a four-step process. They apply their GBC process to several examples in which human health and/or healthcare are at stake, displaying the model's versatility and strength in creating sustainable solutions.

Walter J. Jones and Peggy Honorè outline the importance of business and public health partnerships and identify five categories where policy and regulatory concerns emerge in "Business and Public Health Partnerships: Policy and Regulatory Challenges and Successes." By providing examples of partnership programs, they identify what a business/public health partnership can and cannot provide given the distinct values, interests, and inherent tensions between the two. Jones and Honorè identify an obvious yet overlooked component: choosing the right partner to partner with, which goes to the heart of organizational governance. The article is invaluable in providing specific steps and issues to consider when creating partnerships. They close by saying, "The greatest current challenges result not from past *failures,* but the new conditions created by a by-product of past *successes,"* a nice segue to our next three articles.

Leiyu Shi and Patricia B. Collins begin their article with an overview of community health center achievements and private-public partnership models in public health in "Public-Private Partnerships in Community Health Centers: Addressing the Needs of Underserved Populations." Providing high-quality and cost-effective primary healthcare to underserved populations has been a central component of the community health center model of care. Shi and Collins outline the historic and current role of public-private partnerships in community health. Two initiatives from the Bureau of Primary Health Care, the Health Disparities Collaborative and the Healthy Communities Access Program, are provided as successful models of community health center public-private partnerships. Of critical value is their attention to context: shifts in the political and healthcare market must be considered when we identify what constitutes a successful program.

In "A Healthy Solution to Poverty: Integrating Microfinance and Health Services" by Sameer P. Sheikh, nothing short than the "birth of a revolution" is outlined in these pages. In December 2006, Muhammad Yunus, considered "the godfather of microcredit,"[14] and founder of the Grameen Bank, received the Nobel Peace Prize for his work of providing small individual loans to the impoverished in Bangladesh as a way out of poverty. From an insider's perspective, Sheikh, who works for the Grameen Foundation, provides us with a definition of microfinance and the Grameen Bank Model, the foundation for microfinance institutions (MFIs). Yet he doesn't stop there. He cites two case studies, Grameen Kalyan and Pro Mujer, as examples of MFIs collaborating with healthcare services, in effect expanding the microfinance model to include health education, prevention, and promotion. Sheikh describes the different organizational structures between the two cases and identifies the strength in both through partnering relationships. In the end, the success of the microfinance model and the MFI is not about finance alone; it is about creating community.

Expanding on this partnership approach in community health development is the article by Monica L. Wendel, James N. Burdine, and Kenneth R. McLeroy on "The Evolving

Role of Partnerships in Addressing Community Public Health Issues: Policy and Ethical Implications." They introduce the nine principles of *community health development,* whose aim is to catalyze positive change, as a growing approach in the United States and abroad that can provide "innovative, locally grown solutions" to public health issues. Utilizing the Partnership Approach to Community Health Improvement as a model, Wendel, Burdine, and McLeroy describe the steps to achieving a community's shared vision. The corresponding policy and ethical issues are outlined with the need for a national conversation seeking societal agreement on developing and sustaining community.

In their article, the authors propose an alternative to a rights-based model of care and universal access, with its emphasis on an individual's rights, to a model based on solidarity. Solidarity stems from a place of compassion and understanding — we identify with the other and share a willingness and vulnerability to join "her or his" cause. We close our series, then, with the article by Francis Dominic Degnin and Donna J. Wood on "Levinas and Society's Most Vulnerable: A Philosopher's View of the Business of Healthcare."

The authors begin with a compelling reminder: "The problems of healthcare are deep and broad. Solving them requires more than political will, money, collaboration, and organized effort; it also requires a vibrant, compelling philosophy to explain *why* it is important to strive for solutions." We learn from Levinas that self-interest is essential to human motivation but balanced by a counter impulse, the compulsion to care. How we address this tension between opposites, the capacity to be vulnerable to one another and the need to create a space where real choice can be made are the provocations Degnin and Wood leave us to consider. With poignant clarity, they challenge us with a philosophy particularly relevant to how we "do" healthcare. They outline the need for a balance between profit and human dignity, between the intensely personal with the generalized impersonal, and how our institutions must incorporate, through policies and incentives, a proper mix of motives, behaviors, and outcomes. Through a sobering account of historical example, yet with potential for a hopeful response, they provide a model of a different sort. The rise of ethical desire and our impulse to care may be fragile. But it is in our response to this impulse that we develop our humanity.

We are encouraged as we read these articles; they reinforce the direction of our work on the role of business-public health partnering in creating a sustainable future.[15] We would be remiss if we did not acknowledge the tight deadline our authors agreed to work under. At the time we approached the editors of *OE,* our objective for this *special issue* was to provide a forum to advance the dialogue as to how public health, as an integral aspect of the healthcare system, can relate to and partner with business and influence public policy from an ethical perspective. Our intent was to have the issue precede the *Fourteenth Annual International Business Ethics Conference* in November 2007. The conference, with its theme of Globalization and Poverty: Oxymoron or New Possibilities, is being hosted this year by the Institute for Business and Professional Ethics at DePaul University. Our belief was that the topic of this *special issue* would complement the conference and help engage more voices and participants from the business and academic communities. We believe we met our objective and our goal.

In this body of work you will find more than words on paper. Collectively read, they serve as a call to action and collective action that will result in benefit to the common good. Charles Handy refers to this as cathedral philosophy: "the thinking behind the people who designed and built the great cathedrals, knowing that they would never live long enough to see them finished. The new cathedrals will not be of stone and glass, but of brains and wits. They will take equally long to build and we who start the building may not live to see

the conclusion. That is why we need to look beyond the grave and beyond our generation. It is hard to believe that we will make the sacrifices involved unless we can believe in the long-term existence of our little local world and of the bigger global one. We should, however, remember that there is no need for that continued existence to take the same form as it is in at present. The second curve is different from the first; there has to be change to be continuity. We need to have faith in the future to make sense of the present."[16]

It is with great pride that we introduce you to our colleagues. We are grateful to the editors to serve in the capacity as guest editors; our deepest gratitude and appreciation are to our contributing authors. We thank you.

NOTES

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8. W. Greider, "Beyond Scarcity: A New Story for American Capitalism," *Business Ethics* 17, no. 3 (2003): 9; M. Simms, "What *Is* the Objective of Business: On Social Entrepreneurs, Self-Realization and Organizational Ethics," (paper presented at the 13th Annual International Business Ethics Conference, New York, October 2006).

9. M. Simms, "On Linking Bioethics, Bioterrorism and Business Ethics," *Journal of Business Ethics* 51 (special issue 2004): 211-20.

10. P. Drucker, *The Practice of Management* (New York: Harper Collins, 1955), 342.

11. Institute of Medicine, *The Future of Pubic Health* (Washington, D.C.: National Academies Press, 1998), 40.

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14. C. Bruck, "Millions for Millions," *New Yorker,* 30 October 2006, 62.

15. I. O'Boyle and M. Simms, "Public Health Ethics, Business and Terrorism," in *Community Preparedness and Responses to Terrorism: Responsibilities and Collaboration Among All Sectors of Society,* ed. M. Kennedy, vol. 2 (Greenwood Publishing Group, 2004), 249-56. See also M. Simms, "Emerging Trends and Ethics in Corporate Social Responsibility," *International Journal of Environmental, Cultural, Economic and Social Sustainability* 1 (2005): 34-43; I. O'Boyle et al., "Terrorism and Emergent Challenges in Public Health," *Journal of Health and Human Services Administration* 3, no. 1 (2007).

16. C. Handy, *The Age of Paradox* (Boston: Harvard Business School Press, 1994), 251-2.