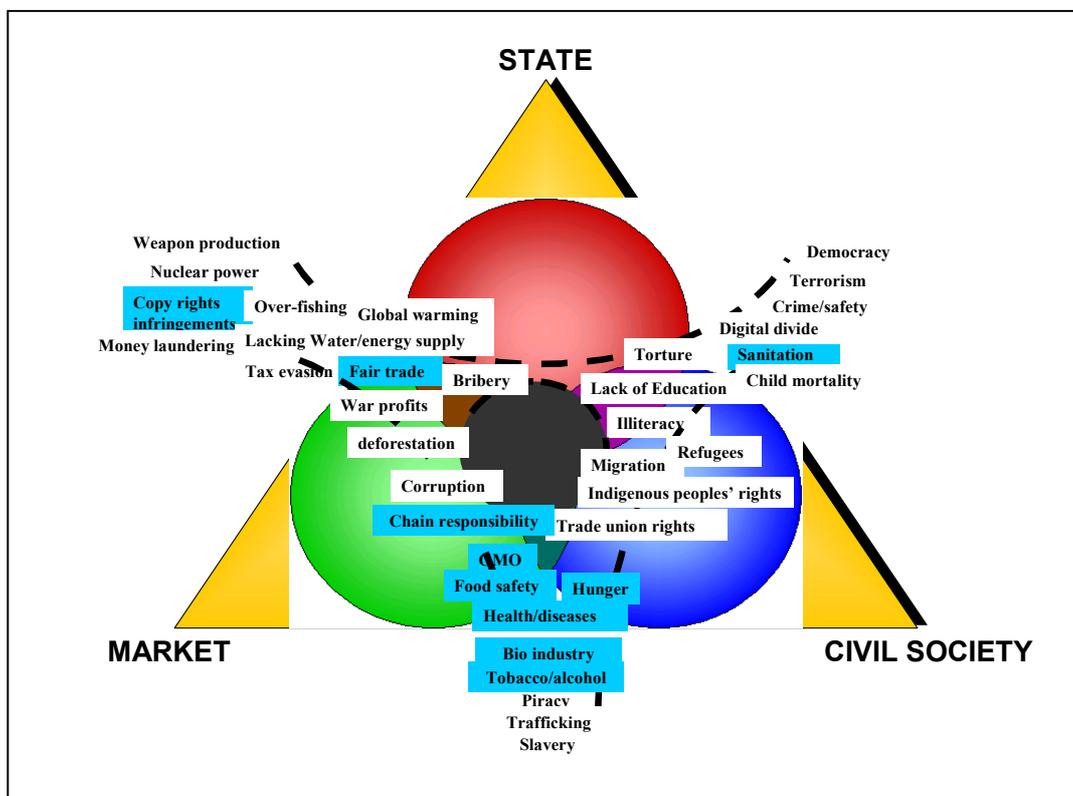


SUSTAINABILITY CHALLENGE # 3:
HEALTH
 TRADING-OFF PROFIT AND NON-PROFIT

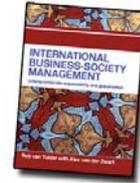
Key Health interface issues



1. Introduction: an unequal distribution of health problems¹

Along the market-civil society interface, individual and social rights are at stake. Individual rights cover issues like health, food safety/security and human rights like freedom, emancipation, lack of forced labor and slavery. Interface controversies very often revolve around the question whether an unequal distribution of individual and

¹ This issue dossier was written by Rob van Tulder. It elaborates one theme that has been addressed in chapter 10 of the book (on 'The Stakes – Firms part of the problem or part of the Solution'). References in the text to Figures, Chapters and Tables, refer to the original book "International Business-Society Management" (Van Tulder with Van der Zwart, 2006). The dossier is intended to illustrate how this particular issue can be approached by both scientists and practitioners. Last updated: March 2006.



social rights is caused and/or can be solved by a greater involvement of markets and for-profit actors. The biggest area of controversy is arguably health, which is strongly related to unequal levels of vulnerability to diseases and unequal access to medicine in specific. Health as an issue has two dimensions: prevention of health problems to appear, and treatment of health problems after they have appeared.

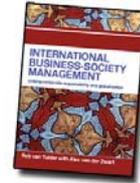
Health as prevention. Health problems and diseases are strongly related to hunger/malnutrition, living conditions (sanitation) and relative poverty.² Malnutrition, firstly, breeds bad health. According to modest estimates of the FAO (2003), more than 840 million people in the world suffer from chronic malnutrition of which 95% lives in developing countries, 4% in transition economies and around 1% in industrialized countries. About 24,000 people die every day from hunger or hunger-related causes. This is down from 35,000 in the 1990s, and 41,000 in the 1980s (www.thehungersite). Malnutrition, by all accounts, remains a non-necessary issue. The world produces enough nutrients per capita. The problem of malnutrition is unequally distributed over population groups. Women, children and elderly suffer more from malnutrition than men. In the 1995-2001 period, the worldwide number of hungry people increased slightly, although primarily due to increases in specific regions like Sub-Sahara and Northern Africa, and the Middle-East. In regions with strong economic growth and a relatively equal distribution of income - in Asia and Latin America - the absolute magnitude of malnutrition declined.

Secondly, bad sanitation literally generates a breeding ground for diseases and bad health. Historically, the diffusion of good sanitation (sewerage systems and related hygiene awareness) has proven the most effective contribution to raising general levels of public health. The health problems of people in developing countries in particular are caused and aggravated by lack of access to basic sanitation provisions. In 2004, this was the case for more than half of the around 4.4 billion people living in developing countries, according to assessments of the World Health Organization (www.who.org). The problems of sanitation and malnutrition are combined in the issue of access to water. In 2001, the World Health Organisation (WHO) assessed that 1.1 billion people do not have access to clean water. 500 million people in 31 countries live with a water supply shortage, which is likely to grow to 3 billion people in 48 countries by the year 2025 (www.wri.org - World Resources 2000-2001) More than 3 billion people have only access to bad quality water (Petrella, 1999: 108) and 1 million children die each month from disease spread by contaminated water (all in low income strata of societies). Water usage is very unequally distributed with 70% of the average water supply used for irrigation, whilst people in cities face supply shortages.³

Thirdly, malnutrition and bad sanitation are difficult to solve by the people themselves for lack of effective demand. Even in rapidly growing or rich economies, serious hunger and sanitation problems can exist in case incomes and buying power are unequally distributed. "Research has repeatedly shown that it is not those who live in the richest

² It is statistically difficult to establish a clear-cut relationship between absolute levels of GDP and health. Countries with comparable levels of GDP show various levels of health and longevity.

³ Access and distribution of water is also a major source for conflicts and war between countries: around 240 of the most important water basins in the world have to be governed by two or more states (Petrella, 1999:10) (www.watersharing.com; www.waterweb.org)



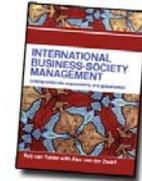
societies, but those who live in societies with the most egalitarian wealth distribution, that have the best health. It is relative income levels that matter, not as one might have thought, absolute ones.” (Hertz, 2001:50). Health problems related to over-consumption of particular commodities also correlates strongly to relative poverty. The biggest number of casualties of tobacco and alcohol addiction, fall in the poorer countries and population groups.⁴ Paradoxically perhaps, obesity – and its related health problems – is also a problem of relative poverty. It is found primarily within the poorer segments of populations in richer countries. So, the structural causes of basic health problems are particularly related to the unequal spread of poverty and income in and amongst societies. This in turn is dependent on the growth regime of the country (see chapter 10 and dossier #5) and the health strategies adopted by citizens and governments.

Health as treatment. Even widespread structural prevention measures, however, can not prevent health problems from appearing. Health treatment becomes necessary. Health treatment issues have four dimensions (a) ‘avoidable’ disease treatments, (b) expensive disease treatments, (c) treatment with unintended side-effects, (d) prospective disease treatments.

Avoidable diseases are diseases for which relatively cheap (generic) medicines are available and for which only a basic access to the national health system (hospitals, general practitioners) is required. According to the WHO, approximately thirty percent of the world’s population has no access to any form of health care. The World Health Organization calculated in 1999 that 48 percent of the people that die before the age of 45, are victim to contaminating diseases. Many of these diseases can be cured. The International Red Cross, assessed for the 1945-1999 period, that the number of people that died of “avoidable diseases” like tuberculosis, malaria, and even diaria amounted to around 150 million people. Compared to war (23 million) this is six-fold the number of casualties. Whereas in 1999 160 times less people died of natural disasters such as earthquakes as compared to the casualties of avoidable diseases. 2.5 billion people are presently deprived of medicine and basic health services. UNICEF has calculated that annually 6 million children die due to lack of vaccines. According to a commission of the WHO, around 66 billion dollar is needed, saving 8 million lives annually. The economic value added of those lives is around 360 billion dollar, whereas the development assistance for health care is less than 6 billion dollar annually.

Expensive diseases: for a number of other diseases and health problems treatments are available, but at high costs. The price of these treatments is sometimes due to the experimental stage of the research, sometimes due to the pricing strategies of for instance the pharmaceutical companies that developed the medicine. High prices of medicine are a

⁴ For developing countries tobacco not only represents a trade-off between health and pleasure. The tobacco industry is a viable industry for many countries. According to the ILO, the tobacco industry gives work to around 40 million people around the world. Some developing countries (like Malawi) are for 80% of export revenues dependent upon tobacco. The ground needed for tobacco is often considerably smaller than for competing crops, so there is also an economic necessity (efficiency) in growing tobacco, whereas developed countries exert big economic sanctions on converting to other crops. The 2005 initiative of the WHO and its 192 member countries to regulate the tobacco industry, primarily addressed the marketing strategies – for instance by agreeing on a ban on cigarette advertisements to children – not the industry as such.

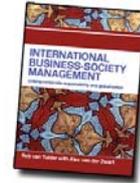


necessary – but strongly disputed - part of the international patenting regime adopted *in principle* to stimulate private companies to invest in the development of new medicines. This part of the health issue strikes at the heart of the global patenting system that was negotiated under the new WTO provisions and better known as the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The TRIPS agreement imposes obligations on the participating countries to grant the owner of a patent, exclusive rights to prevent third parties from making or selling the patented product for a period of not less than 20 years. Prior to TRIPS, developing countries could reduce prices of medicines for instance by not granting patents for pharmaceutical chemicals (Flanagan, Whiteman, 2005).

HIV/Aids provides an excellent example of the consequences of pricing and patenting rules. HIV/AIDs cannot be cured, but it can be contained due to the availability of a ‘cocktail’ of medicines. These medicines, however, are barely out of the experimental phase, extremely expensive and therefore primarily bought by rich patients. The price of HIV medications in the beginning around 2001 was approximately US \$12,000 per person per year – an impossibility for the bulk of the world’s population that has to survive on less than two dollars a day (Flanagan, Whiteman, 2005).⁵ So, people in principle need not die from HIV/AIDs. Nevertheless, the number of poor people affected by and dying of the virus is still growing in Africa, but also in a country like Russia where the income inequality is amongst the biggest in the world. In 2003, 70% of people infected with HIV/AIDS worldwide were living in the sub-Saharan region (UNAIDS, 2003). HIV/AIDS is now the leading death cause in this region. According to the WHO (2003), infection rates are increasing by an average of 10 percent a year. In some countries like Botswana and Swaziland, the prevalence of HIV/AIDS has reached the 40%, a number previously thought impossible (ibid). People are deprived of the medicine because they do not earn enough to buy the medicine and/or because they have no access to a system of health insurance that covers for these extra costs. The latter is not only a problem of developing countries. Forty-five million Americans for instance have no health insurance either (Hertz, 2001: 8). Should pharmaceutical companies be held responsible for selling life-saving drugs at too high prices? Who is going to represent these people in case governments are not willing or not capable of representing them?

Unintended side-effects: what happens in case the treatment creates other health problems? This problem bears on the trade-off between appropriate safety and security regulations vis-à-vis the desire of companies (but also of patients) to quickly bring treatments in the market. Health safety regulation around the world is based on diverging principles (see chapter 12) and cannot substitute for firms’ own responsibilities. For example, in 2004, US pharmaceutical company Merck had to withdraw its pain medication Vioxx (in which the company had invested \$ 2.5 billion), after it was indirectly proven that the drug raised the risk of heart attacks (Business Week, January 10, 2005). This is the traditional area of product reclaims and issues management as crisis management, but with serious liability problems for the company. State regulation had clearly not proven effective in preventing the company from introducing the unsafe

⁵ On a number of 42 million infected people in 2002, 600.000 people primarily in OECD countries are getting treatment with anti-retroviral drugs; in sub-Saharan Africa about 50.000 people get treatment (UNAIDS, 2003).



medicine. The company was also very eager to introduce a new generation of patented drugs because of expiring patents on a large number of its other leading ('blockbuster') drugs. The latter is a timely problem faced by most of the pharmaceutical industry. In the 2002-2007 period, according to pharmacy analysts, the patents expire of drugs representing around 80 billion dollars in annual turnover for drugs majors like GlaxoSmithKline, AstraZeneca, Merck, Pfizer and Sanofi-Aventis (Volkskrant, 22 February 2005). This situation makes it highly probable that a number of other medicines will be pushed to the market and create additional health problems.⁶

Future diseases: the problem of prospective treatments applies to diseases for which no cure (yet) exists and which thus rely on the development of new cures. The growing commercialization of research (see chapter 3; including partnerships between pharmaceutical companies and universities) has resulted in sometimes awkward research priorities. Considerably more research money is for instance directed towards cosmetics and plastic surgery than towards developing basic treatments for typical developing countries' problems like meningitis or tuberculosis. According to assessments of the Global Forum for Health Research (2002) less than 10% of global spending on health research is devoted to diseases or conditions that account for 90% of the global disease burden. It is – wrongfully – supposed that current technical tools are sufficient for effective disease control. There exists a global 'drugs gap' (Reich, 2000), in which the private sector invests almost exclusively in drugs for the developed world.

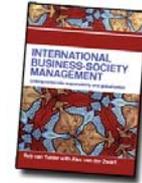
New technological trajectories such as genomics are strongly biased towards searching technological solutions for 'first world' problems, i.e. for which the prospective market is sizable and profitable. This leaves many of the 'poor man's diseases' underfunded. Interestingly, this problem is explicitly addressed by firms, but not primarily by the pharmaceutical industry that is 'trapped' in the market logic of health treatment. Bill Gates, renowned Microsoft chairman and the world's largest corporate philanthropist has become more active in developing medicine for underprivileged groups than the pharmaceutical industry itself. He legitimises this as follows: "The real missing element is applying biology to the diseases of the developing world [...] that's where the market mechanism doesn't work.[...] The government and big pharmaceutical companies will go on investing heavily in genomics. But only philanthropy can create financial incentives to treat common Third World afflictions." (Business Week, May 5, 2003: 56-57). It reveals the same logic as Microsoft's inability to help other software producers develop new software that might ultimately replace Microsoft's blockbuster products like Windows. Can (pharmaceutical) firms be held accountable for *not* investing in the development of medicine?

2. Creating a sustainable corporate story?

2.1 Sustainable health prevention: food, insurance and sanitation

Health issues present a key challenge for developing sustainable corporate stories that deal with the trade-off between profit and non-profit. Health as prevention can be

⁶ The media discussion on Vioxx also revealed that around ten percent of hospitalizations in the world is due to unanticipated side effects of medicines.



considered a prime responsibility for civil society in interaction with their governments. They make the choice for a basic health model – including a view on hygiene. Strategic choices for investments in basic health care or sanitation infrastructure are difficult to implement without the support of governments. Even in case certain parts of a town privatize their health system, they remain vulnerable for the negative externalities and spill-over effects caused by contaminated diseases originating in other parts of the town. It is difficult to keep diseases geographically isolated. Investments in sufficient basic health care, requires a ‘positive duty’ approach (chapter 8) aimed at creating the preconditions for further development, long-term profitability and economic development.

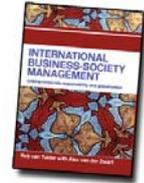
But prevention is also in the direct interest of industries that are either confronted with the negative health effects of a lack of prevention or market health (prevention) products. Three industries are primarily challenged to provide a sustainable corporate story on health: food, insurance and sanitation.

Healthy food. The prime industry that has to consider whether or not to stimulate healthy eating and living habits, is the food processing industry in general and the ‘fast/junk food’ industry in specific. Major food processing firms traditionally have searched for a technological approach to the issue: by investing in so called ‘designer foods’ that are aimed at preventing health problems from appearing. Genomics is applied to come up with healthy food innovations primarily for up-market consumers. Fast food chains and mass food producers like General Mills, Kraft, Nestlé or Coca-Cola on the other hand are particularly well positioned to diffuse more sustainable eating habits with poorer people – without being able to solve the poverty problem. McDonalds has already broadened its food assortment with more healthy and less big portions, following the release of Morgan Spurlock’s critical movie in 2004 (entitled ‘Supersize me’; see also the book accompanying the movie: Spurlock, 2005). Most companies seem to add healthy foods to their product assortment in order to prevent new obesity litigation. General Mills launched a web-based campaign called ‘Mix-Up Dinner; Get Your Greens!’, while Kraft Foods voluntary pledged to stop advertising certain junk foods to the under-11s (Financial Times, 24 February 2005). Whether these initiatives will lead to full scale upgrading of their product assortment, however, remains to be seen. The trade-off between healthy and cheap food, however, poses serious dilemmas. The production of cheap food is also strongly related to ecological problems (see section 10.3.2).

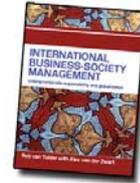
For the up-market segment an international “*slow food*” movement has already been initiated. Founded in Italy, it spreads quickly around the world – including developing countries. The slow food movement is based on Equity principles like creating greater enjoyment in eating and drinking (higher quality of life through food), consumption on the basis of seasonal food which increases ‘localization’ of food consumption and decreases the inclination to move food around the world. The biggest challenge of the slow food movement is to bring these basic ideas to the lower-end of the market and thus provide an economically viable alternative for the fast food movement.

Healthy risks. Insurance companies have always based their risk acceptance profiles on an assessment of the relative health of their prospective customers – to the extent they were allowed by state regulation. Recently, some health insurance companies – in collaboration with food companies - have started to shown an interest in supporting good

www.ib-sm.org



eating habits to prevent specific diseases from appearing. This approach is still



in its infancy, though.

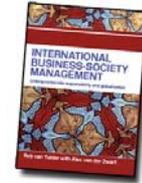
Healthy growth. The most strategic approach to preventing diseases, however, remains economic growth coupled with an equitable distribution of income and/or access to a public health system. In case governments take up their prime governance responsibility, they actively support activities of citizens that improve basic health conditions (for instance by subsidizing or providing sanitation). For sanitation and water utility companies, the health prevention problem poses a more operational challenge. They can consider cross-subsidizing their poorer customers in order to stimulate their well-being, their increased income and ultimately increase their potential market. For most of these utility companies, however, this proves difficult because they have concentrated their short-term activities on the 'marketable' part of the population. This leaves large part of the operational challenge of providing a basic health infrastructure to philanthropists, development organizations and foundations. The Bill and Melinda Gates Foundation, for instance committed more than \$ 3 billion in the 1998-2003 period to bringing basic health care to developing nations (Business Week, May 5, 2003).

2.2 Sustainable health treatment: patents and applications

Health as a treatment problem, allows more room for a negative duty approach in which short-term profitability and market capitalisation can act as triggers for corporate responsibility. This applies in particular to the pharmaceutical and the medical appliances industry. Multinational firms that operate in developing countries where the biggest health problems appear, are faced with a number of additional operational challenges. If they pay their workers below subsistence level, they additionally contribute to their health problems and will probably be confronted with additional transaction costs related to employee drop-outs, lower productivity or extended sick leaves. Even companies that contribute to sustained poverty by paying low wages, often invest in some form of basic health care for their employees. The biggest health problem for most western companies in developing countries have been the advent of AIDs/HIV. According to ILO estimates, around 70 % of the HIV/AIDs infected people are aged 15-49, representing the most productive segment of the labor force. International corporations set up a large number of business driven organizations fighting HIV/AIDs like the Global Business Coalition on HIV/AIDs (GBC) and the Funders Concerned About HIV/AIDs (FCAA). The members of these organizations have invested in partnerships with the international organisations like UNAID, specially designed for creating these kind of partnerships. An analysis of a group of leading companies in applying HIV/AIDs programmes⁷ (Cf. Van Rijsbergen, 2004: 72ff), shows that they all pay some attention to prevention programmes, but very practical (provision of condoms) and to the corporation's employees only – not to the wider local community. The main attention with the majority of these firms lies with the provision of anti-retroviral treatment to their already infected employees. This also seems a typical approach of Multinational Enterprises to other health problems involving their employees.

The pharmaceutical industry in particular is challenged by the strategic trade-offs between a profit and a non-profit orientation. Their product development and marketing

⁷ Containing MNEs from: pharmaceuticals, food/beverages, mining, energy, automotive, consumer electronics, finance.



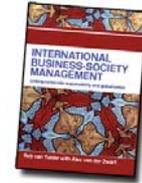
strategies are at stake. Patenting fully developed medication ensures that pharmaceutical companies earn a very high return-on-investment. The pharmaceutical industry has been amongst the most profitable industries in the world for several years. The profits of the ten drug companies listed on the Fortune Global 500 in 2002 represented more than half the (\$69.6 billion) in profits registered for the entire group of 500 companies (Fortune, 2003; Van Rijsbergen, 2004). In case the pharmaceutical industry wants to develop a real sustainable corporate story, it faces five strategic and operational challenges.

Healthy aims. It is argued that listed pharmaceutical majors have moved too far away from their origins – i.e. improving the health of people. Because they have primarily become marketing, patenting and money making machines with profit maximization as the all dominant goal, they have lost their legitimacy – their license to operate. One way of getting out of this predicament is to move away from medicine development into the direction of health prevention. In alliance with food and chemical companies, pharmaceutical companies can become real ‘life sciences’ companies. In case pharmaceutical companies are better able to communicate their strategic commitment to health, they might face less problems in stimulating personnel to work for them and face less problems in possible class action litigation to convince courts and regulators of their right intentions.

Healthy expectations. The commercialization of technological development carries the risk of creating unrealistic and constructed expectations: optimistic reports on technological breakthroughs that are aimed at raising large sums of money on capital markets (box). Constructed expectations are particularly relevant in the health sector – where the pressure to come up with life-saving medicine for wealthy customers is particularly high. Or what about the expectation that eternal life can be achieved through genetic modification? Technological development driven by promises to capital markets is alarming to some, but offers to others the chance of generating large sums of *venture capital* for rapid development of promising techniques.

Constructed expectations

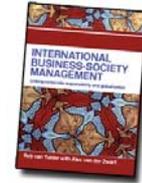
In a newspaper column (Volkskrant (5 June 2002), the internationally renowned geneticist, professor Ronald Plasterk, took a swipe at the influential American philosopher Francis Fukuyama. In his book, “*Our Posthuman Future: The Consequences of the Biotechnology Revolution*” (2000), Fukuyama predicts that, thanks to biotechnology, the end of human nature ‘as we know it’ is in sight. Plasterk writes: “Fukuyama’s most important sources consist of a few random quotes by biologists. Such as the one by the geneticist Bill Haseltine, who has said that ‘as we come to understand the healing process of the body on a genetic level, we can reach the stage where our bodies continue to function normally and perhaps forever’. That Fukuyama as philosopher is incapable of critically examining the scientific merit of such a statement is of less importance than his failure to mention that Haseltine has exchanged his academic position for a biotech company which obtains its funds by raising expectations of *venture capitalists*, and that such claims could not be trusted on face value.” Plasterk’s observation reminds us of the role of ‘contrived’ expectations, which could be a force for technological breakthroughs, but also for major societal disasters, as history has shown.



Healthy prices and patent protection. Pharmaceutical majors have to figure out how to match an effective international patenting regime with a ‘fair’ pricing system. Most pharmaceutical companies developed a ‘one world – one price’ strategy (Flanagan, Whiteman, 2005). This strategy made it possible to recover the enormous investments necessary in the development of new medicine fairly quickly. But in the case of life-saving medicines for poor people, the strategy backlashed and jeopardized the very foundations of their strategy. This point requires some further explanation. The TRIPS agreement seems to safeguard the longer term interests of the pharmaceutical firms. But in practice these interests can only be served if pharmaceutical firms do not abuse their position in the marketplace by reaping monopoly profits. In the case of HIV medication for instance it became clear very soon that firms from developing countries like India and Brasil, were able to produce generic manufacturing of HIV medications at considerably lower prices – estimates of the World Bank run as low as 2%. Soon it became also clear that the TRIPS treaty included some potential exceptions under which countries could adopt ‘compulsory licensing’ – using a patent without authorization of the patent holder. Compulsory licensing is allowed under TRIPS if authorization from the patent holder on “reasonable commercial terms” has not proven possible, or in situations of a “national emergency”, “urgency” or “in cases of public non-commercial use” which allow parties to negotiate for a “reasonable period of time” in which the patent holder can be waived.

The threat of applying compulsory licenses to local producers of generic copies of patented HIV medication has been actively used by a number of developing countries (in particular Thailand, South-Africa and Brazil, supported by a coalition of NGOs), and fiercely opposed by the United States’ government and pharmaceutical majors. Despite their public commitment to address the problems of developing countries, many of the pharmaceuticals majors did respond only re-actively to the operational solutions presented by the developing countries – even if they were allowed to do that under TRIPS rules. In response, the Brazilian government ran a successful advertisement campaign in OECD countries, offering a fundamental choice between “*patient and patent rights*”, but also stressing that it was not against pharmaceutical companies in general. Flanagan and Whiteman (2005) conclude that “through the threat of a compulsory license, Brazil was able both to negotiate lower prices and develop its own domestic capacity to produce HIV medications”. Access to affordable HIV medications became a prime issue in international trade negotiations under the auspices of the WTO. In the 2001 *Doha Declaration on the TRIPS Agreement and Public Health* the strategy of negotiated price reductions through the threat of compulsory licensing was more or less legitimized. It helped governments of some developing countries to negotiate significant price reductions. But in Doha (2003) the issue again acted as a potential deal-breaker. The operational challenge for the pharmaceutical industry will be how to apply a differentiated pricing mechanism over different regions, how to further develop a CSR strategy that uses the TRIPS provisions in a non-defensive manner and prevents developing countries from using compulsory pricing. How to reach poor people in developed as well as developing countries without undermining its future investment capacity for the development of new medicines.

Healthy safety regulation. The third challenge for the pharmaceutical industry is to match commercial interests with safety regulation in a non re-active or defensive manner.



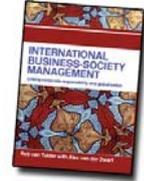
Food and drug administrations around the world have proven not always effective in exerting adequate control on food and drug safety. As a result, medicine (and other health products) can be brought too quickly on the market and - in case of negative side-effects - affect the legitimacy of the whole industry. The problem is exacerbated by a whole industry facing expired patent protection for top-selling drugs, the entrance of cheaper (generic) drug producers and a lack of real new (blockbuster) alternatives. So the inclination to take some risks in bringing new products to the market is considerable and the risk of reputation damage great. How to solve this dilemma? Collaborating with regulatory agencies on developing new joint and high quality safety regulation presents an option. This regulatory dilemma also applies to using new controversial techniques for developing new treatments, like stem cell research and genomics. Where to locate research – in lenient regulatory environments where scientific progress can be uninhibited, or in the major consumer markets even if this would mean slower scientific progress?

Healthy neglect? The fourth strategic challenge is to stimulate vaccine and cure development for neglected diseases like malaria and tuberculosis that do not represent a ‘market’ now or in the near future. Intensive collaboration with the World Health Organization, national health institutes and development foundations with the pharmaceutical companies is a possibility that is already developed by some pharmaceutical companies (cf www.who.org). Another initiative worth mentioning is the Drugs for Neglected Diseases Initiative (DNDi), which was set up in July 2003 by a French academic to ‘tackle the imbalance between the priorities of first-world drug development and the health needs of developing countries’ (Financial Times, 25 February 2005). DNDi’s organizational model is that of a virtual network using partners around the world (a PONGO, see chapter 7). It is funded by big NGOs like MSF and some public research laboratories. A first success has been in the area of malaria where the group has perfected a new therapy to treat malaria, and which has triggered also interest from Novartis. There remain sizable intellectual property problems, though, as well as other categories of ‘most-neglected diseases’ plaguing developing countries, such as sleeping sickness and Chagas disease, that according to the international NGO Médecins Sans Frontières still remain virtually ignored in terms of drug development.

Healthy employees. The last challenge is primarily operational: how to provide own employees around the world with appropriate health care? Should this imply prevention as well as treatment, only for the employees or for the whole community? Only in case of life-threatening diseases or aimed at prevention and other health improving habits?

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