국가 및 지역단위의 건강증진정책 개발

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Building capacity to promote health at national and local levels: after the Bangkok Charter about globalization, policy and partnerships

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Capacity is the ability to carry out stated objectives (Goodman, et al., 1998). Having the capacity to perform a task is a necessary but not sufficient condition for good performance and for objectives to be achieved. Governments and their institutions, organisations (private, NGO, and civil society), and individuals all need capacity to achieve their goals, including but not only, their health goals.

Across the globe, nations and localities have established goals for the improvement of the health of their populations, and have been engaged in amassing the capacity needed to engage in health promotion at country and local levels and to achieve their health goals.

In a paper prepared for the Sixth Global Conference on Health Promotion in Bangkok, Thailand in August 2005, Mittelmark et al (2005) pointed out that 'for at least the past decade, national capacity for health promotion has been the subject of conferences, scholarly dialogue and political debate (French Committee for Health Education, 1995; Wise, 1998;

Wise and Signal, 2000). At the Fifth Global Conference on Health Promotion in Mexico City (June, 2000), national investment for health and the need to build infrastructure for health promotion were dominant themes (Ziglio, et al, 2000a; Moodie, Pisani & Castellarnau, 2000).'

In Korea over the last decade there has been growing interest in identifying and building national and local capacity to promote health. Multiple agencies are responsible, directly, for contributing to national and local initiatives to promote health. The Ministry of Health and Welfare (MOHW) is responsible for implementation and evaluation of Health Plan 2010, the adoption of which will also require building national capacity in the coming period. The Korea Institute for Health and Social Affairs is responsible for developing national programmes to address priority health issues, while the Korea Health Promotion Fund is a major source of funding for national health promotion programs (Oh, 2001; Nam, 2003).

And in countries as diverse as Japan, in Vietnam, and in Indonesia there have been initiatives to build national and local capacity to promote health, using evidence from other nations and adapting it to suit their own political, social, cultural, geographic and economic conditions.

Europe, North America, and Australasia have longer histories of investment in their capacity to promote health continue to learn from the experiences of other nations. Their experiences have demonstrated the elements of success but have also pointed to significant failures, particularly in reducing unjust inequalities in life expectancy and health status within their own populations.

In no country can it be said that the optimal capacity to promote health is completely in place and the Bangkok Charter identified a new set of challenges that must be met if it is to be possible in a globalising world, to achieve the goal of health promotion itself - Health for All.

What capacity?

In a generic sense, it is possible to identify elements or components of the national capacity required to promote health. Drawing on evidence of 'what has worked' in promoting the health of populations - at least in relation to specific health issues or behavioural risk factors - it has been possible to identify resources or factors that had enabled societies to reduce premature mortality or to reduce morbidity, or to reduce the incidence of specific diseases or causes of injury, or to improve health literacy and health behaviours across their populations effectively. With some minor differences, the capacity required included a number of generic components. See Table 1, below.

Table 1: Components of the government and organizational capacity found to be necessary to promote the health of populations

• Systems for monitoring, surveillance and regular reporting • Technical and strategic leadership in promoting health generically and on specific issues - to set priority among courses of action and to plan action • Political Commitment and Leadership • Resources allocated to priorities • Systems for research and evaluation - to identify effective interventions • Action - by relevant public sectors and civil society, and in some cases, the private sector • Partnerships among stakeholders (public, private, civil society) • Systems for workforce development and a skilled, specialist workforce [Adapted from NHMRC, 1997a]

It is possible to identify these elements of organizational capacity in a 'generic sense' - that is, in different combinations operating at different times during the development and implementation of interventions, it has been possible to identify these components of an organizational infrastructure necessary to take action that has been effective in reducing:

- Premature deaths or morbidity from specific causes of non-communicable disease or injury;

- Prevalence of behavioural risk factors; or
- incidence of communicable disease. [Leeder et al, 2004.]

In addition to this focus on the government and organizational capacity necessary to promote health, other authors have identified the elements of the capacity needed by communities to promote their health - see Table 2, below.

Table 2: Elements of community capacity necessary to promote health

• (community) stakeholder participation • the ability (of community stakeholders in particular) to 'ask why' and to control program management, • leadership development • improvement in resource mobilisation. [Gibbon, Labonte and Laverack, 2002]. Bush and Dower (2002) identified community capacity in four domains: • network partnerships • knowledge transfer • problem solving • infrastructure (including investment in the development of policy, social capital, human and financial capital).

There is evidence that, when all or at least many of the elements identified in Tables 1 and 2 are in place, it is possible to improve the health of populations. In each case it is possible to identify the organizational and community capacity that was developed to address the issue. However, it is necessary to point out that the capacity identified above is specific to health promotion, itself. Given that most countries devote less than 2% of their annual health expenditure to health promotion, it is indeed critical that this capacity be built. However, it is important to add that accessible, high quality health care services play significant roles in promoting the health and well-being of populations - not least by providing support and care when people are feeling most vulnerable.

ng or emerging health problems, identifying their causes, and acting to address these. Capacity to work 'upstream' to prevent the emergence of predictable risks to health has not been well developed. The capacity to promote health has been reactive, responding to problems created by other sectors or, in some cases, the health sector, itself.

It is true that this reactive approach has proven to be effective, for example, in reducing the prevalence of tobacco smoking, in improving rates of immunization, control of blood pressure and cholesterol, and in reducing both the numbers and rates of road traffic crashes and the number of deaths and severity of injuries sustained. [IUHPE, EC, 2000; NHMRC, 1997b; Centers for Disease Control and Prevention, 2002].

But successful as these approaches have been, more is needed. In 1986 the Ottawa Charter named equity and social justice as the values on which health promotion, as a discipline and a technology, is based. Through each of the five subsequent global conferences marking the evolution of health promotion on a global scale and assessing global progress in promoting health over the last two decades, there has been evidence of growing inequalities in health within nations and between nations. Our aspirations have not been matched by our achievements.

The inequalities in health have mirrored the inequalities in socioeconomic status that have been growing in the last decade or more. The evidence confirms that the great proportion of these inequalities in health are socially, not biologically determined. [Marmot et al, 2001].

The social determinants of health present nations and localities with significant challenges. The health promotion capacity required to address these includes some of the same capacity already in place. But it is clear that this is insufficient and that new capacity is required.

Globalisation and the Bangkok Charter

Globalisation, it was agreed by participants in Bangkok, constitutes an opportunity and a threat to the health of the world's population and to our environment. The conference, itself, represented one of the opportunities, with delegates from most countries being afforded the opportunity to discuss and negotiate a new global charter for health promotion.

Other opportunities include recognition of the interdependence of human health, social and economic development, and of each of these and the environment. The growing links between countries through international agreements, trade, currency, and tourism have also created opportunities for humans to negotiate directly to achieve our goals. Many, although far from most people, have unprecedented access to information and to mass and targeted communication, the latter offering opportunities to form and build significant networks - personal, professional, and political. These also offer greatly expanded opportunities to exercise global influence through global institutions such as the World Trade Organisation and through global instruments such as the International Convention on Human Rights, or the Convention on the Rights of the Child or the Kyoto Agreement, for example.

On the other hand, the form of economic globalisation that has been promulgated in recent decades has resulted in rapid, often adverse social, economic and demographic changes that affect living and working conditions, learning environments, family patterns, the culture and social fabric of communities and the physical environment. Women and men are affected differently and the vulnerability of children, Indigenous peoples, and marginalized and disabled peoples have increased. [Bangkok Charter, 2005].

Some of the successes in improving the health of populations have come under threat from the changed conditions. Even maintaining our gains is proving to be a challenge.

Furthermore, economic development in all nations has been accompanied by changes in lifestyle that have had or are beginning to have a major impact on the longevity and health

of populations. Obesity, road traffic deaths, lack of physical activity, and changes in nutrition, as well as significant changes in social and physical environments are taking their toll on the mental health and well-being of some populations.

But the greatest challenges to the health of populations in the 21st century are the 'social determinants of health' - factors that are seemingly distant from specific diseases and causes of injury, but that pose risks to health that are the equal of (if not greater than) biological and behavioural factors. And that are, certainly, responsible for the unjust inequalities in health status that have proved so resistant to previous and current initiatives to promote health. In effect, the challenge is to promote health 'upstream' - to create economic, social, and environmental conditions that facilitate and support positive health - in addition to responding to problems as they emerge. This is not a new challenge. [McKinlay 1998]

The Bangkok Charter identified actions that will be necessary to address these determinants, recognizing that to make further progress in promoting health will require strong political action, broad participation and sustained advocacy. Specifically, the Charter identified 5 actions to be taken by all sectors and settings:

- **Advocate** for health based on human rights and solidarity
- **Invest** in sustainable policies, actions and infrastructure to address the determinants of health
- **Build capacity** for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy
- **Regulate and legislate** to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people
- **Partnerships and build alliances** with public, private, nongovernmental and international organisations and civil society to create sustainable actions.

For those of us engaged professionally in promoting health the Charter committed us to making the promotion of health:

- central to the global development agenda
- a core responsibility for all of government
- a key focus of communities and civil society
- a requirement for good corporate practice.

What capacity will be needed to promote health at national and local levels: implementing the Bangkok Charter

At one level, the capacity needed to promote health at national and local levels has been identified, already. The generic specialized infrastructure required by the health sector, particularly, the evidence needed by the health sector and other sectors to design and deliver effective interventions, and the capacity needed by civil society and individuals, and by the private sector has already been proposed. There is also some evidence of the capacity required to sustain positive changes in health literacy and behaviours - and conversely, of the consequences of not sustaining effective interventions. Encouragingly, there is also evidence that it is possible to work globally to challenge the hegemony of multinational companies, the recently negotiated Framework Convention for Tobacco Control being an example.

On another level, though, much more research will be needed to identify, more precisely, the components of the capacity required by different sectors, organisations and people, and its quantity, quality, and location. For example, should population-wide data collection, analysis and reporting be the responsibility of a single, national agency? Or should it be the responsibility of multiple agencies specializing in particular aspects of information gathering and reporting? Or is a combination needed?

Or what specific knowledge, if any, about health and promoting health is needed by

political advisors, by politicians, themselves, and by senior business managers? And what are the most effective mechanisms through which to build such capacity?

Or, what capacity is needed by the health sector as a lead agency in establishing and brokering partnerships among widely disparate stakeholders to achieve particular health goals?

These questions point to the expanded evidence base necessary to inform the development of national and local capacity to promote health.

However, there are particular challenges posed by the Charter for the specialist field of health promotion and the capacity that we will require, as individual professionals, and organizationally, if we are to contribute fully to global, national and local initiatives to address the determinants of health using the values, technology, and strategies of health promotion.

The first is to move the concept of promoting health from that of responding to problems that have emerged already toward that of addressing the social determinants of health and preventing the onset of predictable health problems.

What capacity will be required?

The Bangkok Charter evolved from reflection on global progress toward the goal of Health for All. Building on the strengths of the achievements of the last two decades (since Ottawa), and taking up the opportunities provided by and through globalisation, the Bangkok Charter has set out the challenges ahead. It has proposed actions to be taken by the wide range and number of stakeholders who are or must be engaged if it is to be possible to promote health and achieve social justice in the early years of the 21st century.

Putting evidence into practice on a large scale

Although there is, now, a significant body of research-derived evidence of effective actions to promote the health of populations, governments, NGOs, private sector and civil society organisations have not invested sufficient resources to put the evidence into practice. To promote the health of populations and to achieve social justice will require sustained, systematic implementation of the policies, programs and services that have been shown to 'make a positive difference'. This lies at the heart of the Bangkok Charter's key commitments - to make the promotion of health central to the global development agenda, and to make it a core responsibility for all of government. It also means ensuring that there are sufficient financial and human resources invested over time.

Building the capacity of diverse communities to engage in the development of public policy and to assess progress in promoting health

Working with communities has been one of the major strengths of health promotion to date and there are many examples of community-driven action to promote health and well-being. However, for the future, working with communities that have been marginalized by and from society's decision-making structures and processes to build their capacity to participate will be required. There are examples of countries beginning to build such capacity on a large scale. [UK 2004]

Identifying and challenging discrimination on the basis of race, gender, language, religion, culture, disability or sexuality will be a vital component of the capacity necessary to promote health. Adding cultural competence to the skills required by all health professionals, including health promotion professionals, is one necessary step. [IOM, 2003]. However, investing in research to identify the discriminatory policies and practices of institutions and their agents [Jones, 2002] is a further necessary element of the capacity needed to ensure the Health for All is achieved, genuinely.

Evidence of the relationship between a proposed policy decision and the health of the population. Health impact assessment has been evolving as one technology to provide such evidence and to assist policy makers to devise policy that has a positive impact on health (or that minimizes risks to health).

Active engagement in social decision-making - at national and local levels. This implies that organisations and individuals with a mandate to promote health have the organizational capacity, the knowledge, skills and evidence with which to participate actively in the processes used to make decisions about the social determinants of health. This will mean adding theories, evidence and skills from the disciplines of political science and political economy to those that already comprise the capacity required by individuals and organisations to promote health.

Building capacity to promote health within other disciplines and sectors - working from the inside out. The contributions of government sectors other than health, of most private sector organisations, and of much of civil society to promoting health are not, necessarily, identified as such, nor need they be. For example, the entertainment industry contributes to health not only through the creation or transmission of 'health information' but, perhaps more powerfully, through its employment policies and practices, its energy and waste disposal practices, and through its role modeling of achievement and its ability to create positive social and cultural environments for young people, in particular.

Or, to take a contemporary example, the employment practices, working conditions, and environmental policies of industries such as clothing and footwear clearly have significant influence on the health, not only of employees but surrounding communities.

Examples such as these highlight the interdependence of sectors in achieving their goals - employers require healthy workers, the market requires healthy consumers, and all citizens require living and working environments, and access to products and services that are

conducive to health. Generating new ways of conceptualizing and teaching about this interdependence is a further step in expanding nations and localities capacity to promote health.

As well, however, it will be necessary to expand the capacity of the health sector, in particular, to **work in partnerships and alliances** with other sectors to achieve specific health goals. Here, the focus is on establishing relationships that are sufficiently robust over sufficient time to enable them to achieve specific purposes - such as, for example, a change in the policy re the sale of tobacco products to young people; or establishing criteria for 'healthy food' to be offered by a fast food provider; or developing a planned education program for patients with a chronic condition.

In a globalising world, it will be necessary for governments (perhaps largely through their health sectors) **to form alliances** to address global health problems created by the decisions of global organisations, to contribute to the development of global agreements (e.g. the Millenium Development goals). Civil society, too, will require increasing capacity to negotiate, as equal partners, with the major global and national decision-making bodies responsible for decisions influencing health. The People's Health Movement is one example of a global alliance of 'ordinary' people. There are many other examples of such alliances in areas such as the environment, the rights of Indigenous peoples, or the rights of women.

In conclusion

Capacity is the ability to carry out stated objectives (Goodman, et al., 1998). In other words, in any area of human endeavour, the objectives determine the elements, quantity, quality, and location of the capacity required to achieve the objectives.

Health promotion, at the applied level, has evolved as a technology to identify and solve problems and to enable governments, organisations and people to achieve their objectives.

It has demonstrated that it is an effective methodology to analyse problems, identify their causes or determinants, and to propose and implement solutions. Used in this sense, therefore, the methodology that underpins effective health promotion may be defined as the capacity to promote health.

The objective is, therefore, all important. The capacity required to improve average life expectancy is different from the capacity required to reduce biological or behavioural risks to health. And the capacity required to prevent the onset of disease, or to prevent injury, or to create conditions in which all people have equal opportunities to achieve and maintain good health is different, again.

The Bangkok Charter has framed objectives for this current phase of health promotion in terms of addressing the social determinants of health with the dual purposes of creating social, economic and physical conditions conducive to health, and to achieve health equity.

Much has been learned about the capacity to promote health over the last three decades. Building on and expanding this capacity is our challenge for the future because, although we have achieved much, it is very clear that much more is needed. We need to set more ambitious goals, and to become more ambitious in our efforts to achieve these. Health promotion, as a profession, has evolved as an 'outsider' whose work has focused on reacting or responding to problems created by others.

But the challenges ahead mean that it is necessary to set a new, more ambitious agenda for action, to expand the capacity available to our societies to build a world in which families, communities, and nations can and do provide all people with the living, working, recreational and spiritual conditions that we need to become and stay healthy.

'The matching of capacity to a desired level of action is the art upon which many enterprises succeed or fail. For example, it is a serious mismatch if a car manufacturer

wishes to produce Fords and has the capacity to produce Porsches, or vice-versa.' [Mittelmark et al, 2005]. The Bangkok Charter has identified a new set of objectives. It is our responsibility, now, to develop the capacity to achieve these. This will mean 'tuning' and expanding capacity to achieve the level of action aspired to. [Mittelmark, et al, 2005.]

This paper presents some ideas about what such capacity might be, based on analysis of the implications of the Bangkok Charter. These ideas are for discussion and debate. What is clear, is that the capacity required to promote health is not only strategic and technical; it is also political and personal. Values and evidence must be joined with policy and power, and honed in the fire of political debate. The future of our world depends upon it.

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〈국문요약〉

국가 및 지역단위 건강증진정책 개발: 건강증진을 위한 국가차원과 지역차원의 역량 강화

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역량(capacity)이란 진술된 목표를 수행할 수 있는 능력을 의미하므로, 목표란 그 목표를 성취하기 위해서 요구되는 역량의 구체적 요소, 양, 질, 그리고 역량의 소재를 결정한다.

건강증진이란 문제를 파악하고 해결하기 위한, 그리고 조직이나 사람들이 그들의 목표를 성취하기 위한 응용과학으로 발전되어 왔다. 문제를 분석하고, 문제의 원인이나 결정요인들을 파악하고, 그리고 해결책을 제시하고 이를 실행하는데 있어 효과적인 방법론이 중요하다는 점도 또한 밝혀졌다. 그러므로 효과적인 건강증진의 토대가 되는 방법론은 건강을 증진을 위한 역량으로 정의될 수 있을 것이다.

목표는 매우 중요한 역할을 한다. 평균 기대수명을 향상시키는데 요구되는 능력은 생물학적인 그리고 행동적 건강위험을 감소시키는데 필요한 능력과는 다르다. 그리고 질병의 발생을 예방하고, 또는 상해를 예방하거나 모든 사람들이 좋은 건강상태를 얻고 유지하는데 동등한 기회를 갖는 환경을 조성하는 능력도 다른 특성을 지닌다.

방콕헌장은 현 단계의 건강증진을 위하여 건강에 대한 사회적 결정요인에 대한 해결책과 더불어 건강에 도움이 되는 사회적, 경제적, 그리고 물리적 환경을 조성하여 건강형평성을 달성하고자 하는 목표를 설정하고 있다.

지난 30년간 건강증진을 위한 역량에 대하여 많은 것들을 배울 수 있었다. 이러한 역량을 기르고 확대하는 것이 미래를 위한 도전과제가 되며, 비록 우리가 성취한 것이 많지는 않을지라도, 더 많은 것들이 필요하다는 점은 명백해졌다. 우리는 좀 더 야심 찬 목적을 가져야 하며, 이러한 목적달성을 위하려 좀더 의욕적인 노력을 해야 할 것이다. 전문분야로서 건강증진은 다른 사람들에 의하여 발생된 문제에 대한 대책이나 반응에만 중점을 둔 이방인으로서의 역할을 해왔다. 그러나 우리가 도전해야 할 과제는 좀 더 새롭고, 더욱 야심 찬 활동계획을 설정하고 우리가 건강해지고 건강을 유지하는데 필요한 생활환경, 작업환경, 여가환경, 영적 환경을 모든 사람들에게 제공할 수 있는 가족, 지역사회, 그리고 국가가 있는 세계를 만드는 우리사회의 능력들을 신장하는 것이다.

방콕 헌장은 건강증진을 위한 새로운 일련의 목표들을 제시하고 있다. 이제 이러한 목표를 성취할 수 있도록 역량을 기르는 것은 우리의 책임이 되었다. 이는 원하는 활동수준을 달성하기 위한 역량을 조율하고 확장시키는 것을 의미할 것이다. 구체적으로 기존의 건강증진효과성에 관한 증거들을 좀더 큰 규모의 사업으로 확대시키는 것, 공공정책을 개발하고 건강증진 상태를 평가하는 데 다양한 지역사회의 참여를 촉진시키는 능력, 언어, 인종, 성, 종교, 장애 등과 관련된 건강형평성의 문제를 파악하고 제거하는 노력, 그리고 정책결정과 인구집단의 건강과의 관련성에 대한 증거수집, 국가와 지역차원에서 사회적 의사결정 과정에의 적극적 참여, 다른 부문과의 건강증진을 위한 협력 등이 포함된다고 볼 수 있다.

본 논문은 방콕헌장을 분석함으로써 이러한 역량이란 무엇인가에 대한 본인의 의견을 제시하였다. 이러한 아이디어는 토론과 논쟁을 위하여 제시된 것이다. 명백한 것은 건강증진을 위한 역량은 전략이나 기술적인 능력 뿐 만이 아니라 정치적 능력이나 개인적인 능력도 포함된다는 점이다. 가치와 증거들이 정책이나 권력과 함께 결합되어야 하며, 정치적인 논쟁 속에서 연마되어야 한다. 우리세계의 미래는 역량에 의존하기 때문이다.