

hard”, only that solutions to the issues raised by Mooney are complex and complex solutions are hard to market. We live in an era where particular solutions tend to proliferate because they are simple, not because they are right.

We must move in (at least) two directions. Those of us who see ourselves primarily as ‘empirical workers’, i.e. conducting studies with quantitative outcomes, should quickly come to recognise the values and theory that remain largely unacknowledged in our work.<sup>5</sup> Those of us who see ourselves as change agents or social justice advocates should inspect the practice ethics and professional stance that have been articulated by workers in such areas as community development, anthropology, sociology and social program evaluation (if they have not already done so).<sup>6</sup> Much of this work comes from qualitative researchers whose research takes them closer to people’s experiences than happens in population surveys. Listening and acting on community voices is not as simple as it might seem. For example, the group that asks us into a community may be the most advantaged and least in need of our assistance. How do we protect the interests of the most vulnerable, especially when the most vulnerable can be defined in a variety of ways? To whom are we accountable when we are working ‘invisibly’ to strengthen Indigenous skills?<sup>7</sup> How do we react when communities express interest in pursuing values that we consider oppressive or intolerant of diversity?

Mooney is right that we should be making a lot of noise about these issues. However, the response should be orchestrated and well synthesised. Otherwise, new voices will be lost in the wind.

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## Public health ethics and the limits of evidence

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Medicine has generally been characterised by reductionism, by adherence to the traditional empiricist distinctions between facts and values, reason and emotion, objectivity and subjectivity and pure and applied science and by a commitment to observation and measurement. In recent years, medicine, and public health in particular, have become preoccupied with economics and the

quantification of health outcomes and values in economic terms. While this has helped make the focus on resource allocation more substantial and promoted efficiency, it has also implicitly encouraged the belief that lack of evidence means lack of value.

Unfortunately, EBM and EBPH do not provide a sufficient model for decision-making as many current outcome measures are inadequate, many outcomes, such as social justice, may not be measurable and others, such as happiness, may not even be adequately definable. Even if these difficulties can be overcome, there is no reason to believe that the presence of more evidence, in itself, will ensure that ‘better’ decisions will be made.

Public health decisions are ultimately ethical decisions. They are intrinsically and unavoidably value-laden. If we accept that this is the case then there is no alternative but to elucidate each of the perspectives that may enrich our decisions and clarify our notions of both individual health and community health. This means seeking out the silent voices of those who have been left behind by the industrial, social and economic reforms of the 1990s. Those whose only ‘capital’ is their body or their labour, Indigenous Australians, the working class and the unemployed currently have no voice in the public health debate. Their exclusion is our failure.

If we are to generate more equitable or more ethical public health decisions that are generalisable beyond individuals or individual communities, then we must attempt to clarify the values that underpin different perspectives on health care delivery. For while we may find that different communities differ widely in their beliefs as to what should be delivered by society, by government or by the health system, we may also find that there are shared human perspectives regarding the values that should underpin public health. Indeed, we may find that communities share values such as equity, mutual respect and care and that they value these more highly than economic or scientific imperatives.

In many ways, Gavin Mooney provides a preliminary answer to his own challenge. First, we must be open to listen and to learn and not be constrained by professional, academic or bureaucratic boundaries. Second, we must consider broadly the stakeholders in public health, particularly those who are disenfranchised, and seek a mutually respectful relationship with them which allows them to be heard. Finally, there should be genuine reflection on the values and fundamental principles underlying people’s conceptions of themselves and the society and health system they desire.

## What value is public health?

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Public health must emphasise the needs of groups with low socio-economic status because they have such high mortality and morbidity. As any serious attempt to improve the health of a population must focus on those with the worst health outcomes, public health has to be preoccupied by those health issues which are particularly important for low income groups.

There are perfectly legitimate reasons for major parties on both

sides of politics to strongly support public health approaches. Recognising the long-term high cost of poorly managed major public health issues, conservatives might be attracted to support population health because of a strong desire to minimise public expenditure. Their political opponents might act on the grounds that advocacy for public health inevitably represents support for their natural constituency.

Nothing is value free. Public health is no exception. A strong emphasis on social justice and human rights must be the basis of public health endeavours because improving the health of socially disadvantaged groups is at the core of population health. As Jonathan Mann<sup>1</sup> showed so eloquently, public health and human rights are indivisible. A concern about environmental degradation follows because disadvantaged groups are least able to avoid environmental threats to their health. There are real risks of broadening the range of concerns for public health practitioners. It is increasingly difficult to maintain an expertise in any single discipline.

The public health practitioner who accepts a broad canvas runs the risk of appearing to advocate for some issues with less than optimal expertise. The more issues accepted, the more support for each issue is diluted. Gavin Mooney is right to express concern about the shortcomings of a pre-occupation with quantification. But public health is first and foremost a scientific activity and measurement is the very bed-rock of science. An emphasis on policy and practice based on measurement has risks especially, as is often the case, when some of the important parameters cannot yet be measured for technical reasons. But what is the alternative? Better to base policy and practice on an imperfect set of measures than to rely entirely on subjective assessments.

The values of public health are usually assumed to be altruistic. While this is probably true, more selfish arguments for public health actions are often more persuasive. For example, it is easier to convince the general community of the need for needle syringe programs for the good of the entire population than when arguments are just based on the need to preserve the health of injecting drug users. Also, medical students readily accept the need to maintain excellent control of tuberculosis among disadvantaged populations when it is explained that health care professionals are among the earliest casualties of poorly controlled tuberculosis in a community.

Values clarification is an essential part of teaching about public health. Discussion of well-selected cases in small groups helps students understand principles in a way that didactic teaching cannot. Mooney is also right to emphasise the dismal public health outcomes of Indigenous populations as the central issue of public health in Australia. It is easy to offer excellent health care and achieve outstanding outcomes for the privileged. The real test of both clinical medicine and public health is the standards and outcomes achieved among the most disadvantaged. The health care and public health outcomes achieved among Indigenous Australians are an international as well as a national outrage.

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## Social equity is the key to effective public health

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We will always disagree on matters of value in public health. What matters to one person differs from the next. Our values are the product of our family, history and environment. A satisfactory outcome for any particular group requires insider knowledge of the needs of that group, and the skills of a professional to be applied to the problem. The power of the public health sector is its ability to focus on the identified problems and to mobilise collective resources towards a solution. Our weakness lies in that we do not have sufficient 'insider knowledge' to identify the needs.

Recently, I was chatting with a fellow student, who has diabetes, about how little funding there is for scientific research. He stopped me mid-spiel and pointed out that however little funding there is for this type of medical research, there is even less money spent to help diabetics live as full a life as possible. "I need research done to find out how I, as a diabetic, can deal with everyday life better. It is too late, for *me*, to prevent this disease." As a young person, he felt that his needs were not being met, he wasn't being heard and nobody was interested in listening. How do we know we are asking the right questions if we haven't walked in their shoes?

Those people who perhaps need the most are the least likely to express that need, especially to public health professionals whom they feel can not understand their position. Powerful interests will always be heard, while the disempowered will remain silent and their needs will not be met. Indigenous Australians, young people, the elderly and migrants are some of the groups under-represented in the system, because their voices are often quiet or not listened to. I think it is not surprising that people feel inherent distrust in an institution that is not representative of the community groups it is attempting to service. Inequity breeds distrust in institutions. The rich and powerful feel safer within the system, and are therefore more able to have their voices heard and their needs met.

The means of bettering the health of many Australians is not through more and more technology, but through ensuring that the basic needs of all are met. Providing an environment where people feel they can express their needs is important. This is more than a struggle just for health, but for social equity.

## Public health: just processes?

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As public health increasingly accepts the dominant politico-scientific ideology, I too am concerned that the deprived in our society are being insidiously forgotten. Individualistic cures will not solve the problems of social structure, social disintegration and lack of social capital.

When market forces and individualism predominate, public