A postmodern public health?

Of late, a number of writers have employed the adjective 'postmodern' to describe certain aspects of contemporary public health.[1,2] What is meant by this term, and what does it mean for public health scholarship and practice? One major difficulty with 'postmodern' as a concept is that it is used in complex and confusing ways, often to denote quite different theoretical and political approaches. Sometimes it is conflated with poststructuralism, a theoretical approach that directs attention towards the use of language in the constitution of selfhood and notions of reality.[3] Such a conflation of usage serves to ignore the fact that those who adopt the use of poststructuralist theory would not necessarily regard themselves also as postmodern, and vice versa.

So too, the relationship of modernity with postmodernity is a point of debate in the theoretical literature. The term 'modernity' is generally used to describe the outcome of the processes of modernisation, or the social, economic and political changes taking place in Europe in the eighteenth and nineteenth centuries. These include a turning away from religion towards science and the processes of industrialisation, urbanisation and mechanisation. Modernity depends upon the notion that the key to human progress is objective knowledge of the world through scientific exploration and rationalised thinking and action. As I use the term here, modernity differs from 'modernism', which is generally more narrowly used to refer to an avant-garde movement in the arts that emerged at the end of the nineteenth century and carried on into the mid-twentieth century, concerned with challenging conventional styles of representation.

There are various interpretations in the literature of the major features of postmodernity, the period following modernity. For some theorists, postmodernity represents a rupture, or break, with modernity, while for others it remains a later development of modernity, and thus should more appropriately be termed 'late modernity'. Most agree, however, that post–late modernity is characterised above all by a growing sense of the failed promises of early modernity and a tendency to challenge the key universalisms and essentialisms of this period, particularly those that unproblematically view science and medicine as the vanguards of progression, and that support homogeneity and unity over fragmentation and difference. Here again a distinction may be drawn between 'postmodernity' and 'postmodernism', with the latter term defined as describing more specifically the late twentieth-century aesthetic reaction to modernism in the arts.

In general terms, therefore, the postmodern perspective, to a greater or lesser degree, is seen to be about a questioning of established thought, values and practice, a cynicism towards the naive beliefs of modernity and its lack of self-critique. Thus, Smart defines postmodernity as 'a more modest modernity, a sign of modernity having come to terms with its own limits and limitations'.[4]

The political basis of the postmodern position is also a point of contention in the literature. There is disagreement among theorists about whether the postmodern perspective is ultimately conservative, a 'culture of eclecticism which celebrates the status quo', a nihilistic rejection of ethical principles and truth claims, or whether there is also the space for an affirmative and critical postmodern position that still draws on ethical principles.[4] Rather than deciding that the postmodern is discretely one or another approach, it is perhaps more useful to accept that there is a continuum of postmodern perspectives, ranging from the highly relativist and politically nihilistic (the 'strong' program that tends to be identified with European scholars) to a postmodern approach that embraces principled positions and recognises some universal moral values and truth claims (the 'weak' program, identified with Anglocentric scholarship).[5,6] This latter approach tends to incorporate progressivist or oppositional stances, particularly in the context of feminist critiques and other social movements seeking emancipation and social equality, such as the gay, black and civil rights movements.

A postmodern position, therefore, is not necessarily one that avoids any adherence to values such as democracy, equality and social justice. However, those who adopt it will probably be always cautious and sceptical about accepting values on their face terms and want to look closely to see who might be using them to further their own interests. As Nicholson has put it:

> ... there is no reason why a postmodernist could not appeal, for example, to the very same values of equality or liberty that a modernist might appeal to in defending his or her political stance. The difference is that while the modernist would believe such values to be grounded outside of human history, in the human condition or society as such, the postmodernist has given up on that belief.[7]

How might such approaches be seen to have been incorporated into public health? The most relativist of postmodern perspectives would simply decry the use of any kind of universalising approach to public health, calling into the question the notion of 'health' itself and seeking to destabilise the assumption in all public health endeavours that 'health' should be privileged over other aspects of life. This more extreme end of the postmodern spectrum of thought, however, is rarely found in analyses of public health. The meanings that are ascribed to 'good health' as a universal social good and individual right are rarely challenged, even by the most trenchant critics of public health practices.

The clear challenges to features of the practice of biomedicine, an archetypal modernist institution, evident in many of the discourses of contemporary public health, including 'the new public health', may be described as evidence of a postmodern critique towards the progressive claims of modernity. Rosenau, for example, labels such strategies as community participation, the consumer health movement, 'holistic' health promotion and the adoption of alternative therapies as postmodern.[1] Kelly and Charlton also see health promotion as a particularly postmodern activity, singling out its rejection of medical science as the primary basis for action: its

emphasis on a social model of health; its broad conception of health which incorporates aspects other than the purely biomedical; and its focus on empowerment and community action for health improvements, as its principal postmodern characteristics.[2]

On the other hand, however, it may be argued that the vast network of expertise and bureaucratic organisation that has developed around the problem of public health over the past two centuries remains firmly wedded to, and indeed, inextricably embedded in, the principles of modernist approaches to public health.[8,9] Dominant features of public health, such as epidemiology and the emphasis on personal responsibility for health evident in health promotion and community participation remain underpinned by traditional modernist ideals and practices. Medical, scientific, epidemiological and social scientific knowledges are routinely employed as unchallengeable 'truths' to construct public health 'problems' and find solutions for dealing with them. The current obsession for identifying 'goals' and 'targets' for health 'outcomes' (that can be specifically enumerated, measured and evaluated) is a highly modernist approach to managing public health. Health economics, currently a reigning sub-field in public health because of the promises it offers in rationalising health spending, is a quintessentially modernist enterprise.

While some practices of medicine and public health may be currently challenged by community advocacy groups, this is not in itself a particularly postmodern feature. In the nineteenth century, for example, there was vociferous community critique of, and opposition to, efforts on the part of western governments to vaccinate children against smallpox.[8] Nor do the new social movements, so trenchant in their opposition to some aspects of science and medicine, reject altogether the knowledges offered by modernist institutions. The environmental movement, for example, relies for its own truth claims upon the expert knowledges of sciences such as toxicology, meteorology, ecology and biology, while feminist and gay health activist groups both critique biomedicine as well as continually call for greater access for their constituents to the benefits offered by biomedicine.

Further, although the rhetoric of the new public health champions community involvement, in most public health endeavours professional expertise remains privileged over lay expertise. This is highly evident in health educational advice to populations on how they should regulate their lives to achieve good health. The current Commonwealth Department of Health mass media campaign exhorting smokers to give up their habit, for example, using revolting images of internal organs clogged with gunk and harshly-lit faces of smokers making them appear like living corpses, is highly coercive in its use of shock and fear tactics. Such campaigns go well beyond simply 'giving people the facts' so as to encourage them to voluntarily change their behaviour, retaining the paternalism that was a dominant feature of nineteenth-century public health. They single out a specific social group ('smokers') as the stigmatised 'other', requiring surveillance and discipline on the part of public health authorities.

There is little recognition in such campaigns that individuals may possess rationales for continuing to smoke that they value over any health improvements that giving up the habit might allow them. 'Good health', as it is defined by experts, continues to be privileged over these other rationales. The 'needs' or 'wants' of this particular 'community' are here discounted as irrelevant and ignorant, as barriers to public health goals. The notion of the 'ideal citizen' as taking active steps to avoid ill-health for both personal and the public good is dominant in such campaigns (and virtually all other public health strategies) to the exclusion of other notions of citizenship. So too, ideas about 'the community' and the 'healthy city' in the new public health are often universalistic, tending not to acknowledge the differences between social groups within units that are defined as 'communities' or 'cities'.[8,9]

If it is understood that selfhood and social identity are fragmented, dynamic and contextually-based, as is argued in much of the postmodern literature, it is difficult to continue to argue that individuals share fixed concerns related to membership of defined social groups. A social category is never homogeneous and itself is characterised by differences of experience and access to resources. However many times statistics may be used to show patterns, these always cover up difference. Social groups are not discrete or mutually exclusive entities but overlap with each other, involving multiple membership. There are competing interests and needs within as well as between social groups that cannot necessarily be reconciled.

Challenges to the central ideals and tenets of public health are often met with scorn and hostility by those working within or researching the field. Postmodernist theory for some is regarded as impenetrable, irrelevant or useless, drawing attention away from the main issues and concerns in public health. Advocates of modernist principles may claim that to continue to scientifically measure health indicators, social disadvantage and access to health care; to rationally develop and use expert knowledge to advise populations about how best to prevent ill health; to calculate the most effective use of limited health care and preventive health resources, should all be regarded as important, if not *the* most important endeavours of public health. The trouble with such a position is that it ignores the important problems of such approaches identified by postmodern critics, some of which have been outlined above.

Like it or not, public health at the end of the twentieth century is positioned inextricably within a context of uncertainty, as is 'the public' with whom it concerns itself. In a social, economic and political context in which there has been a continuing undermining of modernist truths, a sense of growing disorder and an emerging distrust of social institutions and traditional authorities on the part of the public,[10] an unexamined modernist approach to public health is no longer tenable. The 'limits and limitations' of public health need to be acknowledged. I

am not championing a wholesale turn towards postmodern perspectives as the way forward for public health. However, some awareness of, and debate about, the postmodern critique as it relates to public health may go some way to formulating important questions (if not necessarily neat answers) about the future direction of the field.

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Hepatitis C, prisons, and public health

Although acknowledging that hepatitis C (HCV) is more prevalent than HIV, the National HIV–AIDS Strategy 1996–1997 to 1998–1999.[1] conceptualises it as one of several markers of HIV risk behaviour. HCV prevalence in the Australian population is estimated to be slightly over one per cent, with 91 per cent of all new infections occurring among injecting drug users (IDU). Sexual transmission is rare, and appears to occur only in conditions of viraemia. This contrasts with Australian HIV transmission patterns, where over 80 per cent of new cases occur among homosexually active men, and prevalence among IDU is approximately two per cent.

Differences between HIV and HCV are probably nowhere more obvious than in prisons, where the demographics of the prison population highlight the differences in epidemiology of both epidemics. As early as 1992 it was evident that HIV prevalence among prison entrants reflected infection rates among IDU in the community, rather than rates among men who have sex with men.[2] While HIV transmission has been documented within prisons, and undoubtedly will continue to occur, the viral pool among inmates apparently has not yet reached such a critical level as to precipitate an epidemic explosion, and prevalence probably remains similar to that among IDU.

The link between drug use, prisons and HCV is forged and mediated by the fact that recreational drug use is designated as criminal behaviour. About half of the general prison population in New South Wales has a history of injecting drugs.[3] A recent study of IDU in a number of Australian cities found that 38 per cent had served a prison sentence; one third of those had injected drugs while in prison; and 60 per cent of those who injected shared needles.[4] One third of men, and two thirds of women, test positive for HCV antibodies on reception into prison, and of those who are HCV-positive, 60 per cent are also positive for HCV RNA by polymerase chain reaction. The infection rate among prisoners at time of release is not known but it can reasonably be assumed to be higher than at reception. Over 80 per cent of HCV-positive inmates report a history of injecting illicit drugs;[5] some continue to inject while incarcerated; and some inmates are introduced to injecting while in jail. Injecting equipment in prisons is contraband, scarce, and inevitably shared, and there is little incentive to clean needles and syringes because surveillance policies induce a need for secrecy and speed to avoid detection and punishment. IDU may inject less frequently while in prison than they do outside jail, but when they do inject they are likely to be forced into equipment sharing networks, among whom the majority of members are likely to be already HCV-positive.

In New South Wales, the Department of Corrective Services provides drug and alcohol counselling and information for inmates, but does not subscribe to harm minimisation measures such as safe injecting areas or needle and syringe exchanges. It vigorously pursues a policy of surveillance and prosecution, with the aim of achieving drug-free prisons—arguably an impossibility, and contrary to the harm minimisation approach to containing blood-borne communicable diseases which has been demonstrably successful in minimising HIV infections among IDU.

Prison drug policies can modify both frequency and patterns of drug use. Cannabis is more difficult to obtain in gaol than powder drugs, because trafficking is easier to detect, and it is less profitable to import per unit volume. Cannabis is detectable through urinalysis for far longer than heroin is, so prisoners are more likely to use the less preferred, but more readily available drug. This leads to the anomalous situation where cannabis, which is smoked and therefore safer in terms of viral transmission, is currently subject to heavier disincentives to its use than heroin and other injectable drugs, which represent the highest of all risks for HCV transmission. The direct consequence of attempts to eradicate drugs and injecting equipment from prisons, is an escalation of the health risks associated with injecting.

Concentrating IDU in an environment where treatment programs may be more difficult to access than drugs, where injecting equipment is shared between many users, where placement on the