Policy Agendas and Path Dependency:

A former bureaucrat accounts for the re-making of HIV in NSW

Thanks for the introduction and for the invitation to be here. I acknowledge the traditional owners of the land we are meeting on and pay my respects to elders past and present. I'd also like to acknowledge my Aboriginal sexual health worker colleagues who are here today.

It's my very great pleasure to have been invited to give this lecture and in doing so, to honour the memory of the late and esteemed Dr Brett Tindall who was such a large part of the Kirby Institute's formative years. I never had the pleasure of meeting Brett, but of course I knew *of* him. Even in the distant land of Queensland where I lived at the time we knew of Brett – of his work with the then National Centre from the mid-80s until his death in 1994. By the early 1990s when Brett was so central to the life of the National Centre, I was on my own journey: coming out, discovering community and friendship and, also, the horrors of HIV and what it was doing to our community. I got angry and I got involved because we were losing people like Brett.

Garrett Prestage, in paying tribute to Brett at last year's symposium, makes me very much wish I had known him. Garrett says he was passionate, outspoken, full of energy, committed, irreverent, cheeky and sexy. Garrett is decidedly emphatic on this last point. He also says Brett was a cornerstone of the Partnership – understanding it and its needs, understanding how science must take its place within it. At his funeral, a letter Brett had prepared before his death was read out and, as he draws to his conclusion, Brett says "What else can I say? I know bits of me will live on in each of you as part of your memories of our wonderful shared experiences." What better way to celebrate those memories and Brett's memory than through this annual public lecture.

So with those thoughts, let me begin.

Public policy is everywhere. It is here in this room. If public policy is an expression of commitment, then we see here, in this room, the commitment of governments to providing world-class higher education, to learning, to knowledge. We see here their commitment to the welfare state, providing us with assurances of retirement income and superannuation. There is the commitment to labour market regulation, so that there are processes for setting our wages and conditions. There is commitment to planning and building codes, to make sure this building is safe. Government is active. Politicians – the public face of government – are active. And busy. And everywhere. We see government at work in the attendance here this morning of Minister Skinner and in her outstanding leadership in HIV – leadership that will be remembered.

It's a bit too simple to say politicians make policy and bureaucrats implement it. But it fits well enough for my starting point today. As a public servant I get to deliver on a government's commitments. On its priorities. On its agenda. My professional practice is public administration. And today, it's both public policy *and* public administration, that I'd like to discuss.

But I'll start with public administration; with bureaucrats and their indiscernible arts. Once we've toured that place, I'll take you back into the light, with a brief scoot through the early history of HIV. From there we venture into theory – to political science – to consider various ways of thinking about and of explaining recent HIV policy change. In my 14 years as a HIV bureaucrat, I never gave a presentation that didn't conclude with the Partnership, and so that's where I'll end my story, both for today and in my career as a HIV bureaucrat. Many of

you will know that I have recently resigned from the Ministry and now work in a new field – mental health. It's a strange thing for me today to feel like I'm on the outside of the HIV Partnership, gazing back in, but it gives me some luxury to comment as a former insider, a former bureaucrat, and to speak in a way that a Ministry official cannot.

So where are we then. It's Thursday afternoon, the weekend isn't far away, you're freshly fed and watered, you're in the warmth of this theatre on a cold winter's day, and so you might be feeling kindly. You might be reflecting at this point on the positives. On what government and its bureaucratic operatives have delivered. We live in a beautiful city. Crime isn't too bad. We've got a good education system. We live to a ripe old age. And on social inequality, we're not at the top of the league table, but we're very far from the bottom.

Or perhaps you take a dimmer view. Perhaps for you the state is merely a servant of capital, correcting the excesses of the market only to such an extent as to ensure its survival. But that's too glum a view for a lecture among friends, so let's keep our glass half full and stick with the proposition that public administration is a more salutary affair: the state serving the people through the delivery of public value.

Bureaucrats are their own class of public servant. In Westminster systems they're part of the government's Executive arm: neither the political class nor the front-line of nurses, teachers and bus drivers. James Button, writing about his time working for Kevin Rudd, described political speechwriting as a job poised somewhere between dreams and delivery. But I think this is a poetic and unbureaucratic description of a bureaucrat's job as well. At the very least, I think it's a good description of what HIV bureaucrats in NSW have tried to do since the very early days.

By 1999, I'd left Brisbane and stopped being so angry. But I was still driven. I still wanted to do something. And so having worked in the community sector around the country I now took the next step. To the bureaucracy. I packed my bags and moved to NSW without a job but determined to work for the NSW Department of Health. It was, according to people I trusted, the last remaining bureaucracy that was deeply invested in HIV problem-solving. I stepped through the doors of the Department on 19 April 1999. Ross Duffin, who is usually so infuriatingly correct was absolutely wrong on this point: he said I'd hate the place. He believed I'd never tolerate the tedium, the paper-pushing, the minutia that is core to all public administration, and which must be overcome in order to do the good stuff, the stuff that will make the difference. He was wrong.

So, what did I find when I walked through those doors. Behind the facade – and bureaucracy does nothing better than to mask its inner workings – what kind of world are public administrators operating in? What's it like in that ivory tower. What forces are at work to shape a public administrators actions? There are many. Let's start at the very top.

We work within policy paradigms that are taken as given – background assumptions that shape every public administrator's options, but which are so foundational as to implicit. Democracy is one and capitalism is another. No internal briefing by a public administrator makes mention of these things, but they're there nonetheless.

At the meso-level and still operating outside the need for internal naming are other influences: our Westminster political system; persistent policy regimes and ideas such as neo-liberalism and risk culture; the forces of technological change and possibility; the rise of the knowledge economy; and of course the media and its endless news cycle. The workings of public administration are also shaped by our changing society – post-materialism and

urbanisation, by notions of citizenship and society's increased expectations of government, particularly the idea that government can and should solve social problems.

And then finally, closest to home, are micro-level forces: administrative structures and powers within which a bureaucrat operates. Are they in the bowels of a weak line agency or working with the prestige and helicopter privileges of central agency command? There is hierarchy. There is always hierarchy. There are government priorities at work – is your portfolio in fashion or out? There are Ministerial advisors – are they standing in front of you or backing you all the way? There is money – sometimes. Often times, not. Resource-scarcity is the default and efficiency the imperative. There are reforms – endless transitions to new administrative processes, restructures upon restructures, centralisation and de-centralisation cycles – each one of which must occupy the mind: they shift the balances of power, they must be attended to if for no other reason than to retain your program's foothold, or your own. There's the New Public Management that gave us contracting out, marketisation and efficiency, and now there's the New Public Governance, which gives us networked governance and banal slogans like 'government is there to steer, not row'. There's the fashions and fads – but you never know which will stay and which will fade – so they all must be watched and managed. Inputs are out. Outputs are in. Outcomes too. The bureaucracy, even though not evidently so, is always in transition. And then there is bounded rationality – simply, do you have enough oxygen, enough stamina, enough mongrel, to do good deeds given the task volume and problem complexity you face. When the in-tray is full and your mind is at the limits of its capacity, what can you get to once you've done the mindless things that must be done? The myth of small armies of bureaucrats labouring over minutia is just that. A myth. Except when it's the exception to the rule. In which case it's an anecdote or a story in the *Daily Telegraph*. But by and large it's a myth and OECD data shows Australia's public sector to be both small and cheap.

So we have at work a range of forces, large and small, that variously constrain and enable public administration practice and that shape the options available. And that's to say nothing of the capabilities of the individual administrator – are they good at what they do? Are they skilled into turning the wheels of bureaucracy? Are they driven? And of course, there's also the small matter of the nature of the policy problem they're addressing.

So having started quite cheerily with the extraordinary pervasiveness of public administration in the social world – it's everywhere, and perhaps it's not too bad, and if it is bad, it could certainly be worse – I've turned to a bewildering array of forces that act against administrative action. We start to see now why policy regimes persist and why constancy is, well, constant. We start to see the frightening power of the path of least resistance. It would be a worry if this were all inadvertent or unintended. But many of these constraining forces are quite deliberate. There are good reasons for state and administrative power to be curbed. And there are many mechanisms at work to ensure that it is so. Indeed, one might begin to think that it is a wonder that anything is achieved at all by public administrators.

So what's the point of all this? Well, the point is that it's a wonder. The endless power and scope of the bureaucracy – its effects are felt in every corner of the social world – and the extraordinary forces that constrain it and that conspire to protect the status quo. And I'll return to the wonder of public administration and bureaucracy before I'm done today. But for now, here we are, in *A New Era* – the NSW HIV Strategy 2012-2015, with its pointed sub-title. If stasis is so ubiquitous and typical, how on earth did the policy changes wrought by the new HIV Strategy come about, and of course, why?

So to consider this, let me turn away from public administration to the matter of policy-making, of public policy, and how HIV got re-made in NSW. Because the story of HIV's recent policy history isn't just about bureaucrats. It's about politics and the re-entry to the Partnership of its most mysterious member – Government. And to tell that story, we need to return to the beginning, because what happens today is about what happened at the beginning – that's the concept of path dependency. Like a flow chart or a game of snakes and ladders, path dependency is the notion that what happens next depends on where you are now, and where you are now depends on where you were before. It's not a radical idea, in fact, it's really just a way for uncomfortable political scientists to avoid having to quote Karl Marx who of course told us that history is made "under circumstances existing already, given and transmitted from the past". There are seven characteristics of HIV's early history that I want to highlight.

First, in public policy terms, HIV is a recent phenomenon. It emerged dramatically in the early 1980s as a novel and rapidly fatal disease about which little was known. It quickly shifted from obscure medical reports to public recognition and shortly thereafter to the public policy agenda – that is, it became a problem for government.

Second, HIV spread rapidly. By the time the first cases were reported, large numbers of people were already infected.

Third, the early period of AIDS was characterised by widespread fears of contagion. In May 1985, Australia became the first nation in the world to introduce HIV testing of the blood supply. This provided public assurance that HIV transmission could at least be prevented by that mode, but it would take until the late 1980s for scientists to be certain about the full

range of modes by which HIV is (and isn't) transmitted and the effectiveness of prevention measures.

Fourth, in this environment of high public anxiety it was feared that HIV would inevitably spread to heterosexuals and that large numbers of people would be infected in countries such as Australia. 'Bridging populations', including bisexual people and sex workers, were particularly feared. In 1987, a high point of public anxiety, the 'Grim Reaper' television advertisement both contributed to and was reflective of these fears. The 'Grim Reaper' also represented a flashover point with the 'AIDS Crisis', as it was then ubiquitously known, shifting from the careful carriage of individual political actors more firmly onto Australia's formal policy agenda.

Fifth, by the time of this flashover, the communities that had been most affected by HIV had long been mobilised in educating themselves and in providing care for those with AIDS. In Australia, affected communities established AIDS Councils and other organisations during 1984 and 1985. These efforts preceded government action and offered governments a nascent architecture upon which 'solutions' could be built.

Sixth, the populations that were most affected by HIV posed a particular challenge for governments. In many Australian states, homosexuality was criminalised. Drug use continues to be criminalised today and the sex industry is heavily regulated. The modes of HIV transmission are intimate and generally private, involving sexual and drug using behaviours that governments have historically struggled to control. Unlike bacterial STIs, the effective control of HIV would require that those who were infected take steps for the remainder of their lives to protect others from infection. This public health problem tilted the promise of a successful long-term HIV prevention response away from the familiar and comfortable public

health realm of clinics and medical professionals into the community where the cooperative efforts of those infected and at-risk would be critical. The Australian Government recognised this profound problem in its Green Paper on HIV – *A Time to Care, A Time to Act*. This problem resulted in early policy efforts characterised by a respect for the human rights of those affected and a recognition of the inter-dependence of governments and affected communities in working jointly to respond to HIV.

Finally, as governments moved publicly to act on the threat of HIV, they did so by publicly embracing and building upon the efforts that had already been taken by those affected. While the threat of HIV continued to loom large and public anxiety remained high, Australia's early community and government cooperation and its effective protection of the blood supply led to the emergence of a discourse of 'success' in Australia's HIV response by as early as 1986. A principle of Partnership, reflecting the recognition of government and community inter-dependence, was also enshrined in national and jurisdictional HIV policy statements. And this principle of partnership – in David Cooper's eloquent terms, 'the enduring Partnership' – continues to be the primary principle of Australia's HIV response and figures centrally in HIV policy discourses. Partnership is a much more complex and elusive phenomena than we often acknowledge. A shifting mixture of demands, expectation and attitude, a series of institutional arrangements, a principle and ideological orientation, and a recognition of mutual interdependence – that is, that in the pursuit of our shared goals, each member of the Partnership must necessarily rely on the cooperation of other members of the partnership. And there's a curiously positive aspect to this recognition: Partnership in its full sense, as performed by the HIV sector, entails an investment in the success of others. For government to succeed in reducing HIV incidence, community must succeed. For medical professionals to succeed in getting the best for their patients, science must succeed. And so on. But what is

this famed, mythologised, unnatural, implausible and occasionally eulogised HIV Partnership in public policy terms?

Well, political scientists would say less romantically that it's a policy sub-system of state and societal actors and institutions that are concerned with policy-making and its implementation. Each actor brings to the policy process distinct perspectives, interests and values, including how they conceptualise the policy problem.

From its earliest days, Australia's HIV Partnership characterised the outcomes of its efforts as 'success'. They – or, rather, we – pointed to our high rates of HIV testing, our high rates of safe injecting and safe sex and, consequently, to our low rates of HIV incidence. Despite early fears, HIV has remained largely contained. This narrative of 'success' remained largely unchanged and unchallenged in the period between the first and sixth National HIV/AIDS Strategies. It forms the dominant narrative – the central story – of a special issue of NSW Health's *Public Health Bulletin*, published in 2010 and titled *HIV in NSW in 2010: Sustaining success in an evolving epidemic*. I proudly co-edited this publication with my Partnership colleagues – Andrew Grulich, Roger Garsia, Nic Parkhill and Kim Browne – and together we sang from different perspectives on the same songsheet – a beautiful harmony. But in 2011, the narrative of 'success' and the direction of NSW HIV policy changed quite suddenly and quite dramatically. And it is the story of this change, and how it occurred, that I will now explore.

There are any numbers of political science theories upon which we can draw to understand the recent history of HIV policy. I'll briefly overview a few, before turning to two of the more interesting ones in detail.

In Australia, the ‘policy cycle’ is the most popularly known of the major theories of policy-making and is widely cited by policy practitioners. We all know the cycle: analyse the problem utilising data and evidence. Formulate a policy. Consult. Make the policy decision. Execute your policy. Then evaluate to generate new evidence. And repeat. It’s a cycle. It starts and finishes with evidence.

Critics decry the policy cycle as overly rationalistic and not reflective of the ‘messiness’ of policy-making. Its lack of explanatory power is particularly criticised. Hal Colebatch perhaps best skewers the problem of the policy cycle. He describes it as a useful ‘account’ of policy-making – ouch. He says it gives policy-makers a way of describing their craft to others in ways that emphasise a concern for evidence, for rationality, for method. It gives policy-makers a way of feeling good about what they do, or more to the point, what they’ve done. Because that’s what the policy cycle approach is: a way of retrofitting the ‘messiness’ of what you did with something that suggests otherwise. Don’t be fooled: no public policy of any significance has ever been made using the policy cycle approach.

What other policy-making theories are there? There’s the advocacy coalition framework that emphasises the interactions and competition of advocacy coalitions within a policy subsystem.

Or there’s policy network analysis, that focuses on the inter-dependence, power relations and endless negotiation of beliefs and interests among actors within policy communities and issue networks.

Then there are the constructivists – who are quite likeable – who emphasise the role of language, meaning and power in agenda setting and policy-making. They draw attention to

the framing of issues and the ways in which these issues come to be defined as policy 'problems' or not seen to be problems, and that are therefore denied access to the policy agenda. For constuctivists, policy change occurs when problem definitions change.

And there are even theories of bureaucratic leadership, but it would be immodest for me to dwell there. So to consider more deeply the case of HIV policy, I want to turn to two theories that are primarily concerned with the agenda-setting stage of policy-making – that is, they seek to explain how particular issues make it on to the policy agenda and, once there, how decisions are made. The two theories are multiple streams theory and punctuated equilibrium.

Multiple streams theory was proposed by John Kingdon and draws on Cohen, March and Olsen's 'garbage can model' of solution selection. This theory holds that three largely independent streams shape the nature of policy output. Within the *problem* stream, changes in data and other forms of feedback provide signals to policy-makers about issues that may require policy action. Focusing events such as crises draw the attention of policy-makers and the public to issues, and in doing so, shift their status from 'conditions' to 'problems'. This in turn overcomes the bounded rationality of policy actors whose time and attention is limited by the crowded policy agenda and information load limits.

Operating alongside the problem stream is a *politics* stream shaped by public opinion, the influence of powerful external actors and the ideological agendas and predispositions of politicians. The third stream, the *policies* stream, includes the 'garbage can' of ideas and solutions that are generated by actors throughout the policy sub-system. Recent ideas are on the top of the garbage can and when the need arises, policy-makers sift around the 'garbage can', starting at the top, to find something that will work and that roughly satisfies tests of feasibility, values alignment and fit with existing policies and programs.

So there you have the three streams. According to multiple streams theory, 'policy windows' open when the three streams are linked, and these moments of opportunity provide the necessary conditions for policy change. Individual policy entrepreneurs play a crucial role in coupling the streams and opening the windows.

So let's apply it HIV policy. As we've seen, Australia's HIV policy has been strongly constant in its essential elements and underpinning features since the beginnings of the epidemic. 2011, however, was a watershed year. Within the *politics* stream, a centre-right Liberal-National coalition government is elected in NSW. While its ideological position is not to challenge the long-standing tradition of political bipartisanship in HIV, senior government officials – that is, political actors – make it blindingly clear to bureaucrats and others within the policy subsystem that the government expects change; it expects improvement in HIV policy outcomes. It decries 16 years of Labor neglect. Government officials communicate these views frequently, widely, loudly and unmistakably. The Government is willing to support positive change, but are bureaucrats? Is the Partnership? Also in 2011, Australia co-chairs the High Level Meeting that results in the United Nations General Assembly committing, for the first time, to bold new HIV prevention targets in its *Political Declaration on HIV/AIDS*. Australia is a signatory.

Pressure from these events in the political stream contributes to the de-stabilisation of the HIV policy sub-system's long-standing analysis of the HIV 'problem'. Data that had previously been interpreted as evidence of 'success', such as high rates of HIV testing and low, stable rates of HIV incidence, is challenged. New data emerges showing that the period between HIV infection and diagnosis in NSW is much longer than previously understood. Questions are being asked of the data upon which the sub-systems deeply held beliefs of

‘success’ are founded. Meanwhile, the stable HIV incidence that NSW has achieved (and that so favourably compares with increases in other Australian jurisdictions and other comparable countries) is being criticised; it is pointed out that stable incidence is contrary to NSW’s stated policy goal of ‘reduced HIV incidence’.

And almost simultaneously, dramatic new evidence emerges showing the powerful effects of HIV treatment not only for people with HIV, but also in reducing onward sexual transmission. 96%! The Partnership’s eyes collectively widen. In effect, HIV treatment is now shown conclusively to also be a powerful tool for prevention. A new tool. Something for the top of the garbage can. Not just treatment for prevention, but better testing and earlier diagnosis too. The garbage can is filling with new ideas, with new possibilities.

In October 2011 a policy window opens: Bill Whittaker, respected HIV activist and, in political science terms, policy entrepreneur, steps forward at the Australasian HIV Conference in Canberra and lays down the gauntlet. He issues a rousing call to action – demanding that Australia’s governments act on their commitments under the UN Declaration. Bureaucrats and others warmly applaud him. After all, we’re nothing in this Partnership if not polite. And reading the writing on the wall – or rather, spotting what was floating around in the three streams – that is, unmistakable expectations of Government in the politics stream; a failure of reduce HIV incidence in the problem stream and a garbage can full of new possibilities in the policies stream, I responded.

Responding to Bill’s call to action, I publicly committed NSW to work with community advocates and other governments to re-examine Australia’s HIV policy-settings against the commitments of the UN Declaration and the opportunities of the moment. When initial attempts to revise these policy settings through inter-governmental mechanisms were

resisted, NSW ran its own race, developing and releasing its own policy, the *NSW HIV Strategy 2012-2015: A New Era*.

Is the Strategy really all that new? Well, that's a matter of perspective. But the policy does significantly depart from previous Australian HIV policy by adding early HIV detection and early treatment to existing behavioural HIV prevention strategies, and in doing so, establishing a new 'combination prevention' framework. It also substantially strengthens the focus on 'supply side' problems of HIV testing and treatment accessibility and it includes, for the first time, measurable time-bound targets to reduce HIV incidence. These targets go beyond the requirements of the UN Declaration from which they are derived.

Key actors in this change process include the political advisors who challenged existing policy sub-system narratives and signalled an expectation of policy change, the HIV activist acting as policy entrepreneur and the senior NSW official who responded to the public challenge. Importantly, we note that the HIV activist had a long history of working closely as a bridge and mediator between the community, bureaucracy and political class and was able to link up the political, policy and problem streams. Indeed he wasn't alone – other policy entrepreneurs such as Chris Puplick and Bill Bowtell and others who should remain anonymous – were also at work.

Multiple streams theory, as applied to the case of NSW HIV policy, offers an interesting account of how policy-change occurs. It emphasises the political, policy and problem dynamics at work and the entrepreneurs who link up and exploit changes in the three streams to create policy windows that give rise to change.

But critics of this theory question whether the each of the three streams really has "a life of its own", as the theory would suggest. While it is possible in the case of HIV to differentiate events within the three streams, and it is useful to highlight the policy window that precipitated concerted policy-making, the streams were *not* operating independently. In the circumstances of 2011, various events in each of the three streams were operating continuously upon one another before and beyond Bill's call to action at the conference. New data on the time between HIV testing and diagnosis in the problem stream was feeding political stream concerns about existing policy settings, and bureaucrats were taking steps within the policy stream to improve the accessibility of HIV testing. Events and actors across the streams interacted continuously throughout the period, not only at the point at which the policy entrepreneur acted to create and exploit the policy window.

Equally, the multiple streams account can be criticised for lionising (or demonising) individual actors while ignoring the institutional dynamics that were operating. For instance, broader changes and dynamics within the health bureaucracy at the time of the policy change are not brought forward within the multiple streams account. Equally, the roles of other actors, such as HIV clinicians and their institutions, are obscured in this account. And the multiple streams account doesn't explain why change occurred in NSW but not in the same way or with the same volition and speed in other jurisdictions where the political, policy and problem streams included similar features to that of NSW and where policy entrepreneurs were also at work.

So is there a theory of policy-change that is more satisfying in explaining what actually happened? Well, let's look at the theory of punctuated equilibrium. It's a good one for explaining both policy constancy as well as change. Punctuated equilibrium theory holds that public policy is generally characterised by long periods of stability, marked only by small,

incremental change, that is equilibrium. Occasionally however, changes in the images and venues associated with a policy interact to produce rapid and substantive, that is, punctuated, change.

'Policy image' is the way a policy is characterised and understood. Policy sub-system actors, that is, members of the HIV Partnership, have privileged access to shaping the policy image and they exercise this privilege to oppose competing images. So what are these images: well they're comprised of information and evidence as well as emotive appeals. The public's acceptance of these images and their causal stories is critical because government actions are heavily determined by public acceptance or rejection. The framing and connection of solutions to problems is also important, and policy-makers and entrepreneurs compete with each other to manipulate the framing of both.

So that's the 'policy image'. What are 'policy venues'? Well, they're the institutions or groups that have decision-making authority for a problem. The venues can shift over time. It could be just one venue, for example, a Department of Health, or it could be multiple venues, such as several Departments or several institutions such as business or professional groups or a mix of all. Just as with policy images, contests occur between policy venues for control of a policy problem, and entrepreneurs work to change policy venues in ways that are favourable to their interests so that they can influence the policy agenda.

Periods of policy constancy are characterised by stability or 'equilibrium' in policy image and venue. Periods of rapid policy change or 'punctuation' occur when crises or changes in the characterisation of policy problems and solutions lead to changes in their associated images and venues.

So let's turn back to HIV. We've seen that HIV policy in Australia can be characterised by constancy over a long period, with relatively stable policy images (such as the notion of 'success') and policy venues (such as the HIV Partnership). We can see that there have been some small, incremental changes over time in policy image, for instance, the realisation during the period between approximately 1990 and 1995 that HIV was not spreading much beyond the groups that had initially been affected. While this generated some public discussion, including claims that the public had been misled about the threat of HIV, it did not substantially destabilise the policy sub-system. In fact, during this period, institutions and groups engaged in the HIV policy sub-system consolidated. The effect of these slow policy image and venue changes was actually to stabilise the sub-system's architecture and to strengthen the roles and dominance of existing actors in policy-making. We can see these incremental adjustments to HIV policy in the second and third National HIV/AIDS Strategies, with both showing a shift away from universal prevention programs towards increasingly targeted programs for those most at risk of HIV.

And then comes 2011: the arrival of a period of rapid change – a punctuation – in policy image and policy venue. The policy image of 'success' is replaced with a new story 'A New Era'. The new *NSW HIV Strategy* is released, substantively re-framing the policy problem and its solutions. New architecture is established by the Strategy to drive its implementation, reflecting shifts in policy venue.

It's big. It's punctuated. So let's step through it more slowly. We know that the contests over the HIV policy image escalated in 2011. What happened to our stable policy image of 'success'? Well, it is unsettled by new information, including the data showing a much longer period between HIV infection and diagnosis than had previously been assumed. It's also unsettled by new prevention science showing the potential of early HIV detection and

treatment to reduce HIV incidence. In fact, this information is especially important because it reveals the potential of new tools for reducing HIV incidence, and so it destabilises our belief that we're at the limits of what prevention can reasonably achieve; we now see new capability, new opportunity. With this information, 'success' becomes relative. In fact, in becomes unhelpful and untrue. It becomes a metaphor for stasis. The policy image is fracturing.

Simultaneously, there are shifts in policy venue. The NSW government changes and new political actors and advisors are highlighting this new information, these new interpretations. They question the prevailing policy image. It is, in their view, the stupefied product of 16 years of Labor neglect. The renewed political interest in HIV is important – it is an active re-entry of 'Government' within the HIV policy sub-system and it is shifting the sub-system's balances of power. We must remember here that HIV policy-making in NSW, during its long period of constancy, had principally become a bureaucratic function, with *NSW HIV Strategies* prior to 2012 being approved at Department-level and provided to Ministers just for noting purposes. The 2012 *NSW HIV Strategy* is the first to be submitted for Cabinet consideration since the late 1980s. With the change of government and its renewed interest we see a new and powerful policy venue emerge. We see actors across the policy sub-system vying for advantage, assuring the Minister and her office of their agreement with the government's contestation of the policy image.

Community-based organisations are especially active in questioning the policy image, pointing to 'supply-side' problems: declining rates of bulk billing by General Practitioners and Australia's slowness to introduce new, rapid HIV testing technologies. What previously seemed like flying – like success – now seems like falling. It's hard to tell. Something's happening. The advocacy efforts strengthen. As the Government nods appreciatively, the

calls become bolder. Actors demand that Governments introduce new solutions. That government go beyond the UN targets – 50% isn't enough. Why not 60? Someone gets a flush and raises the stakes to 70. The calls pull at the stability of the sub-system – at the politeness and cooperation and harmonising of the Partnership. In addition to growing tensions between government and community, ASHM becomes a lightning rod – decried and suspected for its perceived resistance, caution and slowness.

And within this rapidly shifting environment, NSW bureaucrats find advantage, or perhaps it opportunity or even necessity. It depends on your perspective. The policy image of 'success' has failed – it no longer serves its purpose – and the axes of the sub-system are altering. The possibilities of real policy change are in sight. In fact, it is misleading to describe this as a possibility. The change of government, the views of its advisers, and the advocacy of community organisations and entrepreneurs, make policy change imperative. Stasis is not an option. Change or be changed. And so it begins: a bureaucrat-fed policy review process which engages all sub-system actors in shaping new directions and in establishing targets that would exceed those of the UN. The framing of the resultant *NSW HIV Strategy* reflects the shift in policy image: reduced HIV incidence is held to be possible and targets are established for its achievement; long-standing behavioural prevention approaches are supplanted by a 'combination prevention' approach; and 'supply-side' problems and solutions of HIV testing and treatment are emphasised. The narrative of 'success' that has characterised HIV policy since 1986 is fully and finally abandoned. And the Strategy's sub-title, *A New Era*, marks the punctuation. The shift in venue is heralded by the NSW Minister for Health herself, who in her foreword to the Strategy tells us that she is "committed to the reforms… and will be personally driving them through to implementation". Other new actors take their place at the table: Chief Executives of Local Health Districts step forward to deliver on the Minister's vision. The Agency for Clinical Innovation takes its seat. And the Chief Health Officer

watches over it all with energy and expectation. And as for the shift in image, ACON take a stake to heart of the complacent 'success' narrative of yesteryear, launching a campaign to introduce the new era and calling the community and partnership to action with its tagline: "Everything has changed. We can end HIV".

The theory of punctuated equilibrium provides a pretty satisfying account of the processes of change in NSW HIV policy. It is more successful than the multiple streams account in drawing attention to the range of institutional actors, including individual entrepreneurs, whose actions and contests were instrumental. Its attention to policy image accords well with the shift in HIV discourses during 2011 and the emotive narratives of hope and possibility that arose from the new prevention science. Additionally it more faithfully accounts for the reflexive interplay of image and venue that characterised this period. And its long-term focus provides for an explanatory account of both the rapid period of change, as well as the long-standing prior period of constancy and incrementalism.

And so that's about it from me. Or nearly so, anyway. We're done now with theory but I did promise to return to the wonders of public administration and to the matter of Partnership. Earlier we marvelled together at the incredible weight of stasis on bureaucracy and we marvelled that change could ever occur. Clever, remarkable bureaucrats. But are you persuaded? Perhaps it's just me. Seduced by my own words. Do you agree that it's a wonder? Do you agree that it is interesting? Well, for my part, I believe you must. I want to encourage your gaze on public administrators who work in HIV. I want you to be curious about them, about their constraints, about their actions and what it means when they go silent. I want you to ask why. I want you to consider it as something other than individual failure or indifference and to think about the institutional context in which public administrators work.

To think about the macro-, meso- and micro level forces that we discussed earlier, and how they may constrain or threaten or open up new opportunities.

Let me find some common ground here. If it's a stretch to love, to respect or to find interest in public administration, then I know we share a common belief in the Partnership. Its rhetorical power is so strong we could just as readily call it the Force – the metaphysical and ubiquitous energy that binds the galaxy, or at least the sector, together. Partnership is the table at which government, community, researchers and health professionals sit, and it's the open-palmed spirit we bring to our professional relations with each other.

Within the HIV Partnership, of course, is government. But in the strange assembly of guests at the table, government is the most curious. We normally think of Government in the Partnership as 'big g' Government: it's at the table by virtue of the continuing political will and support that allows other members to busily get about doing what must be done. It's the 'big G' government of national leaders endorsing the 2011 Political Declaration on HIV/AIDS at the UN or Australia's health ministers endorsing successive *National HIV Strategy's*. Important, but not especially frequent or present. Public administrators – and in particular, the ways and means of public administrators – are largely invisible within the sector's Partnership discourse.

And sometimes the absence isn't just rhetorical. It's literal. World AIDS Conferences occur with few public administrators in attendance. As though the extraordinary policy actions that HIV demands can be implemented without them. As though needle and syringe programs, or community programs with gay men, or sex workers, or indigenous communities, are straightforward and unproblematic for governments to implement. Without public administrators, political commitment is meaningless. And the challenge for a public

administrator in implementing a needle and syringe program in a country with strong criminal penalties for drug use are formidable. How do you implement a program that appears to condone criminalised conduct? In effect, you are attempting to create something contrary to the system within which it is to exist. You are attempting to create a contradiction. Or that's at least how it is likely to be seen.

This isn't a story just about public administrators working in far-flung jurisdictions elsewhere. It's true here. The public administration of HIV programs and policy is hard. It's hard for its social and public policy complexity, it's hard for its exceptionalism, it's hard because it asks things of bureaucrats that stretch them beyond what is familiar in contemporary public administration practice, and it's hard because your expectations are high, formidably and sometimes unassailably high. And thank goodness for that.

Even when public administrators are visible, their practices and constraints are often not. The voice I speak with today is one made possible only because I am no longer a HIV bureaucrat. If I were still a HIV bureaucrat I'd have told you the story of the NSW HIV Strategy as though it came from the policy cycle – all rationality and evidence and method, no politics, spirit or imperative. It would have been one account of the process, not the most interesting one, but the one my bureaucratic practice would require me to offer. It's part of bureaucratic culture – in terms of our practices, we are opaque. When we speak, we speak with one voice. It's a studied art. We are visible, in NSW we are highly visible, but our ways and means are not. While I might know a reasonable amount about scientific method I venture that few outside bureaucracies know much of bureaucratic method. Sometimes for want of interest, and often for our lack of transparency. And this lack of visibility makes the possibilities and potential of bureaucrats working in different agencies, different cultures, different jurisdictions, difficult to discern. It is why when we think of different bureaucracies, we think

of individual bureaucrats, and ascribe success or failure to them individually, rather than thinking more critically, more analytically, more plausibly, about the underlying institutional and political dynamics at work.

There is one instance in which bureaucratic practice does become visible in HIV sector discourses, and that is when it fails. In the Australian context we hear frequently of 'absences of leadership', though it's not always clear to me what this actually means. In bureaucratic cultures where 'leadership' is considered suspect, as activist or insufficiently dispassionate, such cries must be particularly perplexing. And of course, they are alienating. They widen the distance and entrench mutual misapprehension and silence. And partners certainly notice when defunding occurs. This gets a lot of commentary, but rarely does anyone wonder *why* such things might occur. The failure is noted, often colourfully and at length, but there is no little analytic curiosity about it and therefore no trigger for critical enquiry.

So the absence of referencing public administrators in HIV Partnership discourses is not just a rhetorical matter, it's practical. The lauded Partnership in which public administrators are obscured somewhere behind the back of big 'g' Government is a problem. Policy fails if public administrators are not capable of its delivery. I asked some of Australia's most senior HIV researchers if they knew of any research on the role that public administrators have played in HIV responses domestically. The answer was no. Nothing. Nothing that might reveal what public administrators do and how they have done it, despite our longstanding narrative of success. The lack of curiosity is curious. How do you protect a policy success if you don't know how public administrators achieved it?

So let me encourage you then to rest your gaze critically on bureaucratic practice, on the workings of bureaucrats, on the influences and forces upon them, and the effects of these

things on the possibilities and fortunes of yourselves. It's important that you wonder about bureaucrats and how they participate in the Partnership because when they fail or fall silent, we all notice.

And of course, there's another reason why we should wonder about public administrators and about Partnership – it's the question of was it all an accident? Was it all chance? At a forum not too long ago, a social scientist for whom I have the highest regard was reflecting on Australia's early HIV policy and mused that perhaps a not inconsiderable chunk of the Australian HIV story could be put down to blind luck. More metaphysics. The right people in the right places at the right time. I reacted. Strongly. It seemed to me to be a distasteful analysis. And disrespectful to the efforts of so many over such a long period. A handing over to chaos of the agency and sacrifice of all involved. Luck indeed. And I surprised myself in my reaction, because I've previously thought along similar lines – maybe not quite in terms of luck – but at least in terms of the good fortune of timing.

But on this occasion I had a strong reaction. Partly because it's a question that has been much on my mind and the thought that it was luck was confronting. I now work in the mental health field, in a public sector agency charged with reforming the mental health system and getting a better deal for people who experience mental illness. My agency has consumers avowedly at its centre. Not as a feel good principle. Not because it's fashionable or expected. But because the agency I work for believes that having consumers at the centre is how you get good policy, how you get good outcomes. That it's essential. The agency is riding a wave created by the strengthening of that consumer movement, of the emergence of a consumer vision and philosophy that rejects entrenched models – that is doggedly redefining the relations between consumers and medicine, science and the system. And within this, my

agency is tasked with working with others across the consumer, public, non-government, research and health sectors to bring about change. Sound familiar?

So I find myself wondering could Partnership be replicated? Is that even desirable? And how would you do it – is there a set of principles and attitudes and practices I've learned from my time in HIV that I could take with me to a different field? And if not, does that mean the HIV Partnership is just an accident of history. Random chance. A curiosity. I hope not. I hope something valuable from what I've learned can be extracted and transplanted. So my herculean and maybe slightly messianic task, as I see it, is now to conduct an experiment in a new field. Can Partnership be replicated even in a small way, even if just among a few at first, even if just by force of open-palmed attitude and a belief that if we are to succeed together, then we must succeed as individual partners as well? At this stage I'm not sure it can be replicated or emulated or borrowed, but I reckon it's worth a go. And in that endeavour, I hope you'll wish me luck.