

## **Public Policy and Bureaucracy: 'A New Era' of HIV Policy in NSW**

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Submitted: 9 October 2015

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## **Abstract**

Theories of the policy process provide explanatory models for how issues come to the attention of policymakers and how public policies change. The pluralist orientation of this literature emphasises civil society and political actors in processes of policy change. This orientation is consistent with popular and scholarly accounts of HIV policy in Australia, which centre community activism and political leadership in shaping Australia's lauded HIV policy settings. This research utilises a case study approach to explore whether closer attention to bureaucrats and bureaucracy can improve our understanding of public policy. The case offered is of HIV policy over the period 2007 to 2015 in New South Wales, Australia, including a period of transformative change from 2011. The research describes the arrest of a long period of policy drift and the establishment of new, ambitious policy settings. The case description is compatible with policy process theories but emphasises endogenous sources of change even in the context of rapid exogenous developments in HIV prevention science and technology. It identifies bureaucratic conditions that order and constrain the possibilities for policy change and characterises bureaucratic effort as practices that manage gaps between policy in its real and ideal forms. The study suggests that bureaucratic conditions and practices are independently important in this case of policy change and that greater attention to bureaucracy can aid our understanding of public policy.

## Candidate Statement

I confirm that I have not submitted the work included in this thesis – *Public Policy and Bureaucracy: 'A New Era' of HIV Policy in NSW* – for a higher degree to any other university or institution.

I have indicated within the thesis the sources of information used.

The research presented in this thesis did not require ethics approval.



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9 October 2015

## **Acknowledgement**

I extend my deep appreciation and respect to my Supervisors, Dr Ben Spies-Butcher and Ms Diana Perche, for their guidance and support.

## List of Acronyms

ACON	Formerly the AIDS Council of NSW
AHS	Area Health Service (NSW Health)
AIDB	AIDS/Infectious Diseases Branch
AIDS	Acquired Immune Deficiency Syndrome
BBVSS	Blood-Borne Viruses and Sexually Transmissible Infections Standing Committee
CAS	Ministerial Advisory Committee on HIV and Sexually Transmissible Infections (NSW), formerly the Committee on AIDS Strategy
FDA	Food and Drug Administration
HIV	Human Immunodeficiency Virus
LHD	Local Health District (NSW Health)
MACBBVS	Ministerial Advisory Committee on Blood-Borne Viruses and Sexually Transmissible Infections (Australian Government)
MGM	Metropolitan Gay Men's HIV Prevention Interagency
NSW	New South Wales
STI	Sexually Transmissible Infection
UN	United Nations

## Chapter One – Introduction

Introducing the seminal *Theories of the Policy Process*, Christopher Weible highlights the vital role of theory in managing complexity. He points to “interactions among a large number of diverse people seeking political influence, periodic as well as unexpected events, a complicated mix of policies and programs that span levels of government, and contextual settings characterized by a range of conditions from geographical to socioeconomic” (2014a: 3). For Weible, theory offers a “strategy to help mitigate the effects of... presuppositions by highlighting the most important items for study and specifying the relationships between them” (2014a: 3).

Paul Sabatier and Christopher Weible’s co-edited third volume<sup>1</sup> offers state-of-the-field accounts of the most developed and promising theories of the policy process, including the Multiple Streams Approach, Punctuated Equilibrium Theory and the Advocacy Coalition Framework. While these approaches differ in their scope, levels of analysis, assumptions and models of the individual (Cairney and Heikkila 2014: 367), their shared pluralism accentuates the interactions of political and civil society actors in the policy process and highlights exogenous signals and shocks as sources of policy change.

The foregrounding of these variables orients us to particular aspects of the policy process, such as contests between different actors as they vie for influence or moments of political attention when issues have surged into public consciousness. The selection of these variables for study means, inevitably, that some aspects of the policy process will be emphasised and others obscured. This is necessary for managing the overwhelming number of variables that might be examined, however it risks an inattention to endogenous drivers of policy change: to the heterogeneity, concessions and victories *within* actor categories as policy evolves, and to the hidden processes of puzzlement, formulation and consensus-building that occur behind closed policy doors. This potential bias or omission in the selection of variables extends to an inattention to

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<sup>1</sup> Paul A. Sabatier edited the first and second editions of *Theories of the Policy Process* and died in 2013. Editorship of the third edition, published in 2014, is co-attributed to Sabatier and Weible. Other authoritative accounts of the field include Peter John’s *Analyzing Public Policy* (2012) and Michael Howlett et al.’s *Studying Public Policy: Policy Cycles and Policy Subsystems* (2009).

the role of bureaucracy in the policy process. This may in part reflect the more compelling enticement of macro-political events, but it also may reflect the barriers to examining policy change within subsystems and, more so, within bureaucracies whose internal workings are generally obscured from public and scholarly gaze.

Matthew Nowlin observes that “bureaucracy has not been a major feature of policy process theories” (2011: 54). “Bureaucrats are assumed to be members of advocacy coalitions and government institutions play a role in [punctuated equilibrium]. However, there aren’t explicit hypotheses about the bureaucracy and its role in policymaking” (Nowlin 2011: 57). Similarly, Alisa Hicklin and Erik Godwin observe:

“Public managers rarely play a leading role in policy theory, but they are not altogether missing either. In fact, public managers have played an important role in a number of frameworks, serving as one point in the iron triangles, providers of information, members of advocacy coalitions, facilitators of participatory policymaking, and many more. However, these treatments of public managers are often one-dimensional” (2009: 14).

Recognising this inattention, a number of authors have sought to ‘bring bureaucracy in’ to the policy process literature through synthesis with other literatures, such as public management and governance (Robichau and Lynn 2009; Hicklin and Godwin 2009) or delegation (Lavertu and Weimer 2009). These authors observe the risk, however, that such syntheses invite a reversion to an unhelpful politics/administration dichotomy in which politicians ‘decide’ and bureaucrats ‘implement’ (see Campbell and Peters 1988; Svava 1998, 2001).

As an alternative approach to this problem, this thesis centres the role of bureaucracy in a case study of policy change so that its independent contribution can be considered. Using the case of NSW HIV policy since 2007, I purposively centre bureaucracy in the policy process and consider whether greater attention to its role can improve our understanding of policy change. Put most simply, I ask: do we learn something new about the process of policy change if we bring bureaucracy to the foreground of our exploration?



Australia's response to HIV offers an exceptionally sensitive topic for public policy analysis. During the mid- to late 1980s governments worked cooperatively to craft a far-sighted policy response that would harness the mobilisation of groups affected by HIV, educate the community and provide access to the means of HIV prevention, including sterile injecting equipment (Altman 1992; Ballard 1998; Commonwealth Department of Community Services and Health 1988; Kippax et al. 1993a). These early policy foundations, and the sustained effort that followed, has resulted in Australia having low rates of HIV infection relative to comparable countries (McPherson and Ward 2010).

Popular and scholarly accounts of Australia's HIV response highlight many of the elements of complexity to which Weible and other policy process theorists point (Bowtell 2005; Plummer and Irwin 2006; Power 2011; Robinson and Wilson 2012; Sendziuk 2003). They stress early gay community activism, the influence of these activists on political leaders, debates about the framing of the HIV epidemic and the shape of the response to it, the catalytic political effects of public crises, the challenges of law reform, cooperation between different levels of government as respective roles and funding were negotiated, and the forging of a dense network of actors that became known as the 'HIV partnership'. As early settings were established and the threat of a generalised HIV epidemic faded, so did public anxiety and media and political attention. During the period of this study – 2007 to 2015 – HIV offers an example of middle-range policy of moderate issue salience: it is not an area of intense public or political interest or contestation. In such circumstances, the influence of mid-ranking bureaucrats in policy processes is expected to be higher and we expect to see bureaucrats acting as principal policy actors within the state (Rosati 1981; Preston and 't Hart 1999).

My examination of HIV policy draws from theories of the state and institutionalism, which recognise the state's considerable capacity to withstand exogenous pressures, have its own views and act in its own interests. This recognition is used to resist the pluralist lure of policy process literature, consider the ends to which state interests are directed and wonder about endogenous sources of change, even where exogenous shocks and pressures are evident. In their review of HIV social and political science research, Susan Kippax and Martin Holt (2009) call for research on the drivers and underpinnings of successful policy responses in order to foster learning and strengthen

responses to HIV. This research contributes to that cause. Additionally, the purposive gaze on bureaucrats establishes a vantage point that accords with my own participation in processes of policy change. From 1999 through 2013, I was employed by the New South Wales (NSW) Ministry of Health. I was a lead participant in the policy change described in this research and bring to it my observations of the processes of change. My research motivations include a desire to theoretically reconcile my observations with the greater primacy given by the literature to other actors and drivers in processes of policy change. To this end, institutionalism assists in the analysis of the case, offering “an empirically based prejudice, an assertion that what we observe in the world is inconsistent with the ways in which contemporary theories ask us to talk” (March and Olsen 1984: 747).

## **Thesis Overview**

This thesis explores the contribution that closer consideration of bureaucracy might offer to our understanding of public policy change. In examining theories of the policy process and, particularly, institutionalist accounts of change, I identify analytic tools – the role and capacity of the state, modes of policy change, and gaps between ‘ideal’ and ‘real’ patterns of rules – that underpin my description of HIV policy. The case study is therefore theoretically-guided, providing an account of HIV policy in NSW structured by institutionalist themes. The case is built upon three progressive claims: first, that HIV policy is historically-situated and located within a wider policy milieu of competing policy possibilities; second, and more narrowly, that HIV policy is ordered and constrained by various conditions and problems; and third, that bureaucratic practices are central to the possibilities of policy change. Through these progressive claims, I describe the nature of HIV policy change in NSW in the period from 2007, and show that various bureaucratic conditions and practices shaped the possibilities of, and animated, HIV policy change in NSW. In the discussion, I show that institutionalism can assist our understanding of policy change and apply institutionalist concepts in novel ways to demonstrate the contributing role of bureaucracy. With this overview provided, I now offer a chapter breakdown.

Following this Introduction, I review in Chapter Two the policy process literature. To centre the state as an entity constituted with its own policy interests and capacity, I draw on perspectives that hold the state to be more capable of autonomy than pluralist accounts would suggest. I introduce the work of Wolfgang Streeck and Kathleen Thelen (2005) and Peter Hall (1993) to provide schemas that allow us to observe the trajectories of policy and to conceptualise the role of bureaucrats and bureaucracy in the policy process. I also outline the study methodology.

In Chapter Three I present the case of HIV policy in NSW in the period 2007 through 2015. The early years of this period are characterised by a high degree of cooperation between subsystem actors, mediated through elaborate, bureaucratically-driven mechanisms for policy puzzlement, consensus-building and the extraction of concessions and commitments for change. Policy drift is evident during this period and HIV policy is routinised and incremental, with the conditions for transformative change that characterised early HIV policymaking having dissipated. NSW bureaucrats work intensively to create more fertile conditions for change, and these efforts, together with external conditions, ripen in 2011. At this time, a rapid sequence of exogenous events, coupled with mature bureaucratic conditions, provide the catalyst for bureaucrats to accelerate HIV policy change in NSW.

In Chapter Four, I consider whether greater attention to bureaucracy can improve our understanding of policy. I note the compatibility of the case with policy process theories and utilise institutionalism as an analytic aid to recognise the autonomy of the state, identify endogenous conditions and practices that may be sources of change and conceptualise the nature of bureaucratic practice within the policy process. The examination of the case suggests that bureaucratic conditions and practices that stimulate and enforce ideal policy forms are important sources of policy change, and that closer attention to bureaucracy can aid our understanding of public policy.

## **Chapter Two – Literature Review and Methodology**

A substantial body of literature seeks to describe the processes of policy change. In this chapter I introduce policy process theories and locate bureaucracy within that literature. I explore theories of the state and institutionalism as approaches through which I will later examine the role of bureaucracy in public policy. The chapter concludes with a description of the methodology adopted for this project.

### **Policy and policy change**

Policy process theories ask questions about the “complex phenomenon of continuous interactions involving public policy and its context, events, acts, and outcomes” (Weible 2014b: 391). Edella Schlager and Christopher Weible define policy process research as:

“...the study of stasis and change in public policy over time, entailing (i) the surrounding actors that think and act individually and collectively; (ii) the structures that affect – and are affected by – actor choice including socioeconomic conditions, institutions, culture, infrastructure, and biophysical conditions; and (iii) ...anticipated and unanticipated events” (2013: 390).

Within this definition, we can distil the essential interests of policy process theorists: change, constancy and temporality. We also discern the objects of enquiry: actors and agency, structure and its ordering and constraining effects, and circumstance and contingency.

Two of the more widely-recognised policy process theories – the Multiple Streams Approach and Punctuated Equilibrium Theory – focus on how issues come to the attention of policymakers and onto crowded policy agendas. The Multiple Streams Approach, proposed by John Kingdon (1984), holds that policy agendas are shaped by changes in three largely independent streams – problems, politics and policies. Policy entrepreneurs create and exploit opportunities for policy change by coupling the streams

and creating policy windows. Punctuated Equilibrium Theory, introduced by Frank Baumgartner and Bryan Jones (1993), suggests that policy change is generally rapid and dramatic (punctuation) and is brought about by exogenous shocks following long periods of constancy (equilibrium). Both of these theories have an orientation to moments of transformative policy disruption, wherein issues escape the confines of policy subsystems and come to political and public attention. They highlight the authoritative role of political decision-makers and the causal effects of exogenous actors (such as policy entrepreneurs) and events (such as crises or shocks). While a role for bureaucracy is not precluded by either approach, it is circumscribed by the privileging of political and civil society actors as change agents.

Paul Sabatier and Hank Jenkins-Smith's (1988, 1993) Advocacy Coalition Framework emphasises the interactions and competition of advocacy coalitions within a policy subsystem. Four pathways to policy change are posited: exogenous shock, internal events (including crises or scandals that occur within the confines of the subsystem), policy learning and negotiated agreements between subsystem coalitions (Jenkins-Smith et al. 2014: 202-3). The framework considers these to be necessary but insufficient sources of change. Additional enabling factors are required, including public and political attention, agenda change, changes in the distribution of coalition resources and changes in policy venues (Sabatier and Weible 2007: 198-9).

### **Locating bureaucrats and bureaucracy within theories of the policy process**

These policy process theories, and others, do not disavow a role for bureaucratic actors or for bureaucracy as a context of policy change. On the contrary, bureaucrats are recognised as members of advocacy coalitions (Nowlin 2011: 54; Hicklin and Godwin 2009: 14) and the bounded rationality and information processing limits of policymakers are central to many policy process theories (Cairney and Heikkila 2014: 367). Some *applications* of policy process theories also raise interesting points about the role of bureaucracy. In an exploration of decision-making in the European Union, Robert Ackrill et al. ponder whether, as an alternative to the familiar explanation that policy entrepreneurs sell solutions to passive policymakers, it might not be policymakers who sometimes select ideas and credential the entrepreneurs with whom those ideas are

associated (2013: 881-2). Similarly, Manuel Teodoro explores career mobility among bureaucratic entrepreneurs as a source of policy diffusion (2009). Bureaucratic entrepreneurship is a theme also taken up by others (for example, Bernier and Hafsi 2007; Carpenter 2001; Roberts 2005; Schneider et al. 1995).

While not disavowed, bureaucracy is not strongly theorised in policy process research (Nowlin 2011; Hicklin and Godwin 2009). Several reviews have identified promising avenues for research to address this gap, including through synthetic frameworks (Schlager and Weible 2013; Petridou 2014; Nowlin 2011). Richard Feiock (2013) and John Anderies and Marco Janssen (2013) integrate concepts and lessons from public management with policy process theory. Stéphane Lavertu and David Weimer (2009) argue for the integration of delegation theory with Jones and Baumgartner's (2005) theory of the politics of attention. This is particularly encouraging for its recognition of "political scientists' tendency to treat administrative agents as passive political actors" (2009: 101) and its recognition that an appeal of delegation theory is its underlying assumption that "the preferences of agents potentially diverge from political principals and that agents possess more expertise than these principals" (2009: 96).

These calls for the integration of policy process research with literatures that theorise the role of bureaucracy are welcome, but yet to take root. In concluding the most recent edition of *Theories of the Policy Process*, for instance, Weible is silent on bureaucracy as an avenue for future enquiry (2014b: 391-407). One explanation for this may be the risk of theoretical regression seemingly inherent in such calls, pulling as they do at old dichotomies between politics and administration (see Campbell and Peters 1988; Svara 1998, 2001).

This tension is discernible in Edella Schlager and William Blomquist's argument that further research on political control of the bureaucracy will contribute to "the development of political theories of the policy process that would account for policy implementation and not just policy formulation and adoption" (1996: 652). Robbie Robichau and Laurence Lynn also imply this role distinction: "public policy models tend to de-emphasize that which governance theories tend to emphasize: the influence on government performance of implementation through administrative systems... after a policy has been promulgated by elected officials and interpreted by the courts" (2009:

21). Catherine Althaus et al. distinguish policy from administration, holding the former to be the task of government and the latter to be the domain of public servants who are accountable to Ministers (2007: 20). Theories of the policy process eschew such heuristic role delineations, yet calls for better theorising of bureaucracy appear to re-invite them. In short then, we experience a dilemma: a policy process literature that is inattentive to bureaucracy and a desire for greater attention to bureaucracy that risks being narrowly conceptualised. Where then, might we find an avenue for a richly imagined role for bureaucracy in processes of policy change? Institutionalism offers one possible pathway.

## **Institutionalism**

A number of authors have called for dialogue between literatures on the policy process and institutionalism. Ackrill et al. (2013) point to the potential for the Multiple Streams Approach to be informed by institutionalism. They draw links between the concepts of ‘coupling’ and ‘policy windows’ in the approach and institutionalists’ attention to the inherent vulnerability of institutions and their recognition that “there is nothing automatic about stability” (2013: 878). Similarly, José Real-Dato suggests that institutionalists’ interest in formal and informal rules and social norms offer valuable aids to theorising constraints on individuals’ behaviour in policy processes (2014: 119).

For my part, I look to institutionalism for three purposes: first, to draw upon its recognition of state capacity as a counter to the pluralism of policy process theory; second, as a source of schemas for transformative change in which bureaucrats and bureaucracy may be central; and third, to conceptualise policy broadly, encompassing its formal and informal elements and the adjudicative effort required in its shaping and enforcement. I turn now to each of these purposes.

### ***Institutionalism and the state***

Institutionalists are concerned principally with two questions: “how to construe the relationship between institutions and behaviour and how to explain the process where institutions originate or change” (Hall and Taylor 1996: 937). Institutions are, most

simply, “rules that structure behaviour” (Steinmo 2008: 162). Streeck and Thelen elaborate this with a policing element, highlighting that institutions “may be enforced by calling upon a third party” (2005: 10). They observe that while institutions structure behaviour, “institutional change may be generated as a result of the normal, everyday implementation and enactment of an institution” (2005: 11).

Institutionalism recognises a central role for the state in the policy process. It holds that the state is diverse and complex, has its own varied interests and is capable of withstanding external pressures to a great degree. On the question of change, institutionalists draw from state theorists, who recognised that “the state had independent interests and agendas which were separate and different from the interests and preferences of classes and interest groups that made up society” (Steinmo 2001: 7556). Hall describes theories of the state as a “corrective to pluralist emphases on the societal sources of policy” (1993: 275). Similarly, Theda Skocpol points to the difficulties in recognising state autonomy “against a background of deeply rooted theoretical proclivities that are stubbornly society-centered” (1985: 8). Stephen Krasner suggests that, given these interests and capacity, policy should not be seen as “a vector diagram in which a series of pressures are brought to bear on the state, which then moves in the direction it is forced by the strongest societal forces” (1978: 26).

Hall identifies two theoretical orientations within the statist tradition that he calls state-centric and state-structural (1993: 276). Both traditions emphasise the impact of the structure of the state on policy and consider pluralist perspectives to overstate the degree to which non-state actors influence policy change. Relative to their state-centric peers, state-structuralists give greater recognition to the influences of non-state actors on policy, but recognise the nature and intensity of non-state actors’ demands themselves to be heavily determined by the structure and practices of the state. While recognising the autonomy of the state, state theorists also point to its diversity, with Hall considering the state a ‘black box’ whose interior world remains under-theorised (1993: 275). This diversity is reflected in the state’s constituent elements – political, legal, bureaucratic and coercive systems and apparatus – and by internal diversity within these elements. Krasner (1978: 11) and Finegold and Skocpol (1995: 271), writing on foreign policy and agricultural policy respectively, highlight the insulation of policy arenas from each other and variability in policy capacity across different domains and at different points in time.



Skocpol identifies several features of state capacity that are central to effective policymaking (1985: 16). At the macro-level, she highlights sovereign integrity and administrative-military control of a territory. Within a policy domain, Skocpol points to the role of ideas and solutions, loyal and able administrators, and the availability of allocable financial resources (1985: 15-17). Hugh Heclo points to bureaucrats as central actors in the framing of problems and the fermentation of solutions: “Governments not only ‘power’ (or whatever the verb form of that approach might be); they also puzzle. Policymaking is a form of collective puzzlement of society’s behalf; it entails both deciding and knowing” (1974: 305). Hall highlights three features of policymaking that are characteristic of institutionalism: first, the determinative role of past policy on future policy (that is, path dependence); second, the key role of experts either in the employ of the state (such as bureaucrats) or advising the state from privileged positions (for example, academics and consultants); and third, the belief that states can act autonomously from societal pressure (1993: 277-8). These features allow for explanations of policy that centre bureaucratic actors as principal or central agents.

### ***Conceptualising the nature and magnitude of policy change***

Streeck and Thelen explicitly enfold public policy within their conceptualisation of institutions: “Policies... are institutions in our sense to the extent that they constitute rules for actors other than for the policymakers themselves – [they are] rules that can and need to be implemented and that are legitimate in that they will if necessary be enforced by agents acting on behalf of society as a whole” (2005: 12). They argue that there are various, but not infinite, processes through which institutions change and that a conservative bias can be observed in the literature, with the dominance of Punctuated Equilibrium Theory leading to analyses that overly distinguish between periods of stasis and change. While allowing for the possibility of change of this type, Streeck and Thelen hold that transformative change can also result from the accumulation of gradual changes over time. Their edited volume – *Beyond Continuity: Institutional Change in Advanced Economies* – comprises case studies demonstrating “incremental change with transformative results” (2005: 9). Hall (1993) and Streeck and Thelen seek to explain processes of change – in both cases, the rise of neoliberalism – that have

superficially compelling exogenous explanations but for which endogenous sources of change may be determinative. Streeck and Thelen identify five modes of change – displacement, layering, drift, conversion and exhaustion – through which incremental transformation without punctuated disruption can occur. These processes are not mutually exclusive.

*Displacement* occurs “as new [institutional] models emerge and diffuse which call into question existing, previously taken-for-granted organisational forms and practices” (Streeck and Thelen 2005: 19). Established institutions are displaced over time by emergent forms that commence at the margins and are accompanied by shifts in power. *Layering* occurs with the introduction of new elements to existing institutions without disrupting the status quo so greatly as to provoke counter-mobilisation (Streeck and Thelen 2005: 22). *Drift* refers to the atrophy or erosion of institutions that are insufficiently ‘tended’ (Streeck and Thelen 2005: 24). Drift may be misrecognised as the status quo, however the inadequate maintenance of institutions, including through ‘non-decisions’, will more likely result in institutional decay than stasis. *Conversion* describes the re-direction of institutions to new goals, functions or purposes. One source of conversion is time, with institutions outliving the drivers and actors that led to their formation (2005: 26). Finally, *exhaustion* leads to gradual institutional breakdown rather than change. Unlike drift, in which institutions transform through neglect, exhaustion leads to complete breakdown.

Streeck and Thelen’s schema provides a valuable aid to conceptualising the dynamics and trajectories of institutional change over time. Yet as a macro-level framework it is seemingly actorless. Hall’s 1993 case study, *Policy Paradigms, Social Learning and the State: The Case of Economic Policymaking in Britain*, presents a well-cited schema for policy change that can assist in this regard. Hall posits that three variables – settings, instruments and goals – are central to policy output (1993: 278). Adjustments in these variables characterise different scales of policy change. According to Hall, bureaucrats are often determinative in changes to settings (first order change) and instruments

(second order change), while changes in goals (third order change) involve paradigm shifts that generally require political as well as bureaucratic involvement.<sup>2</sup>

First order policy change is routine, comprising adjustments to the *settings* of various policy levers and instruments. His examples included adjustments in the settings of fiscal and monetary instruments to achieve macro-economic goals. These adjustments can be predicted using a satisficing model and policy at time-1 is formulated against the outcomes of policy at time-0. Hall suggests these processes are “relatively insulated” from pluralist influences and dominated by bureaucrats (1993: 281).

Second order policy change, in Hall’s terms, involves changes in policy *instruments*. These are more substantive and less frequent than changes to settings. The introduction of new instruments can reflect inadequacies or failures in existing policy techniques or emerge through ideas, including their diffusion from other places. Hall finds that the state acted rather autonomously in instrument changes and bureaucrats were the principal drivers of change. Hall cites the introduction of ‘cash limits’ to better control expenditure by public agencies as an example of second order change.<sup>3</sup>

In Hall’s typology, third order changes are infrequent and dramatic. He looks to Thomas Kuhn’s (1970) concept of scientific paradigm shifts, in contrast with ‘normal science’, to characterise changes in policy *goal hierarchies*. Given their magnitude, these changes are accompanied by changes in instruments and settings and occur over long time periods. The period preceding transformative change can, with hindsight, be recognised as a time of fermentation during which policy anomalies and failures not readily explained through extant paradigms accumulate. Hall’s example of third order change is

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<sup>2</sup> While recognising Hall’s contribution to the field, some scholars have criticised his schema for its orthodox presentation of Punctuated Equilibrium Theory, especially at the level of third order change, and offered more nuanced taxonomies of policy components (see, for instance, Cashore and Howlett 2007; Howlett and Cashore 2007, 2009). My interest in Hall stems principally from his recognition of bureaucrats as actors in various scales of policy change, rather than his characterisation of incrementalism and punctuation.

<sup>3</sup> While not highlighted by Hall, developments in *technology* can also result in the availability of new instruments. In the case of HIV, this would include new test kits that offer rapid HIV results or drugs that prevent HIV infection. Such new technologies (instruments) add to the array of tools available to achieve the policy goal of reduced HIV transmission.

the transformation in British macro-economic policy from Keynesian policymaking to monetarist economic policy. Hall highlights substantial shifts in discourse by policymakers and in economic analysis (that is, in the interpretation of data and signals). Third order change is associated with intensified debate in an increasingly wide sphere that spills beyond the control of bureaucrats to civil society and the wider polity. The new paradigm is entrenched through parliamentary and other sources of mediation, following which its control returns to the bureaucracy.

### ***Institutionalism, policy and ‘ideal’ and ‘real’ patterns of rules***

So far I have pointed to macro-level processes of policy change and highlighted the contribution of bureaucracy to different scales of change, but what of the nature of bureaucratic practice? Streeck and Thelen’s observation that the management of gaps between rules in their ‘ideal’ and ‘real’ forms offers a useful way of conceptualising bureaucratic practice. They highlight the work of Richard Bendix (1974 [1956]) in noting that the meanings of rules are never self-evident and that they are subject to interpretation (2005: 14). In ideal circumstances, there will be a shared understanding of a rule and its intended meaning, but this will not always be the case. Even where there is shared understanding and acceptance, the application of a rule in real world settings is a creative and interpretive act. They note that the “*enactment of a social rule is never perfect*” (2005: 14, italics in original), with gaps existing between ‘ideal patterns’ of institutions and the ‘real patterns’ of their enactment. These gaps can be sources of institutional change.

However not all circumstances involve acceptance and agreement about rules, and actors who are subject to rules may utilise the inherent “openness and under-definition” of rules to circumvent them (Streeck and Thelen 2005: 15). “The continuous probing [of a rule and its boundaries] is part of the interpretative struggle that begins as soon as a rule is laid down: it is one mechanism by which the meaning of a rule is both clarified and modified (‘worked out’) in practice” (Streeck and Thelen 2005: 15). Streeck and Thelen argue that determining what a rule ‘really means’ requires a ruling by a “legitimate authority charged with adjudicating between different interpretations” (2005: 14). While institutions are enforceable, there are enforcement costs, including the

effort required by rule-makers to identify and intervene in rule-bending or breaking. This effort will be constrained by the enforcement tools available, the scale and effects of deviation from the rules, the reasons for the deviation and indeed the nature of the rule itself. In practice, there are limits to the extent that rule-makers can prevent or sanction rule breaking.

Recalling that policies may be understood as institutions, we can utilise the tools offered by Streeck and Thelen to conceive of 'real' and 'ideal' patterns of policy. In the case study to be presented, we will distinguish HIV policy 'as it is enacted' from HIV policy 'as it is idealised'. The case will offer a rich example of such distinctions since HIV policy is intrinsically aspirational, being geared to the achievement of idealised goals. An important implication of this is that the source of institutional change can be (and, according to Streeck and Thelen, is often) endogenous (2005: 19). Streeck and Thelen do not identify the categories of actor they consider have 'legitimate authority' for the tending of institutions or the adjudication of gaps between their real and ideal forms. I will show in the case study and subsequent discussion, however, that Streeck and Thelen's concepts can assist us in conceptualising the practices of HIV bureaucrats in NSW in the process of policy change.

## **Summary**

In this chapter I have introduced policy process theories, noting their pluralist emphases that highlight civil society and political actors in the policy process. While bureaucracy is not missing from policy process theories, it is not explicitly theorised. Some theorists have argued for greater attention to be given to learnings from the field of institutionalism. I have introduced institutionalism as a lens for my exploration of bureaucracy in the policy process, noting its value in three key respects: its recognition of considerable state capacity in withstanding societal sources of policy pressure; its schemas for the nature and sources of policy change within which a role for bureaucracy can be conceptualised; and finally, its attention to the active processes of policy enactment and adjudication.

## **Methodology**

In this thesis, I draw from the calls of others (Nowlin 2011; Hicklin and Godwin 2009) to ask whether closer attention to bureaucrats and bureaucracy can improve our understanding of policy. I explore this question by examining the case of HIV policy in NSW. The emergence of HIV in the early 1980s provides a contained time period in which HIV policy can be examined. Additionally, the history of HIV includes periods of great public attention, in which HIV has been high on the political agenda, as well as periods of stability and routinised policy effort. Today, HIV is an example of middle-range policy of moderate issue salience in which political involvement is expected to be low and bureaucratic influence to be high (Rosati 1981; Preston and 't Hart 1999). While the period since the emergence of HIV provides a contained parameter, I examine the case over the period 2007 to 2015, with transformative policy change being evident from 2011. My interest centres on HIV policy in NSW, the Australian jurisdiction most heavily impacted by HIV and where I reside and work. Given the nature of changes in HIV science and technology that will be described in the case, I focus most closely on HIV policy as it relates to the prevention of HIV among gay men.

Central actors in HIV policy have included an organised and mobilised community constituency, political and bureaucratic actors. Indeed, community and political actors are central in dominant narratives of Australia's response to HIV (Bowtell 2005). Within this thesis, I purposefully bring bureaucracy to the foreground of the account of HIV policy. Consequently, the roles of other actors recede or figure through their relations with bureaucracy rather than independently of them. I make no claim to this account being the only account that can be offered of HIV policy in NSW but, rather, use this centring device to self-consciously explore the role of bureaucracy in public policy. This focus upon a single category of actor renders it a partial account but, I would argue, no more so than accounts that obscure bureaucracy.

The case study approach is recognised for its utility in theory building, including at the stage of theory testing (Eckstein 2009: 119; George and Bennett 2005: 19-22). A strength of the method lies in its identification of new variables through the examination of deviant cases or, as is relevant to this research, in its close inspection of variables that

may have been under-recognised in order to build evidence that can assist in the refinement of theory (George and Bennett 2005: 20). Alexander George and Andrew Bennett define a ‘case’ as “an instance of a class of events” (2005: 17). I have considered HIV as a single instance of public policy and have adopted a ‘within-case’ approach to the analysis. This involves the in-depth exploration of a case for the purposes of testing or expanding theory (Paterson 2010: 970-1). Within-case analyses are built upon deep immersion within the data and thick description of a case from which characteristics and patterns are identified. Decisions about the selection and presentation of data are made based on the research question under consideration and the theoretical framework being applied.<sup>4</sup>

Kathleen Eisenhardt proposes a step-wise approach to theory building using case study research (1989: 533). She proposes as initial steps the specification of the research question, selection of the case and the design of data instruments and protocols. According to Eisenhardt, fieldwork (data collection) is followed by data analysis, hypothesis shaping or testing, comparison with existing literature and closure. The design of my research encompasses each of these stages but includes an examination of extant literature as a preceding stage.

A principal source of data for this research is documentary evidence. Peer-reviewed materials have been utilised where available, however there has been surprisingly little scholarly attention to the administrative or structural aspects of Australian HIV policy and none that I have identified that considers Australia’s HIV response utilising policy process theory. The case study also draws upon policy materials publicly available from the NSW Ministry of Health and other sources such as non-government organisations and the Australian Government Department of Health.

My observations and experiences as a gay man and as a policy actor also inform this study. My involvement in Australia’s organised response to HIV has included activist, education and policy roles with community HIV organisations in a number of Australian

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<sup>4</sup> The alternative case study approach – a comparative analysis across cases – would provide for comparisons between HIV and other ‘instances’ of public policy, but would not additionally assist in assessing if examination of any case can enliven our understanding of policy.

jurisdictions as well as nationally. I am currently an employee of ACON, NSW's largest HIV community organisation. During the period 1999 through 2013, I was a NSW Ministry of Health bureaucrat working in HIV policy portfolios of increasing seniority, including director-level responsibility for all aspects of NSW HIV policy from around 2010. The analyses offered in this thesis are informed by my observations in each of these capacities. The research therefore encompasses something of an insider ethnography of HIV policy. This brings to the research the advantages of access to processes, events and materials that would be difficult for other researchers to find. Indeed, one explanation for the inattention to bureaucracy in public policy research will surely be the dilemma of access to the working processes of policy: it is generally easier to observe the participation of external policy actors – political or civil society – than that of bureaucracy, whose inner workings are obscured. My experience has provided that access and informs this research. For these advantages, however, there are compromises: am I equipped to fully critique events and dynamics in which I was involved and do my experiences lead me to give greater significance to these events than is due? These are questions that others ultimately must consider. I would observe, nonetheless, that the account offered is not a personal account, but one that is theoretically-guided, drawing upon institutionalism as a framework for the selection, organisation and analysis of the material presented in the case. In circumstances where the perspective offered is intendedly based on my observations, this is stated.



## **Chapter Three – HIV Policy Change – Case Study**

In this chapter, I present the case of HIV policy change in NSW during the period 2007 through 2015. The presentation of the case is theoretically-guided, drawing upon the statist and institutionalist frameworks and concepts presented in the Literature Review. I progressively describe the milieu, conditions and practices that together characterised and allowed for the transformation of HIV policy in NSW. I will show that during this period, HIV was situated as an area of middle-range policy with high bureaucratic influence. Bureaucratic conditions and possibilities were initially circumscribed but ripened during the period, including through bureaucratic practices that leveraged exogenous changes to bring about transformative policy change. The chapter commences with a discussion of the milieu within which HIV policy in NSW was situated. This draws upon Streeck and Thelen's (2005) thesis that endogenous factors can be independently important sources of gradual policy transformation. The trajectories of HIV policy, which include features of drift and conversion, will be described. The section draws upon institutionalist perspectives on path dependence, with future policy possibilities being heavily determined by historic settings. From this wider milieu, I turn to the conditions and problems of HIV policy, highlighting various features that ordered and constrained HIV bureaucracy in NSW, and the gradual shifts in these features during the period. Here, I draw on concepts highlighted by Skocpol in her discussion of state policy capacity: the role of ideas and solutions, administrative structures and capability and financial capacity. In the third section of this chapter, I turn from bureaucratic conditions to the practices of bureaucrats in the process of HIV policy change. This discussion is guided by Hall's schema for first, second and third order policy change and the determinative role of bureaucrats in adjusting policy settings and instruments and fermenting conditions that allow for policy transformation. I explore bureaucrats' uses of the mechanisms of the 'HIV partnership' as sites of puzzlement, planning and mobilisation. I point to the bureaucratic uses of data and evidence to destabilise prevailing beliefs about the limits of HIV prevention and frame commitments to new, ambitious policy approaches and targets. The chapter concludes with a discussion of the nature and scale of HIV policy change as exogenous and

endogenous conditions ripened and bureaucrats exploited new possibilities for policy in the period from 2011.

## **HIV policy milieu**

HIV policy is historically constituted and, even in 2007, its configuration and possibilities remained highly determined by the nature of its emergence during the early 1980s and the policy settings established in response to it. This policy milieu was complex and dynamic, historically derived, yet changing over time. It existed not in isolation, but within a wider policy context. In this section, I provide an overview of the macro-level features of HIV policy, their origins and the HIV policy subsystem. I observe the declining political and public attention on HIV at the commencement of the period of interest and locate HIV policy within nested and intersecting policy systems.

### ***Historic and macro-level HIV policy settings***

HIV public policy has been periodically expressed through HIV Strategies released by Australian and NSW Governments. These Strategies offer a time-limited articulation of HIV goals, objectives and principles and set directions for efforts in prevention, treatment and care, surveillance and research. At the conclusion of the time period to which the particular Strategy relates, they are usually evaluated in some fashion and a consultative process commences to develop the Strategy's successor. Such Strategies are not unique to HIV and are used commonly for governing, directing and coordinating efforts in health sectors such as mental health, suicide prevention, Aboriginal health and e-health.

In 2007, NSW HIV policy was formally expressed through the *NSW HIV/AIDS Strategy 2006-2009*, published by the (then) NSW Department of Health (2006a). The Strategy was issued as a Policy Directive, meaning that it was binding upon the Department and its operational entities, then known as Area Health Services (AHSs) (NSW Department of Health 2005a: 3). In 2004/05, the Department provided \$63.2 million in HIV program funding to AHSs for HIV prevention, ambulatory care and inpatient services

under the auspices of the Strategy (NSW Department of Health 2006a: 18).<sup>5</sup> The Department and AHSs disbursed a further \$15.8 million to non-government organisations in 2004/05 for HIV prevention, care, support and research (NSW Department of Health 2006a: 18-9). Its binding nature, together with its substantial funding program, gave the Strategy considerable and, relative to similar-type strategies, unusual weight.<sup>6</sup>

NSW HIV policy at this time displayed features characteristic of policy decisions made in response to the threat HIV presented when it emerged in the early 1980s. At the national level, the early ‘workings’ of HIV policy were canvassed in the Australian Government’s Green Paper released in 1988 – *AIDS, a time to care, a time to act: towards a strategy for Australians: a policy discussion paper* (Commonwealth Department of Community Services and Health 1988; see also Altman 1992). The Green Paper was presented to the Commonwealth and all state and territory Parliaments in 1988, reflecting a high degree of intergovernmental and bipartisan cooperation, and provided the basis for the first *National HIV/AIDS Strategy* (Commonwealth Department of Community Services and Health 1989).

By 2007, Australia had commenced its fifth *National HIV/AIDS Strategy*, covering the period 2005-2008 (Australian Government Department of Health and Ageing 2005). National HIV Strategies have provided important articulations of principles and goals, established the program areas of Australia’s response, and set out the roles and responsibilities of different levels of government and of partners – notably researchers, the medical community and the organised community response to HIV – but do so with

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<sup>5</sup> In 2004/05, HIV program funding was predominantly allocated for HIV programs, with a proportion also being directed to related program areas, such as sexually transmissible infections and hepatitis C. The precise calculation of funding distribution is complicated by the inter-relatedness of program responses to these diseases with, for instance, funding for the Needle and Syringe Program contributing to both HIV and hepatitis C prevention goals. For detail on HIV program funding arrangements during this period, see NSW Department of Health (2006b: 17-19; 2007a).

<sup>6</sup> The Strategy established the goals, targets and priorities of NSW HIV policy. An accompanying environmental scan provided context, describing the challenges then faced, the research base for the Strategy and roles and responsibilities (NSW Department of Health 2006b). A separate implementation plan for the delivery of the Strategy within Aboriginal communities was also published (NSW Department of Health 2007c).

limited specificity. This reflects the division of labour under Australia's federal arrangements, with the Australian Government establishing broad directions for the response to HIV, providing access to HIV primary health care, regulating medicines and tests for HIV, and subsidising access to HIV treatments (Australian Government Department of Health and Ageing 2005: 43).

Australia's states and territories, meanwhile, plan and deliver HIV programs and services and were enjoined to establish "State and Territory HIV/AIDS strategies that complement and build upon" the national Strategies, and create "public policy and legislative frameworks consistent with the aims and objectives" of national Strategies (Australian Government Department of Health and Ageing 2005: 47). This enjoiner offered license to jurisdictions to interpret and apply the *National HIV/AIDS Strategy* in accordance with local conditions and to introduce innovations that may be possible at the state and territory, but not national, level. The *NSW HIV/AIDS Strategy 2006-2009*, in its own terms, "translates the priorities within the National HIV/AIDS Strategy into the NSW context" (NSW Department of Health 2006a: 4).<sup>7</sup> Arguably, state and territory HIV Strategies have also extended their national correlates: while the *NSW HIV/AIDS Strategy 2006-2009*, for example, offered a textured account of gay men's risk reduction practices, acknowledging gay men's successful adaptations to HIV through the use of risk reduction practices other than condoms (2006a: 21-2; 28-9), the *National HIV/AIDS Strategy 2005-2008* was more conservative, warning of "complacency" and committing to "education" of this population to "reinforc[e] the need for condom use" (Australian Government Department of Health and Ageing 2005: 20-1). Taken together, the Strategies provide important point-in-time windows to expressed HIV policy in NSW and Australia more widely.

The goals established by the *NSW HIV/AIDS Strategy 2006-2009* were to reduce new HIV infections, improve the health of people living with HIV/AIDS and reduce HIV-

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<sup>7</sup> While national and state HIV Strategies are taxonomically nested, the implied direction of the relationship between them should not be over-assumed. In 1992, the Hon. Ted Pickering, MP, responding to a Parliamentary question on notice, indicated the NSW Government's support for the *National HIV/AIDS Strategy*, but also pointedly observed of NSW: "As the State with the earliest involvement and largest caseload (65% of the National total) many policies and practices have necessarily been 'pioneered' in New South Wales" (NSW, Legislative Council 1992: 7092).

related discrimination and address systemic barriers to HIV health promotion (NSW Department of Health 2006a: 4). These goals were quantified through targets, established for the first time under this Strategy, with the prevention goal to be achieved through the promotion of safe sex and other risk reduction approaches, particularly among gay men and others at greater risk of HIV such as sex workers, and the provision of sterile injecting equipment for people who inject drugs (2006a: 21-6; 29-31; 34). These approaches were embedded within health promotion principles derived from the Ottawa Charter (Brown et al. 2014). The nature of HIV transmission, involving intimate sexual and injecting behaviours, means that its prevention is dependent on the voluntary cooperation of those at risk or who have HIV. Governments' need for such cooperation underpinned the guiding principles of the Strategy, which included partnership, joint action and the involvement of affected communities. The central principle of 'partnership' was described by the Strategy in these terms:

“The NSW HIV/AIDS partnership, which consists of government, affected communities, medical and health services, and research providers, is responsible for advising the NSW Minister for Health on key issues in HIV prevention, treatment, care, support and research. Each member of the partnership has a unique contribution to make... and has different expertise. Effective partnership requires respectful sharing of that expertise, recognition of the unique contribution of each partner, and the undertaking of shared activity where appropriate” (NSW Department of Health 2006a: 8).

Expressed in this way, 'partnership' recognises the mutual interests of subsystem actors in achieving policy goals. It points to an investment in the success of others – a recognition that government cannot succeed in reducing HIV incidence without the community succeeding; that clinicians will not succeed in their care of patients without researchers succeeding; and so on. For Geeta Gupta et al., it reflects a “collective ownership of the epidemic, a willingness to speak openly about risk and to reduce harm, and partnership among researchers, policy makers, and community groups” (2008: 770). Kane Race, a social researcher writing at a later time about his experience of partnership, highlighted convergence as well as difference, describing a “diverse team of interlocutors... epidemiologists, gay men, sex workers, drug-users, bureaucrats, community educators, activists, doctors... actively engaged and enlisted in the making

of science, in articulations that consisted of both formal and informal exchanges... [with] moments of insights and occasional stoushes... unexpected convergences and laughter and difficult exchanges” (2014: 262).<sup>8</sup> Martin Holt has characterised this partnership, seen from a social researcher’s perspective, as an epistemic community (2014).

In 2007, the HIV partnership was enacted through a range of mechanisms. At the highest order:

“The Ministerial Advisory Committee on HIV and Sexually Transmissible Infections (CAS, reflecting its origins as the Committee on AIDS Strategy) consists of invited representatives of the NSW HIV/AIDS partnership.... The CAS is responsible for providing independent expert advice to the Minister... and monitoring the implementation of measures in this HIV/AIDS Strategy” (NSW Department of Health 2006a: 14).

While correct, the Minister appointed members to the CAS on the recommendation of HIV bureaucrats. The CAS, again on bureaucratic recommendation, made appointments to the Health Promotion Sub-Committee. Similarly, while the reporting line was to the Minister, in practice, this involved the provision of Minutes to the Office of the Minister after meetings. The CAS’ primary relationship was with HIV bureaucrats who proposed its meeting agendas in consultation with the Chair, prepared papers, introduced and framed many items of discussion, and produced meeting records.

Writing about this period, Adrian Mindel and Susan Kippax observe:

“A heavy emphasis continues to be placed on partnership in NSW by all parties, with a range of mechanisms – including formal and informal committees and meetings, and the sharing of evidence – available and utilised for relationship management, shared problem identification and solving, consensus building,

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<sup>8</sup> These articulations of the HIV partnership closely follow the features of ‘policy networks’, which are distinctive for their defined membership, the recognition of shared interests among members, interdependence among members and isolation from other networks (Wilks and Wright 1987; see also Rhodes 2007; Howlett et al. 2009).

and strategy, policy and program development. There is a profound sense of engagement and mutual trust and respect between the members of the partnership that is located in the calibre and the commitment of those involved” (2013: 355).

Operationally, there were (and remain) myriad other structures that gave effect to the practice of partnership, including a Metropolitan Gay Men’s HIV Prevention Interagency, which brought together HIV bureaucrats, community organisations, clinicians and researchers to jointly plan HIV prevention responses within the Sydney gay community informed by social, behavioural and epidemiological research. A Culturally and Linguistically Diverse Communities Interagency and a Sexually Transmissible Infections in Gay Men Action (STIGMA) Group were also active, alongside *ad hoc* working groups (Irwin et al. 2008: 215-6). These interagencies were bureaucratically endorsed, with HIV bureaucrats proposing, establishing and participating in them and providing behind-the-scenes support to their direction and efforts.<sup>9</sup>

### ***Political and public attention on HIV***

So far I have described something of HIV policy itself in the period around 2007, its underpinning principles, expression through Strategies, and elaborate, deeply-embedded mechanisms that brought together members of the partnership. However, HIV policy and bureaucratic practice occurred within a trajectory of changing HIV salience.

The extraordinary circumstances of early Australian HIV policy, emerging as it did in an environment of public anxiety and media glare, meant that a decline in attention would be expected. From its improbably high levels of public and political salience in

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<sup>9</sup> The Metropolitan Gay Men’s HIV Prevention Interagency, for instance, was a continuance of a Response Group established and chaired by HIV bureaucrats in 2002 to mobilise a response to increases in HIV notifications. Following the response, the chairing of the group was transitioned to the lead gay men’s community HIV organisation, ACON, while bureaucrats continued to participate. Similarly, the CALD HIV Interagency was established as an action of the *NSW HIV/AIDS Strategy 2006-2009*, prepared by HIV bureaucrats.

the late 1980s, the profile of HIV declined as effective responses to the epidemic were established and the threat of a generalised epidemic receded. By 2007, there was considerably reduced commentary about once-controversial programs to prevent HIV transmission, such as gay men's education campaigns and the Needle and Syringe Program. Media coverage of trends in HIV epidemiology was declining at this time, with coverage tending to focus on more salient related issues such as increases in chlamydia among heterosexual young people (see, for instance, Molloy 2008; Hall 2009; for trends in media coverage to 2004, see Bowtell 2005: 36). Public confidence that policy settings were effective in controlling HIV was generally high (see, for instance, Dolan et al. (2005) on growing public support for the Needle and Syringe Program).<sup>10</sup>

This declining attention and interest in HIV reflects a settling phenomenon: arguably, it was the early hyper-attention to HIV that was atypical, not the decline in attention that followed. By 2007 however, researchers were pointing to an over-correction, with evidence emerging that *insufficient* attention, effort and resources in some jurisdictions was contributing to poorer outcomes (Bernard et al. 2008; Fairley et al. 2008a; Griew 2008). At the national level during this period and beyond, community HIV stakeholders were increasingly concerned by the declining policy ambition of political and bureaucratic actors, and sought to re-mobilise interest through public calls to action (Australian Federation of AIDS Organisations et al. 2012a; ACON 2012; Australian Injecting and Illicit Drug Users League 2012).<sup>11</sup> These concerns had been evident since

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<sup>10</sup> The pattern observed here approximates the 'issue-attention' cycle, as proposed by Anthony Downs, in which public perceptions of crises follow a predictable pattern: at the pre-problem stage the objective conditions of the problem are greater than public awareness of it; dramatic events lead to alarmed public discovery and enthusiasm; relative problem-solving follows, in which the possible responses to the problem are balanced against the social and other costs of those solutions; public interest declines; and finally, at the post problem stage, institutionalised responses have been enacted and public attention becomes sporadic (1972: 39-41).

<sup>11</sup> This trajectory reflects a public health paradox: where prevention efforts succeed in containing a problem, the spectre of the problem recedes; decreased attention results in increased risk, however in conditions of uncertainty, it becomes difficult to marshal the arguments for maintenance or expansion of effort. There are simply not sufficiently robust or available methods for predicting the levels of policy attention or effort required because the point at which the phenomena will tip back from 'issue' to 'problem' is either unknowable or highly contestable (see, for instance, Gostin 2004; Gostin et al. 2004).



at least 2005 and were rhetorically referenced within the sub-title to the fifth *National HIV/AIDS Strategy 2005-2008*: ‘Revitalising Australia’s Response’ (Australian Government Department of Health and Ageing 2005).

The nature of HIV as a policy problem provided some protection relative to other areas of prevention policy: while HIV salience was diminished, a latent threat remained in the public and political consciousness. This threat emerged occasionally at moments where the spectre of uncontrolled HIV transmission was raised, such as through community needle-stick injury or in cases of ‘reckless endangerment’ where a person with HIV may have ‘knowingly’ placed another person at risk of HIV transmission (O’Donnell et al. 2010: 52). In 2007, Victoria’s Minister for Health dismissed the Chief Health Officer for their apparent poor handling of such a case (Ker and Medew 2007; Austin et al. 2007). The dismissal of bureaucrats on performance grounds is rare and, from my observations, senior public health bureaucrats with distal accountability for HIV policy were greatly disquieted by it. Related controversies at this time in South Australia and the Australian Capital Territory underscored the sense of HIV being a public health matter that was unusually sensitised and that had ‘exceptional’ characteristics (Cameron 2007; Cameron and Rule 2009). This latent spectre of HIV, together with the general disinclination of governments and senior bureaucrats to “tamper with policies that have produced acceptable outcomes,” has insulated HIV policy from intrusions (Bowtell 2005: 20).

A practical effect of the settling of policy attention was the gradual devolution over time of accountability for HIV policy from the political to the bureaucratic sphere and, within the bureaucracy, from higher to lower levels of authority.<sup>12</sup> This was evident in the orientation of the CAS to HIV bureaucrats rather than the Minister and in the approval of *NSW HIV/AIDS Strategy 2006-2009* as a Policy Directive by senior bureaucrats, rather than as a policy of the NSW Government approved by Cabinet. For

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<sup>12</sup> Jerel Rosati predicts such transitions in his exploration of executive decision-making in the United States, noting that bureaucratic or local dominance occurs in circumstances where Presidential involvement is low (1981: 247). Policy theories concerned with agenda-setting, such as Punctuated Equilibrium Theory, also observe that within “issue-oriented policy subsystems of ... specialists operating out of the spotlight, most issues, most of the time, are treated within such a community” (Baumgartner, Jones and Mortensen 2014: 62).

bureaucrats such as myself, such devolution could be welcomed, even sought out, since it reduced interference and increased autonomy. However the cost could also be high, with such policy portfolios losing prestige and standing, and their bureaucrats having less authority than might be required to advance the policy or to protect it in the face of ambient, possibly threatening cross-cutting policies.

### ***Locating HIV policy within nested systems***

HIV policy is nested within wider and overlapping policy areas. In NSW, HIV is situated bureaucratically within the broader public health structures of the NSW health system. In 2007, the AIDS/Infectious Diseases Branch (AIDB), which was responsible for HIV policy, was located within the NSW Ministry of Health's Population and Public Health Division.<sup>13</sup> Public health, as a disciplinary domain, describes the practices of the state in its surveillance, regulation and control of disease within populations. HIV has challenged traditional public health practices insofar as its 'control' is dependent on the voluntary cooperation of people with HIV and those 'at risk' to a greater degree than other communicable diseases. Its transmission via sexual and drug-using practices places it within a domain with a long history of attempted and failed state control. Further, in the absence of a cure or vaccine, the state lacks the most effective technological instruments of disease control.

Australian HIV policy has consequently been built upon a principal strategy of behavioural prevention that recognises HIV to be "a profoundly social disease... deeply embedded in social, cultural and political processes" (Kippax et al. 2011: S1). The recognition of the collective experiences and adaptations of affected communities puts HIV policy at odds with traditional public health approaches that emphasise technological or medically-directed techniques of control.<sup>14</sup> Kippax characterises the

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<sup>13</sup> AIDB evolved over time, commencing as the AIDS Bureau in the late 1980s and later assuming wider policy responsibilities. In 2007, its scope included HIV, other blood-borne viruses, sexually transmissible infections, infection control and immunisation. In 2012, it merged with the area responsible for tobacco, obesity and overweight and healthy public policy, forming the Centre for Population Health.

<sup>14</sup> The evolution of HIV policy in the period from 2007 saw a growing emphasis on biomedical prevention technologies, such as pre-exposure prophylaxis (that is, HIV treatment taken by a person before they are exposed to HIV to prevent infection).

approach of HIV policy as a ‘social public health’ in which “the locus of change is not individuals but the social and political medium that enables collective action” (2012: 6). HIV policy therefore has, at its core, an expressed concern for the creation of ‘enabling environments’ in which barriers to gay men’s, sex workers’ and injecting drug users’ adoption of safe practices and access to health services are removed (see, for instance, NSW Ministry of Health 2012a: 11; 36). It is upon this logic that the protection of human rights has been held not only to be compatible with, but necessary for, the achievement of HIV policy goals. The *NSW HIV Strategy 2012-2015* expressly “recognises the continuing role of the law in contributing to an environment that supports safe practices, provides safeguards against discrimination and protects public health” (NSW Ministry of Health 2012a: 11).<sup>15</sup> This contrasts with traditional public health approaches in which human rights and prevention goals are weighed *against* one another in a logic of the rights of the individual *versus* the protection of the public (Mann 1994; Gostin 2001).

Beyond public health, HIV policy intersects with drug policy in the provision of access to sterile injecting equipment to prevent HIV. The reduction of harms to drug users is one of three pillars of Australian drug policy, although the balance of efforts strongly favours supply and demand reduction through policing (Ministerial Council on Drug Strategy 2011). Throughout the period 2007-2015, agreements between police and health authorities were in place to smooth tensions between law enforcement and HIV prevention goals and guidance was issued to workers to limit conflict at the ‘coalface’ of these policies (NSW Police Force 2013; NSW Ministry of Health 2013a). This included rules to limit police activities that would impede drug users accessing sterile equipment or disposing of used equipment. Likewise, the dispensing of needles and syringes was regulated and providers were required not to interfere in interactions between police and drug users.

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This required careful navigation given the principles underpinning HIV policy and was subject to considerable debate regarding tensions between biomedical and behavioural approaches to prevention (see, for instance, Kippax et al. 2011; Kippax 2012).

<sup>15</sup> While this principle is rhetorically important and is staunchly defended by community advocates, the record of positive HIV-related legal reform since the early 1990s, when a great deal of law reform occurred, is poor (Australian National Council on AIDS and Related Diseases 1999; Clayton 2010; Godwin 2009).

These intersections between HIV policy and wider approaches have been remarkably stable, however skirmishes did occur (see for example, The Redfern Society 2013) and the careful management of these intersections was an ongoing task for NSW HIV bureaucrats. Moreover, these wider fields of drug policy and public health include alternative possibilities – such as involuntary treatment – that are alien to HIV policy, and the diligent navigation of the boundaries of HIV policy was as much as exercise in suppressing potential alternatives and guarding against incursion as it was minimising tensions.<sup>16</sup>

Over time, the perimeters of the HIV sector have expanded to encompass emergent policy domains, most notably sexually transmissible infections (STIs) and hepatitis C. The origins of this expansion were evident in the mid-1990s when the *National HIV Strategy* was widened in scope and subtitled “A Strategy framed in the context of sexual health and related communicable diseases” (Commonwealth Department of Health and Family Services 1996). Later National HIV Strategies would resume their singular scope with standalone Strategies addressing these ‘related diseases’ being created. This expansion of the policy domain also occurred in states and territories.

Programs delivered under the new ‘related diseases’ Strategies were resourced largely through the gradual redirection of funds allocated to HIV. By the mid-2000s, the conversion of marginal HIV investments was intensive, with legacy programs such as the NSW HIV dental scheme (see Feeney 2008) being discontinued to fund these wider areas.<sup>17</sup> NSW, being the jurisdiction with the greatest epidemiological burden of HIV, also had the largest financial investment in its HIV response (Butler 1996; Feachem 1996). By comparison with other jurisdictions and the Commonwealth, expansion of

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<sup>16</sup> S. 62(3)(b) of the *Public Health Act 2010* (NSW) includes provision for the making of orders that would require a person with certain conditions, including HIV, to undergo treatment. However to the author’s knowledge, they have not been utilised to compel treatment at any stage, and certainly not since 2000.

<sup>17</sup> My professional observation was that this process of conversion in NSW was of mutual benefit to HIV as well as wider diseases policy. Redirected funds were put to useful effect addressing problems in the wider disease areas but equally, the funds were freed not from essential HIV programs, but from legacy programs. The reform of those historical arrangements *from within* (that is, by HIV bureaucrats) was a controlled alternative to the imposition of reforms by more senior bureaucrats if advocacy for gains in wider disease areas had not been effectively managed.

the sector's perimeter in NSW occurred without materially impacting HIV policy outcomes. By 2007, disinvestment in HIV was resulting in increased HIV diagnoses in some jurisdictions and nationally, but not in NSW (NSW Department of Health 2007b; Fairley et al. 2008a; Griew 2008). Such conversion effects were not only financial: competition for the attention of bureaucrats now working across multiple disease areas has been cited as a contributor to policy failure in some jurisdictions and contrasted with the 'relative success' of NSW HIV policy (Bernard et al. 2008).

### ***Summary***

We have observed multiple evolutionary processes in NSW HIV policy in the period to and from 2007. Acute anxiety about HIV in the 1980s declined during the 1990s as policy efforts produced results, but this gave way by the mid-1990s to a risk of, in Streeck and Thelen's (2005) terms, policy drift. HIV policy was nested within and alongside policy fields, such as public health and drug policy, which have internal logics that are in tension with HIV policy. By 2007, HIV policy resources had been partially re-directed to related diseases such as STIs and hepatitis C. Within Streeck and Thelen's (2005) typology, these processes reflect policy conversion. The effects of conversion on NSW HIV policy were contained, however the costs were greater nationally and in other states and territories. While these gradual transformations in HIV policy are readily discernible, the account so far provides little insight into the conditions and problems of HIV and the actors involved in HIV policy change.

### **The conditions and problems of HIV policy**

In this section, I explore various structural conditions that ordered and constrained bureaucratic action and various problems present in HIV policy during the period from 2007. These included HIV policy being governed through a defined program area with allocable resources; the bureaucrats themselves who had value commitments to the policy domain; and the nature of HIV policy problems and subsystem beliefs about solutions. The possibilities for policy change in response to these conditions and problems were altered over time by developments in science and technology and changes in public and political attention.

### *HIV policy – Structures, resources and people*

The scope of the AIDS/Infectious Diseases Branch (AIDB) was unusually wide, encompassing responsibility for HIV prevention, testing, care and support, ambulatory and inpatient treatment, public health management, research and workforce development. AIDB was headed by a Director-level position with decision-making authority for HIV policy, funding, program design and delivery, strategy formulation and issues management, at least to the extent that decisions accorded with wider bureaucratic policy and goals. While AIDB was responsible for policy domains beyond HIV itself – such as immunisation and infection control – these were introduced at later stages of AIDB's development and its primary identity centred on HIV policy.

During 2007, approximately 13 full-time AIDB staff worked principally on HIV policy, including the Director, two managers and policy, data and administrative officers.<sup>18</sup> Positions were organised by portfolios, with staff responsible for aspects of HIV policy, such as gay men's prevention, research, clinical services, funding and data, and the Needle and Syringe Program. AIDB's staffing capacity allowed for a reasonably full realisation of its functions. In 2007, these were conceptualised in terms that followed an earlier review of the Department – planning, policy, resource allocation and performance monitoring and accountability (Nexus Management Consulting 2003).

In policy spheres with insufficient bureaucratic capacity, attention is necessarily rationed between competing priorities, and the most immediate priorities will generally be administrative in nature, such as attending to reporting requirements, correspondence and the administration of funding and contracts.<sup>19</sup> AIDB's capacity was sufficient that in addition to these administrative tasks, bureaucrats could attend strategically to presenting issues and problems. AIDB therefore had a strong goal and problem-solving

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<sup>18</sup> This approximation is based on those staff whose principal focus is HIV policy. It excludes staff working in related policy areas, such as hepatitis C, sexually transmissible infections, immunisation and infection control.

<sup>19</sup> For discussion of policy capacity in Westminster systems, see Scott and Baehler (2010) and Tiernan (2012). For discussion of the reform of the NSW Department of Health to give greater primacy to Westminster functions, see NSW Department of Health (2011a).

orientation concerned with improving HIV program and service delivery in the public and non-government sectors (Bernard et al. 2008). This was visible through processes such as the development of a strategy to improve care and support for people with HIV who were unable to live independently in the community (NSW Department of Health 2008) and the delivery of large-scale mass media campaigns, such as *Get Tested. Play Safe* and *Safe Sex. No Regrets*, that supported local HIV prevention responses (Brotherton et al. 2005; NSW Department of Health 2005b, 2009).

Such efforts deepened the shared subsystem ownership of the problems of HIV policy and created experiences of successful collective problem solving. In a review of jurisdictional differences in responses to HIV, Diana Bernard et al. observed:

“The New South Wales Health Department team is highly skilled and deeply respected by gay and other community-sector agencies, as are the other members of the partnership. Although ‘partnership’ is not always easy – as each of the partners often has different ways of seeing and responding to the problems – the key has been open communication. According to all our respondents there is a high level of trust and commitment to support the partnership – and a concomitant lack of competitiveness and defensiveness” (2008: 194).

This observation points to collegiality and respect in relationships across the partnership however it should not be over-interpreted. The reference to ‘different ways of seeing and responding to the problems’ speaks to the performance by respective parties of their formal roles (as community actors, bureaucrats etc), the separation of those roles and to differences in perspective and interest. From my own experience and discussions with colleagues, I would observe that our interests as HIV bureaucrats included our legitimacy as bureaucratic actors, as distinct from subsystem actors, where the audience for the performance of such roles is other bureaucrats, including those in senior positions with decision-making authority over HIV policy, and political actors. While it served the bureaucracy’s interests to have a high-performing HIV policy area respected within its subsystem, this did not extend to the policy area being co-opted in ways that were incompatible with those interests.

AIDB's legitimacy, authority and capacity were supported not just by its personnel, but by its control of funding that was recurrently available and annually allocated to public and non-government organisations, subject to AIDB's review and acceptance of proposals (NSW Department of Health 2006a). These funds provided for the delivery of HIV services and programs and for one-off initiatives such as campaigns, forums and consultancies that explored various issues and problems. AIDB's retention of discretionary funding capacity for responses to presenting issues allowed for an active, problem-solving orientation to HIV policy: having the resources available to explore issues as they arose allowed for their early management, prior to them becoming problems.

### ***Bureaucrats, value commitments and the HIV policy subsystem***

Most HIV bureaucrats working in AIDB from 2007 had professional experience in operational HIV roles. These included as community educators and managers, social workers, advocates, researchers and program administrators, sometimes at senior levels, in the public sector, community organisations and universities.<sup>20</sup> These professionals brought to the bureaucracy knowledge and insight to the issues and problems of HIV policy and experience as actors within the HIV subsystem through which they had established networks and relationships. Many also had personal connections to HIV: as gay men, their allies and as professionals with value commitments to the principles and goals of HIV policy. In this respect, we observe the encroachment of the HIV subsystem, and civil society in particular, upon the bureaucracy and the self-governance of HIV policy within the subsystem. It is not possible to comment definitively on the quality or intensity of these connections relative to other bureaucratic policy areas, especially given such goal commitments were evident in other areas, but it is certainly possible to observe that they were strong among NSW HIV bureaucrats.

The traffic of personnel between HIV operational and bureaucratic roles was aided (and to some extent necessitated) by freezes or restrictions on public sector recruitment in

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<sup>20</sup> In the period 2007 to 2015, five of the six appointees to the role of Manager, HIV and STIs (either for extended acting or on-going periods) had prior professional roles in HIV community organisations. The sixth did not, but went on to such a role upon leaving the Ministry.



the period from 2007 (see NSW Department of Premier and Cabinet 2008, 2009, 2010). These restrictions limited the filling of vacancies to secondments and direct appointments of individuals known to have the necessary experience to fill roles. Accordingly, many personnel appointments were from operational agencies, including HIV community organisations. However, the traffic was more than a product of exigency: it also reflected a valuing within the bureaucracy of the capability available from the field and the commitments associated with that.<sup>21</sup>

### ***The problems of HIV policy and subsystem beliefs about solutions***

A strong narrative of ‘success’ about Australia’s response to HIV has been evident since its earliest days, when decisive political responses contrasted with lacklustre action elsewhere (see, for instance, Duckett 1986). This narrative later came to characterise success in HIV prevention as well, with high rates of HIV testing, safe sex and safe injecting being achieved at an early stage (Kippax et al. 1993b; Kippax and Race 2003). The mobilisation, safe practice and adaptation over time of affected communities resulted in Australia having a relatively low rate of HIV incidence, despite periodic concerns about increases in HIV notification (McPherson and Ward 2010).

The characterisation of NSW ‘success’ in its response to HIV was strongly evident in the period leading up to 2007 and immediately beyond. A 1999 report on NSW HIV efforts was subtitled ‘A World Class Success’ (Stewart and Penny 1999); the *NSW HIV/AIDS Health Promotion Plan 2001-2003* was subtitled ‘Surviving Our Success’ (NSW Department of Health 2001); and a special issue of the NSW Public Health Bulletin, for which I was the lead editor, was titled ‘HIV in NSW in 2010: Sustaining Success in an Evolving Epidemic’ (O’Donnell et al. 2010). Underlying this subsystem consensus, however, was an anxiety about the potential for decline in HIV policy, with this being betrayed in the latter two titles: in the former, success must be survived and in the latter, it must be sustained during a period of evolutionary change. Such anxieties stemmed partly from uncertainties about whether the measures taken by affected

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<sup>21</sup> The *Government Sector Employment Act 2013* (NSW) is intended to promote greater lateral movement of staff within and between government agencies. It will be interesting to observe whether this in time reduces the orientation of AIDB to subject-matter specialisation in its recruitment practices.

communities in preventing HIV would continue to be sufficiently effective.<sup>22</sup> They also reflected concern about the vulnerability of HIV policy to interference, such as might occur in response to an increase in HIV notifications or a public incident that created political sensitivity. Equally however, they pointed to certain beliefs among sectoral partners about what more could be achieved within the parameters of HIV prevention practice. The aspirations of HIV policy at the beginning of the period were constrained by the effectiveness of measures already introduced – such as the Needle and Syringe Program – and by the marginal further gains that could be extracted from the armamentarium of available prevention tools. To make further progress, change would be required in the HIV sector’s beliefs about the problems of HIV and in the solutions available.

### ***Data and its interpretation and new science and technology***

In 2011, NSW data emerged showing that, at the time of HIV diagnosis, people had been infected for around four-and-a-half years (reported in NSW Ministry of Health 2012a: 19, and later published in Jansson et al. 2015: 1523). Also around this time, studies in Victoria and Queensland had reported higher than previously assumed rates of undiagnosed HIV infection among gay men (Pedrana et al. 2012; Birrell et al. 2010). The implications were profound as they troubled other data, and the sector’s narrative, of very high levels of HIV testing among gay men. Self-reported survey data had consistently shown rates of HIV testing among gay men in NSW to be upwards of 90 per cent ever tested and upwards of 60-70 per cent in any year (see, for instance, Holt and Mao 2011: 15-6). The data, while incongruent, were not necessarily contradictory, but they required explanation that was not immediately available. They also pushed at sectoral narratives about the limited margins for gains in HIV prevention.

In the same year, Myron Cohen et al. (2011) published research showing a 96 per cent reduction in sexual transmission from people who were effectively treated for HIV. *Science* declared the study the ‘Breakthrough of the year’ (Cohen 2011). While the

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<sup>22</sup> This included debate about the increasing use of non-condom based HIV prevention practices by gay men (including the adoption of ‘serosorting’ in which casual sexual partners decide on condom use based on a discussion of HIV status), with such practices providing variable but lowered levels of HIV protection (Holt 2014).

biological plausibility of such effects had long been recognised (Cohen et al. 2007) and there had previously been observational studies of this effect (Del Romera et al. 2010; Reynolds et al. 2011), Cohen et al.'s study provided conclusive randomised control trial evidence of the effect at the individual and population level.<sup>23</sup> The strength of the effect was considered, even among leading scientists, to be “astounding” (Cohen 2011: 1628).

The results of the trial immediately expanded the policy options available to achieve HIV goals: first, increasing the proportion of people with HIV who were effectively treated would reduce onward HIV transmission; and second, decreasing the time between a person acquiring HIV and being diagnosed through HIV testing would allow earlier treatment and lower the potential for transmission. Hitherto, both of these technologies – treatment and testing – had been important HIV strategies, but for different reasons: while HIV treatment had been recognised for its individual clinical benefit, the new evidence extended and confirmed its benefit for their HIV-negative partners. Also, while HIV testing had long been promoted, its benefit was principally understood as being to inform individuals' decision-making about sexual and injecting risks and about treatment for personal clinical benefit; now its benefit was enlarged to include the protection of others from infection through the possibilities of earlier treatment.

Encouraging, but not yet conclusive efficacy data had also emerged by 2011 pointing to the potential for HIV drugs taken prophylactically to prevent HIV infection (Grant et al. 2010). In this scenario, individuals who do not have HIV take HIV drugs prior to potential risk exposures to prevent infection. By mid-2012, the evidence was sufficient that the United States had approved a HIV medication, Truvada, for use as pre-exposure prophylaxis (Food and Drug Administration 2012) and HIV community organisations had begun calling, cautiously, for research into its use in Australia (Australian Federation of AIDS Organisations 2012b).

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<sup>23</sup> The strength of the evidence provided by Cohen et al. was pivotal. An earlier review of evidence by the Swiss National AIDS Commission – known as the *Swiss Consensus Statement* – had drawn similar conclusions about the effect of viral suppression on HIV infectiousness and transmission (Vernazza et al. 2008). However, it did not lead to substantive policy change and, rather, stimulated intense international debate on the reasonableness of the conclusions drawn and its policy implications (see for instance, Wilson et al. 2008; Cohen 2010).

The policy implications of the accumulating new knowledge were significant: substantial further gains in HIV prevention could be achieved through a rebalancing of policy goals from behavioural prevention to combination prevention, in which existing social and behavioural approaches would be complemented with the use of biomedical technologies to prevent HIV. The full realisation of these gains would require substantial scale-up of HIV testing and treatment to allow more people to access these technologies more conveniently and, in the case of HIV testing, more frequently. To do so, HIV bureaucrats would be required to remove cost and other barriers and improve the availability and design of testing and treatment services.

In Australia, the Australian Government's Therapeutic Goods Administration regulates HIV tests. During 2011, Australia's HIV testing arrangements – as experienced by those seeking a test – remained largely as they were when Australia pioneered HIV testing in 1985. While new generations of HIV tests had been introduced, the practice of HIV testing still involved a visit to a doctor, the drawing of a blood sample that was transported to a laboratory for testing and the return of the patient for their results approximately ten days later (for discussion of barriers to HIV testing, see Prestage et al. 2012; ACON 2014). New technologies in the form of rapid HIV screening tests that could provide results in around 30 minutes at the point-of-care (that is, at the testing site) had been available overseas for some time, but none had yet been approved in Australia.<sup>24</sup> The Australian Government explicitly prohibited the manufacture and sale of home-based HIV self-tests until June 2014 (Dutton 2014). Professional interests, high regulatory barriers and Australia's small market were (and remain) significant barriers to the introduction of new HIV testing technology, but equally, the availability of these tools elsewhere and Australia's slowness to adopt them reflected a level of lethargy in national HIV policy that had long been a source of community stakeholder concern (Whittaker 2011a; ACON 2014).

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<sup>24</sup> The Australian Government Therapeutic Good Administration approved the first, and to date only, HIV rapid test – the Alere Determine HIV Combo test – in December 2012. In contrast, the United States' Food and Drug Administration has approved eight such tests (Henry J Kaiser Family Foundation 2015).

Access to HIV treatment in Australia was similarly constrained in 2011. The Australian Government restricted HIV treatment to accredited doctors who participated in continuing professional development. In NSW in 2011, there were approximately 115 HIV prescribers working in private and public settings (see Australasian Society for HIV Medicine (2015) for current HIV prescriber list). The restrictions on prescribing limited the number and geographic spread of clinicians from who care could be sought. The dispensing of HIV treatments was also restricted by the Australian Government, with individuals being required to pay for and collect medications in person, on a monthly basis, from the outpatient pharmacies of select public hospitals (National Association of People Living With HIV/AIDS 2009). Additionally, until April 2014, the Australian Government restricted access to HIV treatments based on clinical criteria, meaning that many people with HIV were ineligible for subsidised treatment despite it being of clinical benefit (Australasian Society for HIV Medicine 2014; for further discussion of structural barriers to HIV treatment, see National Association of People Living With HIV/AIDS 2009; McAllister et al. 2013; Wilkinson et al. 2014).

### ***Changes in political and public attention and ambient policy***

In this changing HIV landscape, the political and bureaucratic landscape was also in flux. In 2011, a centre-right NSW Government that was newly elected following 16 years in Opposition, introduced major reforms of the health portfolio and the public service more broadly. A review of “functions, responsibilities, structure and relationships” within the health system resulted in large-scale re-organisation of the arrangements between the Department and its AHSs (NSW Department of Health 2011a: 2). The review led to the devolution of authority and accountability to operational agencies, with the Department becoming a tightly-focused Ministry “providing Westminster functions supporting the Minister and Government, regulatory functions, public health functions... and system manager functions in state-wide planning, purchasing and performance monitoring” (NSW Department of Health 2011a: 2).

This reduced HIV bureaucrats’ control over HIV funding to AHSs (which were at this time re-titled Local Health Districts) on the basis that LHDs should have operational

discretion in how funds were applied in the achievement of policy goals. As system manager, however, Ministry HIV bureaucrats were able to utilise newly-strengthened purchasing and performance monitoring instruments (NSW Ministry of Health 2013b). For non-government organisations, parallel reforms to transition funding from a grants-basis to a purchasing basis were announced (Puplick 2012). A government-appointed taskforce recommended that Whitlam-era arrangements recognising the expertise of non-government providers in defining the nature of the activities to be undertaken (Sawer 2002) be replaced, with bureaucrats now specifying the activity to be purchased and procuring it from 'the market'. While the reforms would test the cooperative arrangements between HIV bureaucrats and the HIV non-government sector, they provided another instrument through which the activity of providers could be more closely directed towards HIV policy goals. These governance changes and purchasing reforms are examples of contingent, cross-cutting policy reforms that intersect with sectarian policy domains such as HIV, and alter their trajectories in positive or adverse ways.

The election of the new NSW Government portended other changes as well, with advisors in the new Minister for Health's office having a greater interest in HIV than in prior years. One advisor was a gay man with long-standing interests in HIV policy, having formerly been a member of the boards of NSW HIV community organisations. In other jurisdictions, there were also political changes: a gay man advising the newly elected Queensland Government's Minister for Health, the Hon. Lawrence Springborg MP, was also interested in HIV policy. In Victoria, the Minister for Health, the Hon. David Davis MLC, became involved in arrangements for the hosting of the 2014 International AIDS Conference, anticipated to be the largest scientific conference ever hosted by Australia. Preparations commenced in 2011 and the impending scrutiny of the international community on Australian HIV policy generated sectoral introspection and hope for change. Federally, the Hon. Tanya Plibersek MP was elected Minister for Health in late 2011. As the Member for Sydney, her electorate included a large gay community constituency, of whom she had been a strong supporter.

These events closely followed Australia's co-chairing in June 2011 of the United Nations (UN) High-Level Meeting on HIV/AIDS. That meeting resulted in the General Assembly for the first time setting ambitious targets to reduce HIV incidence through

its *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS* (UN 2011). This was a major UN initiative and Australia was a signatory to the agreement. The Australian delegation was led by the Foreign Minister and included other Members of Parliament and HIV community sector participants (see Australia, Senate 2011: 4156). Australia's global leadership on HIV policy at the UN, together with growing coincident interest among Ministerial advisors and Ministers, and the awareness that Australia's HIV policy would be a focus of international attention at the forthcoming International AIDS Conference in Melbourne, all served to heighten attention on the conditions of HIV policy and on available solutions. Local activists were also increasingly calling for greater ambition in Australia's HIV policy settings, including the setting of targets and introduction of new technologies such as rapid HIV testing (Whittaker 2011a). Endogenous and exogenous conditions, it seemed, were ripening.

Before turning to the practices through which HIV policy change in NSW occurred, there remains the preceding question of *why* bureaucrats would act upon the opportunities afforded by these developing conditions, or even recognise these as opportunities. From my own experience of the period, NSW HIV bureaucrats acted because they had sufficient capacity to do so, it accorded with their underlying value orientation, offered the opportunity to strengthen their own power and authority, and because the alternative – to resist the momentum of the period – posed risks to their own standing. A bureaucratic consensus for ambitious new policy settings had evolved within the AIDS/Infectious Diseases Branch during the period of 2011 and 2012 as the new science and data emerged, but these ambitious settings were fundamentally compatible with the pre-existing goal orientation and practices of these bureaucrats in pursuing strategies to reduce HIV infections. The emerging data, science and technology of the period simply provided powerful new arguments and means to achieve these goals. The effective deployment of testing and treatment technologies, at scale, also required new actions to reduce barriers to access. These were not abstract opportunities, but ones that could be realised through bureaucratic influence on sectoral partners. The possibilities moreover, in being visible and in having the potential to drive down HIV infections, were exciting and erased any suggestion that the subsystem was operating at the limits of HIV prevention possibility. The option existed to not act, or to act in minimal ways, but this would have been inconsistent with both the past practices

and orientation of HIV bureaucrats and with the expectations of the NSW Government. A failure to act would have invited criticism and pressure from political and community actors, whereas acting upon the changing environment allowed HIV bureaucrats to entrench their standing and authority for HIV policy, foreclose the possibilities of political or more senior bureaucratic interference, and establish with new and sceptical political actors their relevance and credentials. The close interest of the Office of the Minister for Health entailed threat but also advantage, with HIV bureaucrats being emboldened by newfound permission to substantially enlarge and act upon their pre-existing vision. This permission strengthened, rather than initiated or altered, the bureaucratic efforts in this period and HIV bureaucrats recognised the changing environment as one in which their own ambitions for greater sectoral efforts and outcomes could be realised.

### **Bureaucratic practices and HIV policy change**

In this section I show that as conditions matured, NSW HIV bureaucrats utilised sites of HIV partnership to mobilise discussion toward the realisation of new policy opportunities. Emerging science and evidence was translated and calibrated to support its expression in policy and ‘real-world’ application to NSW HIV programs and services. Efforts were mobilised through shared planning and delivery as well as self-regulation by agencies in the public performance of their roles within the partnership. Performance requirements attached to funding were utilised by HIV bureaucrats to drive policy change.

#### ***The puzzling of the partnership***

As we have seen, the policy architecture necessary to grapple with the changing HIV environment was in place in NSW during 2011: the subsystem had embedded mechanisms for policy development; underpinning policy principles were stable and enduring; incremental policy adjustments were expressed through periodically released Strategies; a high degree of consensus and trust existed among subsystem partners; significant funding supported the delivery of programs and services; and goal-oriented HIV bureaucrats guided policy change. Underlying this, however, was concern about



the trajectory of declining political and public interest and attention on HIV, and the risk of reduced commitment and investment in HIV policy. Likewise there was concern among NSW bureaucrats about emerging HIV testing data, subsystem beliefs about the limits of prevention and the ‘supply-side environment’, with national regulatory and policy inertia leaving NSW without access to new testing technologies and with out-dated arrangements that inhibited access to testing and treatment services.

During this period, there was enormous routine policy activity. The close, collegial relationships between HIV bureaucrats and subsystem partners were neither inadvertent nor realised without effort. They were given effect through direct relationships, project reference groups, agency governance arrangements and the general mechanisms already described – the Ministerial Advisory Committee on HIV and STIs, its Health Promotion Sub-Committee and other forums that brought bureaucrats, clinicians, educators and researchers together. Typically, the work within these spaces included reviewing and determining health promotion responses to newly released behavioural or epidemiological data; conceiving of and overseeing projects to address emerging issues and problems; coordinating cross-agency efforts; and reviewing protocols and guidelines. HIV bureaucrats utilised these ongoing and *ad hoc* mechanisms to secure commitments and drive policy implementation by subsystem actors. These mechanisms were predicated on a mutual promise: for non-state actors, it was of access and influence to bureaucratic decision-makers; for bureaucrats, it was of influence and compliance, offering a vehicle for the promulgation of policy direction, collective puzzlement and problem-solving, surveillance of compliance and dissent, collaboration across organisational and disciplinary boundaries, and achieving self-regulation among subsystem actors. The delivery of policy occurred substantively through the weight of expectations set within these forums and commitments extracted. These were fluid and relational sites, established and managed with goal-seeking purposes, not administrative ‘make-work’ spaces.

As the new prevention science heralded by Cohen et al. (2011) unfolded, HIV bureaucrats mobilised the subsystem through this architecture, directing it towards debate about how the new evidence could be harnessed to drive a bolder, more ambitious HIV response. The CAS Health Promotion Sub-Committee, chaired by Professor Andrew Grulich, a medical epidemiologist and physician, discussed the

findings of the HPTN 052 trial – reported by Cohen et al. – in May 2011, two months before those findings appeared in the peer review literature. The Sub-Committee recognised their significance, writing to its parent Committee to appraise them. Over coming months, other governance forums, such as the state-wide network of LHD HIV program managers and the Metropolitan Gay Men’s HIV Prevention Interagency were mobilised, with the latter reconstituting itself to reflect the new “HIV Combination Prevention Environment” (MGM 2012: 1). The Terms of Reference of a working group established in November 2002 to plan a trial of HIV point-of-care testing were expanded by May 2012 to scale-up HIV testing more broadly. In November 2011, HIV bureaucrats appointed Professor Grulich to chair a Targets and Indicators Working Group to debate and advise on ambitious new targets for HIV testing and treatment.

NSW actors also sought to create national momentum for change. In October 2011, a respected activist, Bill Whittaker, used the platform of a national HIV conference to call on Australia’s governments to act on the UN *Political Declaration on HIV/AIDS* (Whittaker 2011a). In my role as the NSW representative to Australia’s inter-governmental HIV policy forum, the Blood-Borne Viruses and STIs Standing Committee (BBVSS), I committed at the Conference closing plenary to take the issues forward for national discussion and action.<sup>25</sup> By November 2011, BBVSS had agreed to brief all Australian Ministers for Health on the developments and commenced planning an update of the *National HIV Strategy*. A joint meeting of BBVSS and the Australian Government’s Ministerial Advisory Committee on Blood-Blood Viruses and STIs (MACBBVS) was convened in March 2012. Whittaker also briefed bureaucrats, political advisors and Ministers in other jurisdictions and pressed for change. While there was interest, national change would take a slower and more ponderous path than in NSW. Momentum from the March 2013 joint meeting of national committees foundered for want of capacity and urgency.<sup>26</sup> Whittaker’s advocacy included the

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<sup>25</sup> BBVSS reported to the inter-governmental Standing Committee on Health, attended by Australia’s Health Ministers, via the Australian Population Health Development Principal Committee and the Australian Health Ministers’ Advisory Council.

<sup>26</sup> Additional barriers included caution about the science and its application to the Australian setting, together with concern that any mid-term update of the *National HIV Strategy* may require simultaneous revision of related Strategies, such as for hepatitis C, due to pressure from advocates for those related diseases. The cautious posture of Australian Government bureaucrats and the concerns of advocates for wider disease areas are detailed in documents released under Freedom of

publication and occasional revision of a widely-circulated paper setting out his call to action (Whittaker 2011a; 2011b; 2012a; 2012b). The paper advocated for Australian commitment to the UN targets, set out the emerging prevention science evidence, further argued the case for change in areas of debate or resistance and, importantly, identified ambitious actions. These actions provided a foundation against which NSW bureaucrats could test and argue for policy options in sectoral forums. This was especially useful since, while a momentum for change emerged rapidly, support was not universal.

Some clinicians, in particular, were cautious about arguments for earlier initiation of HIV treatment, with debates on the optimal time to commence HIV treatment for individual clinical benefit not being fully resolved at the time.<sup>27</sup> The debate was sufficiently intense that the peak group representing HIV clinicians, the Australasian Society for HIV Medicine, would later release a communiqué to clarify and provide assurance to partners of clinicians' broad commitments to the policy directions that were established (2013). Likewise, the setting of ambitious, time-bound targets for HIV testing and treatment, the dispensing of injecting equipment and for reductions in HIV incidence was subject of intense debate. Some service providers feared that they would be sanctioned if they failed to achieve the targets. There were practical concerns about the sufficiency of funds to achieve the targets (for instance, in the purchasing of greater volumes of sterile injecting equipment) as well as questions about the evidence upon which the targets had been set. The proposed targets being derived from the UN Declaration, to which Australia was a signatory, nullified some of the debate since NSW could not feasibly propose a less ambitious posture, and the argument for the

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Information legislation. See, for instance FOI Request 033-1314, which provides briefings from bureaucrats to the Australian Government Minister for Health (available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/FOI%20Request%20033-1314>). For further discussion of considerations of the time, see the Minutes of MACBBVS, held 16 March 2012, the day following the joint meeting with BBVSS: FOI Request 105-1213 (available at [http://www.health.gov.au/internet/main/publishing.nsf/Content/foi-disc-log-2012-13/\\$File/FOI%20105-1213%20Document%20for%20release%202.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/foi-disc-log-2012-13/$File/FOI%20105-1213%20Document%20for%20release%202.pdf)).

<sup>27</sup> The debate about the optimal time to commence treatment was resolved with the publication of findings from the START (Strategic Timing of Antiretroviral Treatment) Study in August 2015 (The INSIGHT START Study Group 2015). Those findings showed conclusively that immediate HIV treatment is strongly beneficial to people with HIV.

targets was further made through advocacy from Whittaker and ACON, NSW's largest community HIV organisation (Price and Parkhill 2015).

I have observed in the presentation of this case a strong orientation among HIV policy actors to consensus-building within a relatively closed, stable subsystem. Consensus, in the sense intended here, should not be mistaken for complacent agreement. Rather, the emphasis is on *building*, through practices led by bureaucrats to genuinely solve puzzles, shape new understandings, and win concessions and commitments among actors responsible for the delivery of HIV policy. The consensus that emerged comprised rhetorical elements, with there being a shared, evolving understanding and general agreement about the expression of problems and framings, and also a 'structured disunity', with consensus acting as "a metaphor for a particularly robust network, one which allows various actors to act 'as if' they were all doing and thinking the same thing (that is, 'as if' there were unity)" (Halfon 2006: 784). Halfon's *network* concept of consensus is useful in considering the nature of agreement within the HIV partnership, especially during the period of emerging evidence and shifting interpretation. It emphasises the interpretive flexibility of actors within strong networks that share general agreements and the strategic deployment of consensus to achieve functional coherence that allows actors to 'get along' in their work (2006: 787-8). The achievement of an evolving HIV consensus required great effort and commitment among subsystem actors and a willingness to yield to higher-order purposes in areas of difference and in the face of the emerging collective wisdom of the HIV partnership, and more powerful actors, including bureaucrats. Science and data were key tools of this puzzlement and consensus-building.

### ***The uses and translation of science and data***

Australia has world-class HIV research institutes that inform policy and the two leading institutes are based at the University of NSW: the Centre for Social Research in Health, which focuses on behavioural and social research, and the Kirby Institute for Infection and Immunity in Society, which has strong programs in epidemiology and clinical

research.<sup>28</sup> While the centres have national and international research programs, NSW HIV bureaucrats worked closely with both, commissioning research that would inform local policy development and program delivery. The funding conditions of research required the establishment of reference groups that included representatives of community organisations and the publication of findings in reports for practitioners. Researchers, moreover, participated in the subsystem's governance mechanisms, routinely informing (and being informed by) policy discussions and debates.

The social, behavioural, epidemiological and clinical data generated through this research had been utilised by HIV bureaucrats to an unusual degree to understand problems, set priorities and influence practice. While this occurred routinely, it was also used periodically to critically examine and adjust policy settings. In 2007, for instance, NSW HIV bureaucrats convened a research 'Think Tank' to examine why HIV notifications were increasing in a number of Australian states and territories but stable in NSW. In addition to understanding the drivers of jurisdictional variation, the forum sought to identify "what has been different in the NSW epidemic and response that needs to be maintained and reinforced... [and] what more needs to be known or done to guard against future [HIV] increases" (NSW Department of Health 2007b: 2). The resultant Consensus Statement drew conclusions from research and other inputs, including funding data, to make recommendations to bureaucrats and practitioners (NSW Department of Health 2007b). The considerable data analysis undertaken by researchers in preparing for the forum, and the intellectual outputs of the forum, were the subject of a special issue of *Sexual Health* (Fairley et al. 2008b). Mindel and Kippax would later present the Think Tank as a case study in effective HIV partnership (2013: 354-5). While research forums are not in themselves unusual, this forum illustrated the depth and intensity of relationships and practices, with researchers undertaking original research utilising existing datasets or other rapid techniques to understand a problem presented to them by HIV bureaucrats. The Think Tank was a one-off forum, however the relationships between policy, research and practice that it illustrates typified those within the NSW HIV subsystem and had been carefully cultivated by HIV bureaucrats over a long period.

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<sup>28</sup> Both research centres have had recent name changes: the latter changing in 2011 from the National Centre in HIV Epidemiology and Clinical Research and the former changing in 2013 from the National Centre in HIV Social Research.

In the unfolding environment of 2011, the contributions of respected HIV researchers were essential to the possibilities of policy change. Professor Grulich, the epidemiologist appointed by NSW bureaucrats to lead the Targets and Indicators Working Group, was also appointed by them to head the Expert Technical Advisory Group on prevention targets for the proposed revisions to the *National HIV Strategy*. Appointing researchers to such positions strengthened the case for policy change by demonstrating change to be built upon credible foundations (see, for instance, the presentation of evidence at the joint BBVSS and MACBBVS forum – Grulich 2012). Equally, these contributions assisted in calibrating HIV policy settings. To inform HIV policy options, NSW HIV bureaucrats commissioned research on the acceptability to gay men of potential interventions (such as HIV testing at various frequencies) (Wilson et al. 2011). Mathematical modelling was also commissioned to “simulate the expected population incidence and prevalence of HIV in NSW according to [these] scenarios” (Wilson et al. 2011; Gray and Wilson 2012).

### ***Mobilisation through shared planning and delivery and self-regulation***

Implementing the intervention scenarios that had been tested and modelled by the research would require solutions to supply-side problems of inhibited access to HIV treatment and testing. As many of these solutions rested with the Australian Government and prospects for rapid change were low, NSW HIV bureaucrats implemented a series of local workarounds (see NSW Ministry of Health 2013c, 2014a, 2014b). These included the funding of a research trial to provide gay men at high risk of acquiring HIV with access to pre-exposure prophylaxis. HIV rapid tests were purchased centrally and provided to clinics across NSW to bring greater scale to this new technology and allow more patients to receive their results at the time of testing. A postal scheme delivering HIV medications to people’s homes or a retail chemist was introduced to make it easier and more convenient to commence and stay on treatment. Likewise, changes were made so that people with HIV could receive three-months of medication each time it was dispensed, up from one month, and charging arrangements for HIV medications were adjusted, reducing the cost to patients. While helpful, these workarounds could not achieve the scale of Australian Government solutions that

would be delivered largely through the Medicare Benefits Scheme and Pharmaceutical Benefits Scheme, and so were accompanied by intensive bi-lateral and inter-jurisdictional pressure and advocacy.

HIV bureaucrats also facilitated improvements in service design by NSW public clinics. NSW HIV testing operating procedures were reviewed to remove out-dated practices (such as requirements that patients return to the clinic in person for HIV results),<sup>29</sup> and achieve rapid-throughput and one-stop HIV testing. Clinical guidelines on the frequency of testing recommended for various populations were revised. HIV bureaucrats also allocated funding to establish community-based testing sites for gay men utilising peer educators alongside clinicians to provide greater convenience and reach those reluctant to attend clinics (ACON 2015a). As a side-effect of these changes, General Practitioners working in private practices that saw large numbers of gay men and people with HIV also improved their models of HIV testing and clinicians gradually lowered their thresholds for the initiation of HIV treatment.

Traditional public health controls were also enlarged based on the findings of the mathematical modelling and acceptability analyses (Wilson et al. 2011). These included enhanced contact tracing where the partners of a person diagnosed with HIV are contacted to recommend that they be tested for HIV; improved epidemiological surveillance; steps to avoid recently diagnosed patients being ‘lost’ from care; and follow-up of doctors to support their clinical management of HIV-positive patients (NSW Ministry of Health 2013d).

The reforms are remarkable both for their range and rapid introduction over the period from around 2011 through 2013. While federal/state health system arrangements, together with federal inertia, might be expected to foreclose possibilities, the availability of partnership mechanisms and the practices of bureaucracy in NSW allowed for substantive policy-directed program and service change. The rapid introduction of these reforms was carefully planned through partnership forums, with partners taking care to ensure their changes aligned with policy directions. Most service-level changes were driven locally, reflecting a self-regulation by agencies in

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<sup>29</sup> Under new arrangements, most patients could receive negative HIV results by phone or SMS.

their alignment of activity to policy. It would not be true, however, to imply that such self-regulation occurred independently of expressed policy intent or the spectre of peer or bureaucratic censure or coercion, such as funding adjustment.

### ***Funding and its conditions***

While NSW HIV policy is expressed in Strategies, the ability to give effect to its directions has historically rested in the authority of HIV bureaucrats to allocate and adjust funding to partners. From the early 1990s until 2011/12, HIV bureaucrats annually reviewed and approved AHS funding proposals. This provided a means of re-directing resources to areas of policy priority. While the responsibility for local planning rested with AHSs, guidelines issued by HIV bureaucrats required that funding plans reflect the priorities of NSW HIV policy (NSW Department of Health 2007a). Similar arrangements with non-government organisations provided for the triennial negotiation of Funding and Performance Agreements that specified objectives, strategies and performance indicators aligned with HIV policy, and for annual activity and financial reporting against those requirements (NSW Department of Health 2011b). While such processes allowed for the re-negotiation of priorities within existing funding, the de-funding of activities or organisations occurred on occasion, where those activities were no longer consistent with policy priorities.

At the wider level, regular reviews of HIV funding were undertaken. A Resource Distribution Formula established by HIV bureaucrats in 1990/91 and revised in 2004, 2006 and 2010 (Eckstein 2006; Green et al. 2010a, 2010b) determined the geographic distribution and the relative split of funds (for instance, by disease areas, and for prevention, Needle and Syringe Program, inpatient, outpatient, surveillance and pathology services). The formula was based on population needs and adjustments were used to re-distribute funding to better match policy (for instance, by increasing funding for prevention and limiting expenditure growth on clinical services). Likewise, in 2007, HIV bureaucrats reviewed state-wide services that provided infrastructure to the HIV program (such as the Workforce Development Program or specialised pathology services) or services to populations or clients (such as the AIDS Dementia and HIV Psychiatry Service and the Multicultural HIV Service). The implementation of the



Review saw 22 services reduced to 11 through a combination of service amalgamation or de-funding (Berino Projects 2008).

Changes to NSW health system governance arrangements in 2011 would potentially weaken the policy control of HIV bureaucrats, with greater autonomy being extended to operational agencies. The new funding arrangements worked optimally for purchasing hospital activities (for which the specification of activity volumes had been a longstanding discipline), however earlier work undertaken by HIV bureaucrats to improve data collection for Needle and Syringe Program activity and HIV ambulatory care meant the new arrangements could be leveraged in place of the old funding mechanisms. In 2012, HIV was one of the first areas of population health activity to be incorporated within the agreements (NSW Ministry of Health 2012b). These measures have been successively strengthened in annually renegotiated agreements (for instance, NSW Ministry of Health 2014c).

The introduction of purchasing and performance measures for non-hospital activity was a complex task: the instruments are not well-suited to activities that are lower-volume, have data lag times or are not well characterised as ‘widgets’ of activity. Nonetheless, reforms that in effect mainstreamed HIV funding and that might have seen funds diverted to meeting hospital overruns were leveraged in support of HIV policy. Indeed, the reforms allowed HIV bureaucrats to elevate the profile of HIV goals, bringing them directly to the attention of LHD Chief Executives through their inclusion in Service Agreements that formed part of the employment agreements of those Executives. The ambitious targets set in 2012 to increase HIV testing and treatment were incorporated within these Service Agreements as new measures against which LHD performance would be routinely measured.

Taken together, these incremental or radical funding adjustments ensured programs and services could be aligned with changing policy intent. Moreover, the regular practice of reviewing and adjusting funding had both symbolic and practical effect: the *potential* for HIV bureaucrats to review a provider’s funding resulted in providers self-regulating their activities in accordance with HIV policy, and forced re-alignment of funding was often not necessary.

## The nature and scale of policy change

Through the processes leading up to and beyond 2011 we observe a transformative shift in NSW HIV policy from a response characterised by behavioural prevention, to a framework of combination prevention, encompassing biomedical and behavioural strategies. This shift was most strikingly revealed in the *NSW HIV Strategy 2012-2015* (NSW Ministry of Health 2012). The hierarchy of goals in NSW HIV policy was expressly altered by the Strategy in its requirements and targets for:

- increased testing as a strategy to reduce the time between infection and diagnosis and provide a pathway to treatment
- increased treatment as a strategy to reduce HIV transmission and provide individual clinical benefit
- the introduction or enhancement of tools such as pre- and post-exposure prophylaxis and public health follow-up as strategies to prevent transmission, and
- maintenance of behavioural goals.

The ordering of the above goals is deliberate. It is notable that the behavioural goal is for the *maintenance* of existing rates of safe practice: this reflects a transformative recognition of the limits of existing approaches and the availability of alternative tools to achieve marginal gains in HIV prevention. While behavioural prevention places an onus on those most affected, notably gay men, the deployment and use of these new tools – increased access to testing, treatment and new technology – falls to both state and non-state actors. The altered hierarchy of goals also reflected a re-emergence of public health techniques, such as enhanced surveillance and contact tracing.

The shift in goals was anchored in the possibilities of new technologies that provided scope for significantly greater policy outcomes, expressed through ambitious time-limited targets. The *NSW HIV Strategy 2012-2015* was the first public policy in the world to commit to a timeframe for the elimination of HIV (by 2020). The alteration of policy goals was associated with heightened policy attention with a widened range of actors drawn into the policy process. For HIV bureaucrats, the changes saw the renewal

of HIV policy activity and heightened attention and salience after a period of steady decline.

The intense period of policy adjustment and service change from 2011 through 2013 has been sustained, with advocacy, further re-design and new technologies being progressively deployed (NSW Ministry of Health 2013c, 2014a, 2014b). Since the release of the Strategy, the scientific evidence and consensus for the enlarged approach and ambitious goals has strengthened considerably, dissipating the initial resistance of some actors and entrenching the policy settings of the Strategy as the new benchmark for future HIV policy. In April 2015, the NSW Ministry of Health reported striking year-on-year increases in HIV testing; stabilised, possibly declining, HIV notifications; reductions in number of people with undiagnosed HIV; and strong results in earlier and more effective HIV treatment (NSW Ministry of Health 2015). It remains too early to know if the ambitious targets of the Strategy can be realised, but its aspiration to ‘A New Era’ of policy attention and mobilisation, as denoted in its sub-title, can plainly be claimed.

## **Chapter Four – Discussion**

In this chapter, I return to the research question: can closer attention to bureaucrats and bureaucracy improve our understanding of policy? I also place limits on the claims made before concluding with an exploration of questions arising from the research.

We can distil from the case study the constructs of policy process theories: actors making choices, institutions, networks and subsystems, ideas and beliefs, policy context, and events (Cairney and Heikkila 2014: 364-5). These constructs can be utilised to analyse HIV policy change in the terms offered by policy process theories. An analysis utilising the Advocacy Coalition Framework would emphasise coalition interaction (that is, the dynamics of the HIV partnership), policy learning, challenges to policy core beliefs and changes in secondary beliefs about the limits of HIV prevention and the promise of new science and technologies. A Multiple Streams analysis would highlight the catalytic role of civil society (and possibly bureaucratic) entrepreneurs in coupling the changing politics, problems and policies streams during a period of ambiguity. Punctuated Equilibrium Theory would emphasise the transformative nature of changes wrought from 2011 following a period of stasis or incrementalism; shocks and exogenous pressures on HIV narratives within and beyond the subsystem would be highlighted.

These analyses would provide satisfying accounts of HIV policy change. The emphases of each account would flow from the assumptions underlying the theories and choices made in the selection of variables. As observed in the Introduction, theories guide us in selection of items for study but, by corollary, they variously emphasise and obscure points of enquiry. While there is no preclusion on reading into these theories a role for bureaucracy, there is no invitation to it and such a role is not explicitly theorised. We therefore lack an analytic frame through which to conceptualise the nature and impact of bureaucratic conditions, the practices of bureaucrats and the relationship of such conditions and practices to policy change.

Institutionalism can aid our theorising of bureaucracy in processes of policy change. In the discussion that follows, I utilise institutionalism as an analytic aid in three ways: to recognise the autonomy, capacity and interests of the state; to identify endogenous conditions and practices that may be sources of change; and to conceptualise the nature of bureaucratic practice within the policy process. I apply and extend institutionalist concepts, such as the tending of gaps between ideal and real forms of rules, to characterise the independent contribution of bureaucracy to HIV policy change in NSW.

### **State autonomy and HIV policy change**

Institutionalists' recognition of state structure and capacity offers a counter to the pluralism of policy process theory. Drawing on statist perspectives, I purposively centred bureaucracy in the presentation of the case study. Such a perspective recognises the state to be institutionally diverse, to be capable of withstanding exogenous pressures to a great degree, to have its own perspectives and interests, and to act (or omit to act) accordingly. A statist perspective does not preclude the state responding to exogenous pressure, but nor does it presuppose it. Further, it assumes the demands of non-state actors to be heavily determined by the structure and practices of the state.

In the case study we observe the diversity of the state: bureaucracy is one part of the state, responsive to and yet distinct within Executive Government, and HIV bureaucracy is distinctive within the wider health bureaucracy in which it is situated. The boundaries that distinguish HIV bureaucracy from the wider bureaucracy are clear in terms of organisational structures, but more difficult to discern in relation to interests, values and practices. These boundaries are presumably vulnerable to shifts over time as allegiances, conditions and personnel change. HIV policy is nested within a wider milieu and is variously consistent with and in tension with ambient policy. The case does not reflect passivity, but the exercise of considerable agency by HIV bureaucrats navigating a wider bureaucratic system as they activate the power of the state in the realisation of HIV policy goals.

The interests of HIV bureaucrats at the beginning of the period include the protection and safeguarding of gains made in HIV policy. As described in the special issue of the

Public Health Bulletin, they are “sustaining success in an evolving epidemic” (O’Donnell et al. 2010). As conditions ripen in 2011, bureaucratic goals become more ambitious and bureaucrats catalyse the changed conditions to transform HIV policy. The flow of personnel from the subsystem to the bureaucracy enlarges state capacity by providing it with a deeper understanding of the social contexts of HIV, value commitments and goal-orientation among its bureaucratic actors. This raises a question: what allows for these respective interests – of the state, HIV bureaucracy and the HIV subsystem – to be recognised as aligned? In NSW, the acceptance by the state that it shares interests with HIV actors has been unusually enduring and intense. However, the appearance of ‘acceptance’ warrants attention: while political and senior bureaucratic interest and commitment has intensified in NSW in the period since 2011, there are periods prior to this when HIV policy drift pointed to the state ‘not being opposed’ to sectoral interests, rather than unambiguously accepting that it shares those interests. State-structuralists’ contention that the demands of non-state actors are themselves shaped by the practices and structure of the state suggests that the state’s interests might include a HIV bureaucracy that aids the state’s control of the subsystem by mediating its demands. This raises questions about the potential for dissonance between the actual and expressed interests of non-state actors. Tension in these interests was evident, for example, in the advocacy of community organisations, such as ACON, for the ambitious HIV prevention targets set during 2011, despite those organisations being subject to performance requirements to achieve those targets.

### **Endogenous conditions and practices in HIV policy change**

Streeck and Thelen (2005) offer a schema for transformative change through incremental, potentially endogenous, processes. In their terms, HIV policy in the period to 2007 is subject to drift, with the tending of it by HIV bureaucrats being insufficient to arrest a trajectory of declining political and public attention and interest. There are also other signs of institutional pressure, including displacement at the margins of HIV policy from proximate policy arenas, such as hepatitis C and traditional public health models. These comprise alternative, alien policy possibilities and technologies, such as involuntary treatment. In the case, bureaucrats monitored and managed weaknesses at the boundaries of the policy domain through the re-investment of legacy HIV funding in

new arenas and through negotiated agreements to manage the potential for conflict between frontline police and Needle and Syringe Program workers. There is a very real sense apparent in HIV policy that its characteristic arrangements are only as safe as their effectiveness: if the policy approach is seen to fail, these alien alternatives may be invoked through (senior) bureaucratic or political interference. Recognised in this way, we observe HIV policy not to be in a steady state in the period to 2011 but, rather, subject to powerful undercurrents about which bureaucrats are acutely sensitised and actively, but not fully effectively, resisting.

Hall's (2005) schema for policy change allows us to more closely centre and observe the micro-work of bureaucratic actors operating in the midst of these institutional flows. By utilising Hall's schema, and drawing on Skocpol (1985), I highlighted the role of bureaucrats in changes to policy settings and instruments, identified various practices that can be conceptualised in this way and pointed to these as tools of bureaucratic practice involving routine adjustment in the tending of policy domains. Through this, we observe the purposeful use of funding instruments to direct subsystem efforts, the use of policy forums – a type of instrument – as sites of policy formulation, contestation and self-regulation, and the direction of data towards the achievement of policy goals. We also observe the central role of bureaucrats in the transformation of HIV policy when exogenous and endogenous conditions mature. In recognising this central role, and examining the contributions of bureaucrats to policy change, we avoid unhelpful dichotomies that presuppose policy to be made politically and implemented bureaucratically. There is little in the case study that would support such a distinction and much that suggests otherwise.

### **Conceptualising bureaucratic practice in HIV policy change**

Institutionalists conceptualise policy broadly, holding that it encompasses formal and informal elements and that adjudicative effort is required to shape and enforce it. They consider policies to be institutions insofar as they constitute rules for actors. These rules have legitimacy, require implementation and will be enforced if necessary.

Conceptualising policy in this way orients us to the role of bureaucracy in legitimating policy, particularly during periods of change or uncertainty.

While formal expressions of policy, such as the HIV Strategy, offer point-in-time windows to policy, an institutionalist perspective emphasises the fluid nature of policy. The *NSW HIV Strategy 2012-2015* was as much a consolidation and legitimisation of policy shifts that had happened as it was an expression of forthcoming reforms and ambitious goals. The myriad changes to HIV policy described in the case – such as the removal of barriers to testing and treatment and improvements in service design – both precede and follow the release of the Strategy in 2012. The Strategy offers a valuable aid to policy analysis, but can easily be over-recognised: policy is not so much made by the Strategy as expressed and legitimated by it. Even the aspirational expressions of the Strategy, such as its targets, have been previously determined through bureaucratic policy processes.

Notwithstanding this, to the extent that the Strategies are aspirational, they express an unbridled normativity. They do not limit options or codify minimum requirements, as regulatory policy would, but formally signal to actors the ends to which efforts are to be directed, with these reflecting *better* outcomes. It is this aspirational nature that underlies the goal-seeking of HIV bureaucracy. The bureaucratically-mediated sites of HIV partnership serve this goal-seeking through their puzzlement, planning and self-alignment of agency efforts with policy goals. During 2011, HIV bureaucrats gave privileged access to the agendas of these sites, with the presentation of new evidence and data fermenting discussions that were disruptive of existing policy and that laid the foundations for the pursuit of more ambitious HIV prevention goals.

While NSW HIV bureaucrats governed the mechanisms of partnership through which new policy was formulated and led the processes of policy formulation, we also saw in the period from 2011 an intensification of engagement by other actors – political, non-government, research and medical – in the specification of new settings and the shaping of the change narrative. The *experience* of policy transformation for subsystem actors, especially in responses to signals that progress is being made, has further reinforced commitments to change. Such processes not only lock in new policy commitments: the dense partnership networks and intense, cohesive process of change is visible beyond the subsystem's confines and has reinforced the perceived power of the HIV



partnership. This benefits the subsystem collectively by providing some measure of protection for the HIV bureaucracy and HIV policy from other state actors.<sup>30</sup>

In the case study, I have extended Streeck and Thelen's observation that policy can be regarded as an institution by proposing that bureaucracies are central sites of institutional enforcement and change, and by suggesting that bureaucratic practices constitute a tending of the gaps between the ideal and real patterns of institutions. In the case of HIV, the ideal pattern is expressed through aspirational targets and the array of changes that can be imagined to realise these ambitions. The real pattern of HIV policy exists in the status quo, in achievements that must be protected and in the willingness (or otherwise) of subsystem actors to mobilise towards new possibilities. These real patterns are signalled to the subsystem through behavioural, epidemiological and clinical data that capture the experiences and responses of affected communities to HIV. Streeck and Thelen point to the management of gaps between these ideal and real patterns of rules as important sources of policy change but do not suggest this to be a bureaucratic task. I would argue that this offers a powerful means of conceptualising the practices of bureaucracy observed in this case study. A great deal of bureaucratic activity – whether governing partnership forums, funding practices, or the creation of workarounds to regulatory problems – can be seen as a tending of these gaps, with this effecting policy change. In this case study, these practices were evident in the period prior to and beyond the exogenous changes represented by new science and political interest. In the period from 2007 but preceding these exogenous changes, the management of gaps contributes to, but is ultimately insufficient in, arresting HIV policy drift. However, the change in exogenous conditions, catalysed through bureaucratic practice in favourable bureaucratic conditions, allowed for the possibilities of transformative change from 2011.

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<sup>30</sup> Political advocacy, led by ACON, provides an example of a subsystem actor's recognition that their interests are served by protecting the subsystem as a whole: ACON's 2015 Electoral survey sought (and received) commitments from political parties on the continuance of HIV policy, as expressed through the *NSW HIV Strategy*, and the maintenance of investment in HIV (ACON 2015b). These advocacy efforts protect not only of ACON, but the HIV subsystem more broadly, including the HIV bureaucracy.

## **Observing bureaucracy can aid our understanding of public policy**

Taken together, this case points to endogenous conditions and practices as important sources of policy change. While changes in HIV science and technology opened up new policy possibilities, they did so in the presence of distinctive endogenous conditions, especially in the form of state capacity. This includes a recognised, legitimate, bureaucratic source of policymaking authority; governance of dense policy networks by bureaucrats with knowledge expertise (and access to such expertise); and adequate, allocable funding. Drawing on theories of institutional change, HIV bureaucrats can be recognised as being engaged in intensive practices that tended gaps between policy in its real and ideal forms. This tending occurred through myriad partnerships forums, the purposeful allocation and attachment of conditions to funding and the shared examination of evidence and interrogation of data. In NSW HIV policy, the ideal form of policy is bureaucratically-engineered and effect is given to it through directed puzzlement, mobilisation and strategy implementation.

The endogenous sources of change apparent in this study might in other accounts be obscured by the more evident environmental context, characterised as it is during 2011 by powerful advocacy and rapid developments in HIV prevention science and technology. If such factors explained policy change in NSW, we would expect to see change in other Australian jurisdictions where such pressures are also evident, yet we do not. Rather, we see transformative change in NSW and a later process of policy diffusion from NSW to other jurisdictions, including nationally<sup>31</sup>, suggesting that these exogenous forces may be contextual or contributory, rather than causal. While exogenous changes and shocks are relevant, the process of policy change in NSW during this period is catalysed through bureaucratic conditions and practices that appear to be independently important. The case study cautions us to consider endogenous contexts in cases of policy transformation, even where exogenous pressures might appear to explain change. These exogenous sources include the actions of entrepreneurs

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<sup>31</sup> Charles Shipan and Craig Volden (2008) identify various patterns of policy diffusion, including from larger to smaller jurisdictions. They distinguish diffusion based on learning from diffusion based on imitation. State capacity would seem a relevant consideration in explorations of these distinctions.

whose dissenting endeavours, while seemingly independent, may be encouraged and legitimated by bureaucratic actors seeking to ferment policy change.

The analysis of this case study suggests that greater attention to bureaucrats and bureaucracy *can* aid our understanding of public policy. I observe this in two respects. First, when a purposive gaze is placed upon bureaucrats and bureaucracy in NSW, a set of conditions and practices become visible that appear independently important in the processes of HIV policy change. Closely examining these conditions and practices provides insight to variables that, at least in this case, are material to policy change. Importantly however, they are also amenable to influence: with recognition of these variables comes the possibility that we might protect, even foster, these conditions and practices in pursuit of better public policy. Second, and in contrast, had we *not* centred the gaze of this case bureaucratically, it seems likely that other more visible drivers in this case of change would have been recognised and the role of bureaucracy, however determinative, obscured. This is consistent with pluralist accounts that emphasise civil society and political actors in the policy process. The potential to *disappear* bureaucracy in accounts of policy change seems somewhat peculiar, or at least highly exaggerated, with this category of policy actor. It is difficult to imagine the case being told without reference to changing HIV science or the roles of community actors, yet accounts of policy change in which bureaucracy is missing abound. The case suggests we would do well to look for bureaucracy in our explanations of policy change.

I also offer two observations about the relative contribution of endogenous and exogenous factors in this instance of policy change. First, the bureaucratic conditions and practices in NSW that appear independently important are present from 2007 but do not result in transformation from that time. Rather they catalyse from 2011 in the presence of exogenous developments, suggesting that endogenous drivers alone were insufficient to bring about policy transformation. In this case of change and despite positive endogenous conditions, policy transformation was animated only once exogenous changes allowed for that possibility.<sup>32</sup> Second, it seems possible that, in

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<sup>32</sup> This is not to imply that transformation through endogenous processes alone, as highlighted by the case studies presented by Streeck and Thelen (2005), is not possible, only that exogenous pressures contributed to transformation in this case study of HIV.

other circumstances, the reverse may also have occurred: that is, despite the overwhelming shifts in exogenous conditions during 2011, transformation may *not* have occurred had endogenous conditions and practices been insufficient. The absence of endogenous policy change in other jurisdictions, despite similar exogenous pressures, suggests an insufficiency in those places in the bureaucratic conditions and practices necessary for transformation. These conditions include sufficient bureaucratic capacity to independently respond to the changes in policy opportunity that presented in 2011.<sup>33</sup>

In this way, it seems reasonable to surmise the independent contribution of bureaucratic conditions and practices to policy change, the potential to miss this contribution if bureaucracy is not considered, the need in some instances for exogenous pressures to contribute to transformation, and the potential for such pressures to require favourable endogenous conditions if transformation is to occur.

### **Limitations and questions for further research**

Some important limits must be placed on the claims made in this discussion. Centring bureaucracy in the policy process, as I have in the case study, obscures other actors in ways that mirror the inattention to bureaucracy that I seek to redress. There is no intention to understate the roles or contributions of other actors, but merely to fix the gaze of the case study in such a way that exogenous events do not overwhelm the description or become presupposed to be sufficient explanations of change. The gaze presumes bureaucracy to have some role in the policy process and to invite the empirical questions: ‘in what ways’ and ‘to what extent’. Equally, there is no intention to present a caricature of bureaucratic goal-orientation or the practices of bureaucrats that implies these to be always noble or successful. The interests and practices of the state and its bureaucracies in HIV policy include aspects that are distasteful and regressive, such as legislation that criminalises HIV transmission and censoring practices in the bureaucratic ‘approval’ of HIV education campaigns. Likewise, the practices of bureaucracy – in HIV and elsewhere – are littered with initiatives that fail

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<sup>33</sup> We are reminded, in this way, that the pressures of newly emerging evidence, no matter how ‘astounding’, as the HPTN 052 study was described, are insufficient as sources of policy change. Indeed, a great deal of evidence fails to stimulate policy change.

to realise their intentions. I also make no claim to this case being representative of policy more broadly. All policy is idiosyncratic; the question being to what extent our observations reflect case particularities or more general phenomena. HIV is an example of mid-range policy where we would expect greater bureaucratic control than in higher profile, politicised domains. It is unclear whether similar conclusions would be drawn from studies of other policy domains.

The exploration of this case raises interesting questions, including some that would allow for the critical development of theory through further research. This would include empirically establishing the range and contribution of variables in studies of bureaucracy and policy change. Additionally, while in NSW the state has recognised that it shares interests with its HIV bureaucracy and the HIV subsystem, research to identify the conditions that sustain these circumstances could benefit HIV as well as wider policy domains.

## Conclusion

To study policy change, scholars must select from a seemingly unlimited number of variables. In this study I centred bureaucracy and asked whether doing so could improve our understanding of public policy. Bureaucracy is recognised by the policy process literature, but under-studied. Applications of policy process theories can variously present the state as an actorless ‘black box’ or, in attending to the state, can privilege political actors. Likewise, policy can be conceptualised in ways that over-assume its products and pronouncements at the expense of ideas, puzzlement, contestation and enforcement.

The fixed gaze of this study on bureaucracy has shown the state to be diverse and complex: not a black box but an ecosystem teeming with life. Within it: peril, rules, order (of sorts), change, constraint, contingency, decline and perhaps even occasional adventure (and misadventure). In this study, policy is not a fixed, limiting tool but a constantly tended process within formal and informal relationships in which bureaucrats are deeply embedded and determinative.

Within the HIV subsystem, ‘partnership’ is a valued principle and practice that is sometimes given almost mystical properties. Such mysticism could only be warranted if we believe the state’s acceptance of mutual interests with the HIV subsystem to be unique or non-reproducible. It seems implausible to claim HIV to be so truly exceptional, despite its clearly unusual features, and even were it to be so, it does not follow that it might not be a source of policy learning. If greater attention to bureaucracy in the policy process can offer a pathway to learning and better public policy, it would seem a topic about which we would do well to further puzzle.

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