The Constitution of AIDS in Australia:
Taking 'Government at a Distance' Seriously

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Australia's policy response to AIDS has frequently been held up as a model of global best practice. The few comparative analyses of national AIDS policies (Kirp and Bayer 1992; Mann and Tarantola 1996) portray the Australian approach as enlightened and innovative, and a recent evaluation of Australia's National HIV/AIDS Strategy (Feachem 1995) has found such indices as its low rate of HIV incidence exceptionally good. But there has been little attempt to interpret this perceived success.

A diagnosis of the conditions of possibility for government policy offers potential for a rich interpretation of this perceived success Drawing on Foucault's concept of governmentality, Nikolas Rose and Peter Miller argue that a liberal problematics of government is "dependent upon technologies for 'governing at a distance', seeking to create locales, entities and persons able to operate a regulated autonomy" (1992: 173). Government is a problematizing activity, elaborating programs around perceived difficulties and failures and making "the objects of government thinkable in such a way that their ills appear susceptible to diagnosis, prescription and cure by calculating and normalizing intervention" (1992: 183). The strategies, techniques and procedures through which programs are rendered operable are designated "technologies of government" (1992: 185) and elsewhere Rose (1995) examines the operation and effects of these technologies in the shaping of the human subject.

Rose and Miller raise questions not posed directly by more traditional literature on public policy. They provide a perspective for interpreting the ways in which government in Australia recognised AIDS as a problem for which it was responsible, and then applied a choice of available technologies to limit HIV transmission. In return the Australian response to AIDS offers an exceptionally sensitive application of the Rose and Miller approach, since the novelty of AIDS makes it possible to discern precisely the processes of problematisation, choice of technology and subjectification.

Problematising AIDS

Early perceptions of AIDS have been recounted not only by journalists and historians picking through the evidence of individual and institutional records and memories (Shilts 1987, Grmek 1990, Garrett 1994), but also in several papers which examine more broadly the discourses which shaped AIDS as a new issue. Altman (1984) produced an early set of insights in a paper on the homosexualisation, medicalisation and Americanisation of AIDS, while Plummer (1988), Treichler (1988) and Patton (1990) have examined the structuring of scientific, social and political perceptions.

Epidemiology had a central role in the initial recognition and definition of AIDS. Concerned with the distribution of disease within populations, epidemiologists have come to see themselves as cartographers, drawing boundaries around risk. But while epidemiologists use highly sophisticated statistical techniques in the manipulation of data, their categories of identity for specifying risk are untheorised and drawn from everyday cultural classifications. This is perhaps inevitable in the preliminary identification of an epidemiological problem, when symptoms are the only evidence available and specific "risk behaviours" and aetiological agents are unknown. But "risk groups" are readily conflated with "risk behaviours", particularly when the groups in question lie outside the pale of normality defined by the culture of the epidemiologists of a particular time and place.

Thus epidemiologists of the US Centers for Disease Control (CDC) in Atlanta, confronted in 1981 with evidence that exotic forms of cancer and pneumonia were appearing among young men whose only common feature was sexual activity with many male partners, adopted the category of "homosexual" as its initial "risk group". In doing so they embraced a category with a century of psychological, medical and legal authority behind it, as well as a decade of social mobilisation by gay men in the US in terms of their sexual identity. As AIDS was gradually recognised among people who did not fit the initial category, further ready-made risk groups were identified as "heroin abusers", "Haitians" and "hemophiliacs". Further research by CDC and others identified specific risk behaviours of body fluid exchange through sexual penetration, needle sharing and transfusion of blood and blood products, and these were confirmed once an aetiological agent (later named the Human Immunodeficiency Virus) was accorded recognition by scientific authority in the most respected peer-reviewed journals. Despite their lack of congruence with these risk behaviours, the designated "risk groups" remained intact, enshrined in epidemiological statistics and adopted in the design of public policy, social research and educational programs.

As cartographers, epidemiologists are analogous to others who must identify, define, demarcate and label populations in the process of rendering them amenable to intervention. They provide "the 'representation' of that which is to be governed" (Rose and Miller 1992: 185). In comparable fashion early colonial administrators, when confronted with populations which needed to be differentiated for purposes of incorporation, segregation, control and "development", defined "tribal" and "ethnic" groups within which to identify collaborative "chiefs" and around which to draw administrative boundaries. These categories take on a life of their own as they become socially and politically useful for those who are ascribed or who assume an ethnic identity, and the same can be said of the evolution of a homosexual group identity over the past century in response to the activities of government (Ballard 1987, 1992b).

AIDS would not have been identified as early as it was but for the appearance of rare opportunistic infections among young gay men in Los Angeles and New York; its contemporary appearance in Africa and Europe was sufficiently buried among other symptoms to remain unrecognised and would have raised different categories of risk. The attribution of diverse symptoms to a conception of immune disorder was made possible only by developments in immunology in the 1970s, and the relative strengths of the competing disciplines of immunology and virology determined the metaphors that continued to define AIDS as an immune disorder rather than "HIV disease" (Patton 1990: 58-62).

AIDS was perceived as a syndrome of rare diseases, with no clearly established methods of transmission and an assumption during the early years that it was fatal within months after transmission. This raised justifiable fears based in part on previous publicity given to toxic shock, Legionnaires' disease and the deadly viruses producing Ebola, Lassa and Marburg fevers. Yet identifying AIDS as a disease primarily affecting socially stigmatised groups meant that stigma was central to the construction of AIDS as a medical, social and policy issue (Treichler 1988). It could be argued that, without homophobia and the initial identification of AIDS as a fatal disease, it might have aroused little more public interest than another sexually transmitted disease, genital warts, which can produce cervical cancer. In addition, if AIDS had not been identified in Anglo-Saxon societies as a disease of gay men, a group already mobilised around a stigmatised identity, there is little likelihood that AIDS would have elicited a strong community response; it failed to do so in other societies.

The particularities of the time and place of recognition, together with the initial categorisation of risk of transmission, created conditions of possibility for the problematisation of AIDS.

These did not in themselves require a governmental response, as is evident from the absence of response by the US federal government and many others during the first years. The fact that the Australian Commonwealth government responded earlier than others suggests that there were further stages of problematisation.

A few Australian scientists and gay men followed the development of news in the United States about a new disease among gay men; the gay Sydney Star reported the first CDC notification in July 1981 within a week, long before Australian medical journals paid attention. But not until the first case of AIDS in Australia (diagnosed late in 1982) was announced in May 1983 was there substantial media and public interest, and this was amplified by an appeal from the Director of the Sydney Red Cross Blood Transfusion Service for gay men to refrain from donating blood. (Details of the Australian response to AIDS can be found in Ballard 1992a.)

Australia, like most of the English-speaking world, had gradually adopted the logic of the Wolfenden Report of 1956, reconstructing homosexuality and prostitution in terms of public proscription and private freedom; this was an early application of the liberal problematics of government (Hall 1980). Governments had withdrawn from the active policing of private consensual sex and were thus no longer responsible for its outcomes. As long as AIDS was seen as a problem arising primarily from homosexual activity, governments were not inclined to consider it their concern. However the possibility of transmission of AIDS through blood transfusion and blood products raised a particular concern for Australian governments. Geographical isolation had given rise to an exceptional measure of blood self-sufficiency, and the Commonwealth and state governments funded the collection and distribution of blood and blood products through the Australian Red Cross and the production of blood-clotting concentrates through the Commonwealth Serum Laboratories.

After an initial burst of activity in mid-1983, with the formation of AIDS Action Committees in the urban gay communities and the appointment of a working party of the National Health and Medical Research Council to plan AIDS surveillance and care, there was no serious concern focused on AIDS for a year. Despite a mounting number of AIDS cases and deaths among gay men, it was not until July 1984, with announcement of the first Australian case of transmission by blood transfusion of the newly identified retrovirus, that media and government attention was seriously aroused. Until then, it was assumed that Australia's self-sufficient system of voluntary blood donation would be safe from contamination.

Close links between Australia's medical scientists and the US centres which were developing the first tests for the virus made possible the detection of blood transmission and soon produced evidence of its wide spread among Sydney's gay men. In October 1984 it was discovered that the virus was present in the blood of one-third of those with haemophilia who had received Factor VIII concentrate, produced from the blood of large numbers of donors by the Commonwealth Serum Laboratories. Steps were quickly taken to exclude risk groups from blood donation and to apply heat treatment to kill the virus in Factor VIII (Ballard 1996).

What firmly established AIDS as a problem for government was an announcement by the Queensland Minister for Health on 16 November 1984, in the midst of a Commonwealth election campaign, that three babies had died after receiving contaminated blood from a gay donor. This traumatised the media and galvanised the Commonwealth Minister of Health, Neal Blewett. He called an emergency meeting of health ministers and advisers to standardise donor-exclusion procedures, fund the development of viral test kits and establish both a medical AIDS Task Force and a National Advisory Committee on AIDS. The latter, given responsibility for devising education programs, was broadly representative and included leaders of the Sydney and Melbourne AIDS Councils.

Elsewhere governments did not problematise AIDS in the same fashion since responsibility for blood safety was seldom clearly that of government, but more often diffused by commercial supply and importation. The nexus between Australian governments, the Australian Red Cross Blood Transfusion Services and the Commonwealth Serum Laboratories was unique. In addition, exceptionally close linkages with scientists in the United States meant that viral tests developed there were available almost immediately in Australia, though not elsewhere. Australian virology laboratories were the only group outside the US invited to participate in the evaluation of viral antibody test kits, enabling Australia by May 1985 to become the first country with a fully tested blood supply. In January 1985 its Factor VIII supply was the first to become fully heat-treated. Evidence of slower response by governments and suppliers of blood and Factor VIII raised major political scandals later in France, Canada and Japan.

While blood control was an issue in all Western countries by 1985, only in Australia did it serve to define AIDS as a problem both requiring and enabling political intervention. In Australia, as elsewhere, AIDS retained its identification with marginalised groups, but the political crisis created by blood contamination provided an opening in Australia for the incorporation of these groups into policy-making on AIDS. Other Western governments

acknowledged responsibility for AIDS and began seriously funding education programs only after an international AIDS conference in July 1986 provided consensus among scientists on the actuality of vaginal transmission and, hence, risk to the "general population".

Technologies of Government

If Australia gained advantage from its early recognition of AIDS as a problem for government, it also benefited from its choice of technology for intervention in behaviour. While medical science and government funding could resolve the problem of blood transmission, there was no comparable solution in the form of a vaccine to prevent transmission of the virus through sexual intercourse and shared needles. There was, however, a choice of strategies for preventing transmission.

As in most countries, a battery of direct public health controls was enshrined in Australian legislation dating from early in the century, based on experience with tuberculosis and sexually transmitted diseases. These involved surveillance, testing, notification, contact-tracing, treatment (when available) and quarantine. An alternative strategy of health promotion had been articulated since the 1960s, eventually promulgated by the World Health Organisation in the Ottawa Charter of 1986. Emphasising community-based education and self-regulation, this strategy fitted with the ideas of the community health and women's health movements in Australia and had gained substantial legitimacy within demedicalised health departments through the perceived success of anti-tobacco programs in the late 1970s. Health promotion was institutionalised in Blewett's restructuring of the Commonwealth Department of Health in late 1984, with the regrouping of public health activities in a Health Advancement Division and the appointment of a leading exponent of the anti-tobacco campaigns as Secretary of the Department.

These two public health strategies neatly encapsulate the distinction drawn by Michael Mann (1986) between "despotic" individualised direct control and the "infrastructural", regular, continuing and indirect controls consistent with liberal principles. In their discussion of technologies of government, Rose and Miller describe a similar shift in the 1970s in British health policy, from a "medico-administrative enclosure of health" to new forms of managerial rationality and health consumer autonomy, producing "a new 'neo-liberal' mode of government of health" (1992: 195). In coping with AIDS, Cuba has been the only country which attempted to establish a "despotic" regime of systematic quarantine, although Vietnam's initial response to its first cases of AIDS in 1993-94 was to launch a campaign

against the "Three Social Evils" of AIDS, drugs and prostitution through isolation in rehabilitation centres.

In Australia the allocation of AIDS to different branches within departments of health provides an index to initial differences in problematisation and associated technologies. In the Commonwealth department, an AIDS Co-ordinating Unit was established within the new Division of Health Promotion, and there was an exceptional measure of political initiative from the Minister's office for the first year. In Queensland, Tasmania and South Australia AIDS was assigned to offices concerned with sexually transmitted diseases and tended to be dealt with through the containment strategies applied to these. By contrast, AIDS was allocated in Western Australia and Victoria to health promotion branches with quite different results in the early years. In Victoria the director of health promotion considered that only gay men understood the possibilities of health education for gay men; over strong objections from medical specialists she hired two leaders of the Victorian AIDS Council to organise community education programs and she agreed to fund a Gay Men's Community Health Centre. This provided the Commonwealth government with a model for treating AIDS as a problem for health promotion.

The two contending approaches of containment and education became institutionalised during 1985-87 at the Commonwealth level in the two advisory committees, the medical AIDS Task Force, headed by the forceful Dean of the University of Melbourne Faculty of Medicine, David Penington, and the National Advisory Council (NACAIDS), with its strong community representation. Penington initially proposed the closure of gay bath-houses and argued for testing risk groups. NACAIDS, supported by Blewett's office and the Commonwealth department, consistently opted for community-based education in the absence of any available treatment. The challenge to community and health promotion posed by Penington's assertion of a medical rationality served to bind the AIDS Councils, NACAIDS and the Commonwealth Department together; the states, with the exception of Queensland, were willing to follow the logic of Commonwealth financial support.

There ensued a veiled conflict over the ownership of AIDS, with Penington and later the Australian Medical Association accusing Blewett of following a "gay agenda". Blewett's success in persuading the opposition parties to participate in a Parliamentary Liaison Group on AIDS, together with the absence in Australia of politically mobilised Christian fundamentalism, forestalled politicisation of the conflict. By 1989 the development of a broad range of technologies was articulated in the world's first National Strategy on HIV/AIDS, based on extensive community consultation, with an explicit commitment to the

principles of the Ottawa Charter and formal support from the Parliamentary opposition. Following on the comprehensive approach of the National Strategy, a Legal Working Party examined all fields of state law impinging on AIDS issues and recommended model laws consonant with the principles of health promotion.

AIDS and Citizenship

Rose and Miller argue that, in the liberal welfare state, "[p]ower is not so much a matter of imposing constraints upon citizens as of 'making up' citizens capable of bearing a kind of regulated freedom" (1992: 174). In exercising power, "[p]olitical forces have sought to utilise, instrumentalise and mobilize [sic] techniques and agents other than those of 'the State' in order to govern 'at a distance'" (1992: 181). Health promotion through community education provided a technology for precisely this kind of government at a distance, but community education required as a site for action a community whose representatives had potential legitimacy for (re)defining responsible citizenship within the community.

In the 1970s the US tradition of ethnic group mobilisation offered a model for the development of gay communities in the English-speaking world and beyond. In Sydney, echoing San Francisco, a gay ghetto developed, facilitating mobilisation and communication, and less concentrated communities appeared in the other capital cities. An informal national network grew up among a cohort of gay students who were active in the radical university politics of the mid-1970s; with organisational and political skills honed in labour unions, journalism and campaigns for the decriminalisation of homosexuality in each state, they mobilised the AIDS Action Committees of 1983-84, predecessors of the AIDS Councils. The gay media maintained detailed coverage of AIDS news from the US, providing education on risk well before government-funded health promotion began. Despite the marginalised status of homosexuality, no conceivable "risk group" was better placed to raise a community response and contribute to policy-making (see Altman 1994). By contrast, gay men in France, without legal sanctions against which to develop a politics of identity, failed for several years to organise a community response to AIDS.

The Victorian AIDS Council, invited by the State health department to help shape AIDS education, was well integrated with the Melbourne gay community and had developed substantial expertise on AIDS. It was the Victorian AIDS Council, drawing initially on programs developed by Gay Men's Health Crisis in New York, which articulated early in 1985 a concept of safe sex for gay men emphasising the use of condoms. In Sydney by

contrast, despite several initiatives within a much larger gay community, both community and government responses were diffused among a number of organisations, with limited collaboration until 1988. Only then did the AIDS Council of New South Wales and the new state AIDS Bureau begin to set the pace in AIDS program innovation.

Gay sexuality since the 1960s had proved exceptionally plastic, and the notion of safe sex, unencumbered by the insistence in the US on the narrower rationality of "safer sex" (as on "drug abuse"), was open to creative and inventive talents. Safe sex was a technique of the self, a form of ethical citizenship, which served several purposes. It was sex-positive at a time of maximum stigmatisation of gay men, whose self-image was vulnerable at the best of times. The Victorian AIDS Council produced the first educational poster, the erotic "You'll Never Forget the Feeling of Safe Sex", while a program of "Happy, Healthy and Gay" workshops were organised in Canberra; both were widely copied elsewhere. Safe sex reinforced the image of community, needed both for collective subjectivity and for legitimation of the Councils in the eyes of government. It also provided a credible alternative to Penington's proposal for testing of those at risk, an approach which was individualist rather than community-based and which was seen as having the potential to divide the community between seropositive and seronegative men. As an effective strategy of prevention, safe sex was later validated by epidemiological cohort studies (Donovan and Tindall 1989, Feachem 1995).

Further education and research programs grew up around the model of community safe-sex education developed by the AIDS Councils, encouraged and funded by the Commonwealth's AIDS Unit and gradually also by the state health departments (Parnell 1992). The participation of the AIDS Council of New South Wales in the design and implementation of the Social Aspects of the Prevention of AIDS (SAPA) research project at Macquarie University helped establish an innovative approach to theorised surveys with continuous feedback into community programs (Kippax et al 1993). The focus on the broad subjectivity and lived experience of gay men which typified safe sex community education was maintained in SAPA and succeeding research programs. This contrasted with the dominant individual rationalist mode of AIDS social research, comprising untheorised, normalising surveys of knowledge, attitudes, behaviour and practice -- a form of social epidemiology which could fuel only centralised, broadcast education programs.

Following on the perceived success of the AIDS Councils, the logic of community health promotion began to be applied to other groups. Funding of the Australian Prostitutes Collective in Sydney for condom education in 1986 and the establishment of needle

exchanges in drug-user-friendly settings in Sydney and Canberra in 1986-87 raised no publicity and none of the political protest that hindered such programs in the US. The discourses of safe sex and clean needles then became a focus for the mobilisation of networks as communities of identity among sex workers and drug users. After a substantial increase in AIDS program funding in 1987, governments began actively to promote the formation of state and national organisations of sex workers, injecting drug users and people living with HIV/AIDS. The education and support programs elaborated through these groups involved the promulgation of new forms of responsible citizenship. They also implied a measure of recognition by governments that sex workers and drug users, in many cases still subject to legal sanctions for their community-defining practices, had a capacity for citizenship.

Perhaps the most difficult test for government at a distance, challenging the entrenchment of neo-liberal as against despotic rationality, arose in relation to cases of "recalcitrant" individuals known to be HIV-infected and engaging in unsafe practices. The problematising of this issue arose in 1989 in the case of "Charlene", a drug-using sex worker in Sydney who was persuaded by The Australian and television's '60 Minutes' to admit to "unprotected sex" with clients. This raised a media and political furore and an expectation that public health law sanctions would be imposed, as they had been earlier in the isolation of a Queensland Aboriginal woman. Instead, the New South Wales government's AIDS Bureau and the Australian Prostitutes Collective negotiated a community-based response in the form of pastoral case management. A sequence of graded stages of community-based re-education and official warnings, culminating in a court hearing before the imposition of sanctions, was articulated and legislated, and variations on this scheme were adopted in other states (Gibson 1996).

Government at a distance served quite instrumental purposes in relation to AIDS education. It allowed governments to claim credit for all successes and to maintain a safe distance from any programs that aroused public or political dissent; on the rare occasions that explicit posters and pamphlets from AIDS Councils raised protest, governments could disclaim responsibility (see Bartos 1996). This fitted with a longstanding Australian tradition in the use of statutory authorities and royal commissions, autonomous from government, to undertake work which might create political risks. By contrast, in programs under direct government control, public AIDS education by television and publication provoked occasional political embarrassment, while AIDS education in schools moved slowly and the provision of condoms and needles in prisons not at all.

A further contrast is instructive about the extent to which programs for marginalised groups required a particular kind of government. A federation of state haemophilia organisations had been formed prior to the arrival of AIDS, similar to other groups organised for purposes of sharing information on treatment in close interaction with medical specialists. Once a large proportion of Australians who had received anti-haemophilia Factor VIII were found to have been infected, the Commonwealth government gave substantial funding to the federation for education and counselling and its national co-ordinator served as an active member of NACAIDS. The focus of government support here was not intervention in behaviour to prevent transmission, but an extension of existing practices and politics concerning the funding of care and treatment, and later concerning compensation for infection through medical treatment. Government at a distance in this case was not so much a matter of making up citizens with new kinds of responsibility, as incorporating claimants into structures with well established precedents.

As issues beyond those of health promotion made the politics of AIDS and of Councils more complex, a discordant plurality of technologies of government appeared. The politics of treatment for people with HIV and AIDS, ostensibly analogous to those of people with haemophilia, became heavily contested after the first few years. Since Australia from 1984 maintained a system of universal community-rated health insurance, medical care was not an issue. However, as new AIDS treatments became available in the US and the radical AIDS Coalition to Unleash Power (ACT-UP) mobilised there around access to care and treatment, an Australian ACT-UP in 1990 demanded rapid approval of new drugs. Its campaign was successful in provoking the reform of approval procedures, but its deployment of a politics of emotion presaged tensions which arose during the 1990s between the AIDS Councils, organised primarily for prevention and care and dependent on government funding, and organisations of people living with AIDS, concerned with the politics of specific claims (Ariss 1993).

Normalising AIDS

The National HIV/AIDS Strategy of 1989, with its substantial increase in funding for a period of three years, proved to be the high point of government commitment to AIDS as a special problem. Shortly after its promulgation, Blewett, who had served as Minister of Health for a record seven years, moved to another portfolio and his key advisers, architects of the Strategy, departed. Their successors had other priorities.

The two years of extensive consultation preceding the National Strategy indicated that the creative phase of AIDS policy was being consolidated. There was further articulation of refinements in health promotion and community care, as well as their application to increasingly diversified and peripheral populations without community sites, e.g., men who have sex with men at public "beats" and casual weekend injecting drug users. But the establishment of conventional project funding schemes under the Strategy meant an increasing bureaucratisation of the burgeoning Commonwealth and state AIDS bureaux and of the well funded Councils. Access to treatment of AIDS with new drugs was not even mentioned in the National Strategy, but quickly emerged as an issue requiring integration into conventional routines.

Two other considerations favoured a managerial approach to AIDS: the failure of a predicted heterosexual epidemic to materialise and the increasing strength of public choice ideology within governments. Recognition of the risk of vaginal transmission of the virus had engendered a new problematisation of AIDS in 1986 and a flurry of government-designed health promotion campaigns ensued. In Australia the first televised public education message, the Grim Reaper of April 1987, provoked a substantial rise in government funding for AIDS programs and opened the door for sexual education in schools. All responsible citizens were expected to become publicly knowledgeable, articulate and ethical about condoms and oral, if not anal, sex. By 1990, however, the very limited increase in recognised instances of vaginal transmission created a sense that a heterosexual epidemic would not occur in the West. The continuity of statistics showing that over 80% of Australians with HIV were gay or bisexual men was taken both as evidence that the epidemic had been "contained" and that there had been complicity between governments and gay communities to dilute the image of AIDS and "responsibility" for it.

The managerial language of accountability and evaluation which pervaded Australian governments in the early 1990s implied a homogeneous approach to all programs. In the case of AIDS, while there was recognition of its wider impact on standards of health promotion, infection control and community care, there was also increased demand for "mainstreaming" AIDS programs into broader strategies covering all infectious diseases or all "public health". One of the first actions of Blewett's successor as minister was to instigate an inquiry into the rationalisation of funding for all peak health and welfare organisations comparable to the Australian Federation of AIDS Organisations.

In the design of the Second National Strategy during 1992-93, perfunctory consultation led to competition for control between the Commonwealth department and the AIDS Councils,

in conjunction with the advisory Australian National Council on AIDS, though all parties were ostensibly committed to "partnership". The negotiated result was essentially a continuation of the first Strategy, but it was accompanied by the Commonwealth department's determination to assert stronger control over future AIDS policy.

Planning towards a Third National Strategy during 1995-96 was conducted on more obviously managerial lines. A prominent international consultant was engaged and committed to evaluation in cost-benefit terms that would satisfy the guardians of the Commonwealth budget. Although his report (Feachem 1995) was fulsome in its praise of Australian achievement as measured by transmission rates, and advocated more precisely targeted programs, its narrow conception foreclosed consideration of the broader preconditions of that achievement and of continued innovation.

The advent of a federal Coalition government in early 1996, displacing 13 years of Labor rule, hastened the normalising or reproblematising of AIDS. Devolution of programs to the states, already under way, meant a diminution of Commonwealth involvement, and this was ensured by a reorganisation and sharp reduction of Commonwealth department staff: the expertise of the large and well respected AIDS and Communicable Diseases Branch was dispersed as disease-specific programs were dissolved within a generic Public Health Division. This was not so much a process of "mainstreaming" as a reconceptualisation of public health management. AIDS was the only section of the health budget that was not subjected to substantial pruning, though the Third National Strategy and the new Australian National Council on AIDS and Related Diseases were broadened to cover sexually transmitted diseases and the new concern with Hepatitis C. The relationship between the Commonwealth department and the Australian Federation of AIDS Organisations matured from a variety of controls and co-ordinating mechanisms to the more fashionable contracting out of planning and programs.

Conclusion

AIDS had been too traumatic an experience for Australian public policy and public consciousness to allow for full absorption under the generic rubric of public health. Although AIDS took up only a small percentage of the budget for health services, these services had in many cases been reshaped in terms of the experience with AIDS. This was most notable in the extent to which community participation had become the norm "in all aspects of program delivery, from prevention and support through to treatment and research"

(Hamilton 1988: 11). New health issues are problematised and dealt with through technologies reconceived in the context of the AIDS experience.

As primary bearers of the "truth" of AIDS in Australia, the gay communities were also changed, refined and redefined by the experience of AIDS (Dowsett 1996). Safe sex citizenship, a set of ethical norms shared with other communities, was only a part of the burden of AIDS, but it refocused the creative and assertive thrust of the gay social movement of the 1970s. The expertise of the AIDS Councils and other community-based groups, central to the perceived success of Australian management of AIDS, contributed to a new legitimacy for the communities themselves in Australian public discourse.

Government at a distance made good sense for a progressive government confronting a difficult new issue. It allowed the groups most concerned with the issue to deal with it, while constraining expenditure on medical solutions and avoiding public arguments conducted in moral terms. As a form of rationality, government at a distance had the advantage of flexibility, incorporating the rationalities of other groups and encouraging innovation. It reflected classic justifications of liberalism without adopting the limitations of individualism.

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