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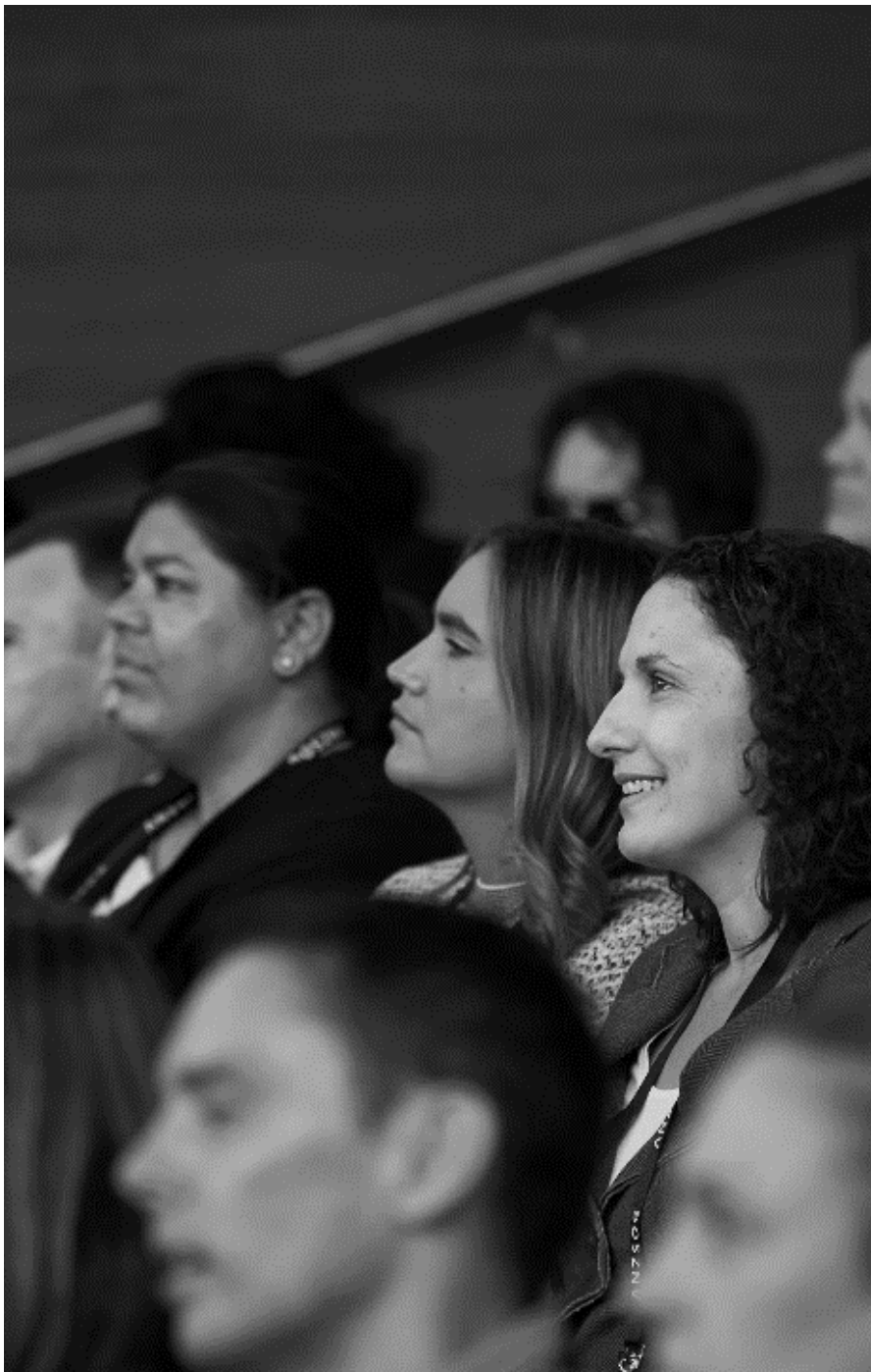
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AUSTRALIA: HOW HAS TECHNICAL AND EXPERT POLICY ADVICE BEEN USED FOR RAPID RESPONSE POLICY DECISION-MAKING?



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Introduction

In 2020, the coronavirus SARS-COV-2, and the ensuing disease, COVID-19, have shaken the world in way that is unprecedented in living memory (Weible 2020). Until July 2020, Australia's response was considered to one of the most successful in the world, given an 'A' rating by a report commission for the UN (Thwaites 2020). Despite the arrival of a second wave in July, principally in the state of Victoria, Australia is still considered to be broadly successful in its response. As of 21 September 2020, Australia has 26,912 positive cases and 851 deaths (Source: Johns Hopkins Coronavirus Resource Center), placing it globally in the lowest quartile for deaths per million population (source: ourworldindata.org).

Australia has pursued a 'suppression strategy' (as opposed to New Zealand's 'elimination strategy' (Bromfield and McConnell, 2020 forthcoming). The key elements of Australia's response been based on (i) travel bans and quarantine (ii) enforced lockdowns and restrictions on home and public gathering (iii) tracking/testing/tracing and (iv) multiple stimuli and support packages, including for employers, employees and those on welfare benefits. The strategic narrative of policy makers has been based on 'listening to the experts' and 'following the science', and a refusal to distance government from scientific advice.

But is this unity between 'government' and 'the science' the case? The goal of this paper is to examine whether experts and expertise have played a dominant role in shaping Australia's largely successful response. As will be argued, even although the relations between 'the science' and 'policy' are looser than we might think, this very fact actually assists the *functioning* of the crisis response and goes some way to explaining Australia's relative success story.

COVID-19 as a 'Crisis' for Australia

COVID-19 is a crisis by any conceptualisation of the term. One definition which captures the system-shattering aspects of crisis is that of 't Hart (1993: 39) who argues that crisis is a 'a breakdown of familiar symbolic frameworks legitimating the pre-existing socio-political order'. While Australia is well-used to natural disasters such as bushfires and hurricanes (for example, the 2003 Canberra Bushfires, 2009 Black Saturday bushfires in Victoria and the 2010-11 Queensland Floods) and some recently have been particularly extreme (the Black Summer bushfires of 2019-2020 affecting every state and territory in Australia) there has been nothing quite like the challenges of COVID-19.

COVID-19 exemplifies, three widely held characteristic of crisis: threats, uncertainty and time constraints (Rosenthal et al. 2001). Examining each provides initial clues to help us unpack the benefits, and limits, or crisis expertise in a pandemic.

First, for Australia's population of circa 25 million, there are high levels of threat around a highly transmittable virus that can produce infections in all corners of society, from homes and workplaces to restaurants, sporting venues and public institutions. Not only can it lead to respiratory illness and death, but it also has multi-system health effects, impacting chronically and fatally on major organs such as the heart, liver, kidneys and brain.

Second, there are high levels of uncertainty around the behaviours of the virus and its relationship to the disease itself. Data and evidence are gathered in real time, and there remain uncertainties over precise transmission rates, impact on specific age groups (young people aged under-18 were initially thought to be largely immune) and why some people can be infected by the virus but not have any symptoms or adverse effects at all. For example, two prominent Australian epidemiologists held differing views on the number of hidden cases not reflected in official figures because of asymptomatic transmission (one arguing there were double, and the other arguing that the hidden cases were almost ten times greater than confirmed cases) (Scott and Clark, 2020).

Third, there is a high degree of urgency or a ‘ticking clock’ as crisis research often portrays it. One study of the Australian state of Victoria estimated that in the absence of specific intervention measures, that there would have been between 9,000-37,000 cases in a one-month period (Saul et al. 2020: 1).

Yet COVID-19 is more than simply a health ‘crisis’. It is a ‘transboundary’ crisis where threats can incubate beyond the jurisdictional boundaries of any particular government or political system (Boin and Lodge 2016).

Transboundary crises produce cascading affects across nation state and policy sectors, often interacting in complex and unpredictable ways. Hence, COVID in Australia is not just a health crisis, it is also an economic crisis. The Commonwealth’s Treasury’s own economic outlook indicated a decline in GDP of 7 per cent in the June quarter (the highest on record) with the costs of economic support in 2018-2020 as \$289 billion i.e. equivalent to roughly 14.6 per cent of GDP in 2019-2020 (Treasury, 2020: 26 and 43). One overview of the social costs of COVID-19 in Australia reveals data indicating high levels of stress and fears around job (in)security, physical health, mental health and domestic violence (O’Sullivan et al. 2020: 140). It is also a political crisis, the ‘normal’ rhythms and agendas of policy makers are shattered, while putting them in the spotlight in a way that would have been unimaginable – even for a nation where political leaders are never far from dealing with ‘natural’ disasters.

Broadly, the crisis management challenges for the Australian government are typical of the long-running and dual challenges of managing major crisis (Drennan et al. 2015). They must manage and seek to eliminate, isolate or at least mitigate the threat (in this case the virus and its community transmission), as well as managing the political and social turmoil (public fears, anxieties, agitation and collective desire to restore some kind of ‘normality’). The sheer complexity of interwoven threats, provides some clue to the complex challenges of managing COVID-19.

An ‘Idealised’ Version of Evidence-Based Policy Making

Australia is one of many liberal democracies that, over the past three decades or so, have turned to the language of ‘evidence-based policy making’ (Sanderson 2002; Cairney 2016). At its core, it is based on the premise that policies should be based on the best research and evidence available. In many respects, it looks initially as though such idealised conditions apply – or at least are articulated as being the principles upon which crisis decisions are made in Australia. For example, Deputy Chief Medical Officer Dr Nick Coatsworth stated: ‘...it’s critically important we get the best advice from the best people in Australia. And that’s replicated in all of the government committees that advise the Department of Health and advise our ministers and our Prime Minister’ (Australian Government Department of Health, 2020).

Distilled into its key elements, an idealised approach to evidence-based policy makes the following assumptions

1. There is a single, coherent body of expertise and evidence around an issue or issues.
2. Governmental administrative and political processes act as ‘filters’, creating the conditions under which the most relevant and thorough research and expertise can come to the attention of decision makers.
3. Evidence is interpreted by decision makers in a neutral fashion
4. Decisions themselves are based around expert assumptions and recommendations. Policy makers and political leaders are mere ciphers for experts.

In principle, evidence based-policy making has both policy and political advantages i.e. ‘better’ policy making. In terms of COVID-19, the assumption is that experts can draw on many years and decades of research and experience. This can include virologists studying viruses and their structures, transmission mechanism and capacities to mutate, as well as epidemiologists who study patterns of disease and projections under different scenarios. A major study of COVID-related trust in Australia, found that scientists and experts had the highest level of trust (77%) as a source of information, compared to various other media outlets (Evans and Grattan 2020: 14).

On the other hand, such a ‘science-based’ approach has a political benefit of seeming to ‘depoliticise’ controversial topics, especially in the face of worrying systemic trends such as declining trust in political parties, and scepticism about the intentions of political leaders (Parkhurst 2017). All things being equal, measures such as mask wearing, social distancing and closure of workplaces and large gatherings, are likely to have a higher degree of legitimacy and compliance, if citizens feel such measures are based on ‘evidence’, rather than ‘politics’.

Australia in Practice: Evidence, Complexity and Politics

We can take each of the four idealised conditions around expertise and evidence in Australia and demonstrate that realities fall short of idealised goals and language. In part this is explained by unrealistic assumptions around evidence-based policy making, but compounded by the fragmented governance of Australia and its federal system.

There is no single, coherent body of expertise and evidence around COVID-19 in Australia

There are several key reasons. They are connected but can be separated here for the purposes of clarity.

Incomplete understanding of a pandemic happening in real time: Pandemic viruses do not arrive and provide us with ‘complete’ information. All infectious diseases are different and even although Australia has had experience of potential pandemics before (1917 ‘Spanish’ flu, 2009 H1N1), and there are groups of virologist, epidemiologists and others, with extensive expertise, the precise characteristics of COVID are gathered incrementally and selectively in ‘real time’. This includes critical information such as infection risks in different population cohorts (e.g. based on age, race, gender), reproduction numbers (R_0), and the success likelihood and risks of measures such as mask wearing and social distancing. The challenges are helped (but also compounded) because much of the expertise and lessons lie in other parts of Australia (beyond inner circles of crisis committees) and indeed the world – including universities, research institutions, hospitals and public sector departments and agencies. Australia, in common with all countries, is faced with eradicating a virus and disease that, in practical terms, provides limited, provisional and context-specific understanding of their characteristics and behaviour.

Multiple areas of expertise and evidence: COVID is a crisis of multiple sectors and so the range of expertise, especially when we include possible response measures are huge. In terms of COVID in Australia, the range of experts and some examples of expertise includes but is not limited to:

- Medicine and public health: virus behaviour and health impacts, infection control in hospitals and aged care, immunity, vaccinations
- Economics: modelling public debt, reductions in consumer demand, fiscal stimulus packages
- Law: enforceability of quarantine and travel bans, legal liability for withholding ventilator treatment, Commonwealth/state jurisdictional issues around border control
- Policing; management of protests, enforcement issues and public gatherings
- Infrastructure and supply chains: maintaining transport logistics, energy and water supplies, core food supply chains
- Social psychology and behaviour: mental health, behavioural messaging around masks and social distancing

One implication is that experts do not ‘speak with one voice’, even within single disciplines. Dr Mohamed Patel (2020), Honorary Professor in Applied Epidemiology at the Australian National University states that:

I have worked for 40 years in outbreak control. I led responses to large outbreaks in the Northern Territory, worked in WHO teams responding to outbreaks of SARS in south-east Asia, influenza in Hunan, China and cholera in South Sudan. I have also helped establish training programs focused on outbreak preparedness and response in

countries including China, India and Vietnam. If I've learnt one thing, it's that disagreement among health experts is the rule rather than the exception. The disagreement may be stronger when the stakes are high and the facts of the disease are uncertain.

Australia's federal system means that there are multiple domains of experts and expertise: Australia's modern federal system, embedded in the Constitution in 1901, codifies the national/commonwealth level responsibility for broad area of national concern such as defence, currency and immigration. What is now six states (plus two self-governing territories) are left with powers over areas such as transport, hospitals and schools. In reality, there are concurrent powers, powers partly separated and shared via Commonwealth funding but state responsibility for service delivery e.g. public hospitals and primary care.

Each of these nine jurisdictions in total (led by the Commonwealth government), has their own separate elections and administrative arrangements. The Commonwealth response to COVID-19 is based partly on prior five contingency plans (including the 2017 Australian Government Crisis Management Framework and the 2019 the Australian Health Management Plan for Pandemic Influenza (2019), as well several additions and adaptations in response to COVID-19 (such as the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19 and The National Partnership on COVID-19 Response).

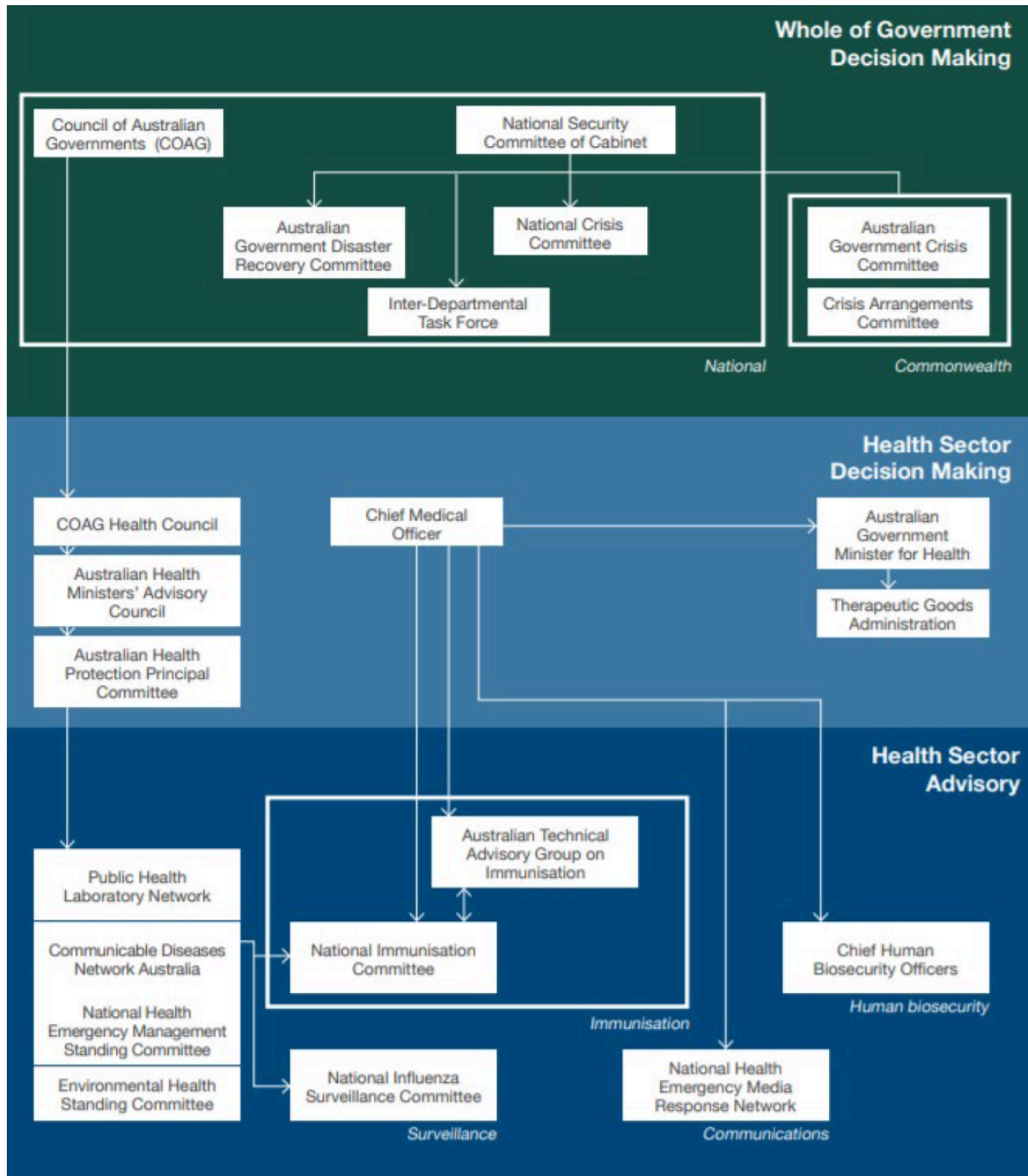
The distribution of COVID-19 response measures among the various forms of government overlaps at times in complex ways. Nevertheless, some of the main responsibilities translate as follows:

Commonwealth: International travel restrictions, international quarantine rules, Jobkeeper support, fiscal stimuli, welfare benefits, childcare funding.

States: hospital admissions and treatments, testing and contact tracing, policing of gatherings, declaration of emergency powers, internal border controls between states, curfews, lockdown measures, school closures, mask wearing.

Australia's response to COVID-19 is based on a decade-old commitment to a 'whole of government' crisis response i.e. an integrated response, working across departmental committees and boundaries (Carayannopoulos 2018). Some degree and form of expert advice operates in every forum. Diagram 1 below depicts Australia's whole-of-government approach to a pandemic and is the foundation of the COVID-19 response.

Diagram 1: Australia's Whole-of-Government Health Sector Decision Making in a Pandemic



Each state and territory also has its own crisis decision-making plans and decision-making coordination structures, which – depending on the specific threat – draws on the expertise of officials (and sometimes beyond the public sector) in realms such as medicine, public health, psychiatry, transport, policing and critical infrastructure. The key point is that experts and expertise are scattered across multiple jurisdictions in the Australian system. This is not necessarily a bad thing, especially because in a large and geographically diverse country such as Australia, it can allow for some aspects of the response, to be tailored to 'local' circumstances. Regardless, it does indicate a further reason why, there is no single expert group or single domain of expertise around COVID in Australia.

Government crisis processes do not act strictly as a filter to discern the ‘best’ experts and evidence

Australia’s crisis decision-making certainly draws on considerable expertise and it goes some way to including experts and evidence in decision-making processes, but we should not mistake such processes as a means for identifying the ‘best’. There are several reasons.

Overload: One might dispute what constitutes an ‘expert’ but even a broad-brush approach indicates that experts reside in multiple fields such as the public sector, private sector, non-governmental organisations, universities, independent search institutions, think tanks and charities. There is no policy sector in Australia that is untouched by COVID, whether it is economic regeneration, arts, transport, or mental health. Yet those included in crisis decision-making processes tend to already have strong connections to government, as part of ‘epistemic communities’ whose expertise is already valued. David Thodey, for example, is Deputy Chair of the COVID-19 Commission (Advisory Board), and Chair of the CSIRO, Australia’s national scientific research agency, while having previously chaired a major review in 2018-19 of the Australian Public Service. There is nothing ‘wrong’ with such narrowly-drawn processes. The point is simply to demonstrate that governments’ filter for expertise is not to identify and draw on ‘the best’ in a normative sense. The argument made by Cairney (2020) in his study of COVID-19 experts in the UK applies equally to Australia, where ministers saying they are following the science, they mean *their own* scientists – not ‘science’ or experts. In general, overload ‘at the top’ is a well-recognised pathology of crisis decision making (‘t Hart et al. 1993). By drawing on a limited range of experts, Australia is using a standard coping mechanism of crisis leadership.

Agenda Priorities: Beyond issues of overload, no governments are the same. All have their instincts and values which can help shape how they respond to crisis. The Australian Commonwealth Government, a ‘conservative’ government led by the Australia Liberal Party in coalition with the National Party (it’s long-standing coalition partner for almost a century), was focused very much on jobs, infrastructure investment and economic growth (Simms 2020). It is unsurprising therefore, that a key feature of its response was via the creation of a national COVID-19 Commission (Advisory Board). Its membership broadly reflected the ideology and links of the Liberal-National Coalition, with the Commission, chaired by Neville Power, senior business leaders in the mining, resources, and tourism sectors, with other members holding senior positions and expertise in areas such in supply chains, telecommunications, science research and agriculture.

COVID evidence is not interpreted in a neutral fashion

A long-running criticism of the rhetoric of evidence-based policy making is that it is impossible for governments to adopt a neutral approach when presented with research evidence and the recommendations of experts (Cairney 2016). While there are as yet no publicly available records of debates in Australia in any of the expert committees, commissions or forums, we can discern some of the key ‘evidence’ issues they would have dealt with. At the very least, there are two types of issues that they would need to address – each undermining the argument that government can interpret expert views in a neutral way.

Need to reconcile competing evidence: One example of differing experts view is in the state of Victoria, where a second wave has led to Stage Four measures in Melbourne. The key issue has become – when should the Stage 4 measures be removed and scaled back to Stage Three or even Stage Two restrictions. Leading health experts and epidemiologist have differing views, from an ‘elimination’ strategy and a target of zero daily infections, to a two-tier approach, with an easing of restrictions in the general population and tighter restrictions in complex settings and higher risk settings such as health and aged care (Fowler 2020).

Need to ‘fill-in’ evidence shortfalls, grey areas and ambiguities: Research evidence and advice is often partial, qualified and provisional. Australia’s crisis decision makers need to interpret and ‘fill in the blanks’, making judgement on what evidence shortfalls and lack of clarity are important, and what are not important in the grander

scheme of things. In the example of ‘hidden cases’ of community transmission, political leaders need to judge how significant such gaps in our understanding actually are when forming views (and policies).

Crisis decisions are not based solely on ‘the evidence’

The Commonwealth government in Australia has stated repeatedly that its difficult decisions are based on ‘experts’ and ‘evidence’. The default position of keeping schools open, for example, was based on the recommendation of the Australian Health Protection Principal Committee, comprised of chief health officers from all the main jurisdictions in Australia. Notwithstanding the points made in the previous sections, there are several reasons what it is better to conceive of crisis policy making in Australia as being *informed* by evidence (where research/expertise is one factor which influences COVID-19 decision-making), *rather than based directly* on evidence (where the decisions are simply a direct translation of research into policy). Decisions can certainly be ‘informed’ by evidence, or ‘evidence enough’ (Lancaster et al. 2020). Here, evidence is one factor that informs decisions. Two factors help our understanding.

COVID decision-making requires difficult choices and trade-offs: There is no ideal way to resolve a crisis. Crisis management, especially in the stressful context of high levels of threat, deep uncertainties and with time at a premium, involves instincts, judgement and a preparedness to take decisions that may satisfy some interests and alienate (and even damage others). Premier Daniel Andrews, has been at pains in his daily briefings to emphasise how he understands that Stage 3 and Stage 4 measures in Victoria, are painful for many business and employers who are already struggling financially. Indeed, many of the issues around COVID-19 require judgements around what might happen if particular measures are pursued. Implementation of many COVID-19 issues relies heavily on government encouraging responsible behaviours (such as the wearing of masks, and maintaining 1.5m social distancing). Citizen behaviours are notoriously difficult to model. More generally, modelling work undertaken by epidemiologists are projections, contingent on the stability of a number of possible contexts, rather than predictions.

Scientific expertise on COVID-19 is only one form of expertise used to inform decision making. As Australian Professor and ex- public servant Brian Head (2008) argues in his analysis of the ‘three lenses of evidence-based policy making’, much of the debate around the role of experts in decision making, assumes (erroneously) that expertise resides only the field of science. In the case of COVID-19, this would revolve medicine, virology and epidemiology and even behavioural science. Yet as Head argues, public decision-makers are also informed by experts and expertise and political and administration/ bureaucracy. Science and health experts do not have a monopoly on what constitutes ‘expertise’. Politically, therefore, crisis decision making around COVID-19 in Australia, draws on expertise (such as political advisors and polling expertise) on what any particular response measure might mean for party political support, citizen’s trust in government, and key industry lobby groups (such as construction and farming). Assessing the political risks of policy initiatives is a routine issue in Australia (Althaus 2008). In term of administration/bureaucracy, expert advice is needed on issues such as – is policy initiative capable of being implemented? it is affordable? and is the right technology available?

Overall, therefore, while we might associate COVID-19 expertise to converge around ‘the science’, the reality is that decisions are informed by three broad domains of experts and expertise: ‘science’, politics and administration. There is a gap between the rhetoric of the COVID response being based on the best available science, and the realities which are much more complex.

How does the Australian response to COVID-19 function when it is based only loosely on the advice of experts?

Although what constitutes crisis management success can be contestable and depends particularly on the issue of success for whom? (McConnell 2020), how do we explain Australia’s broadly successful response that is based only loosely on expert advice. Three issues worthy of particular consideration.

Broad consensus on the 'problem' of COVID-19 and the broad direction of intervention measures. Despite some differences of opinions, government and experts across the spectrum in Australia are in broad agreement that COVID-19 represents a serious systemic threat to the health, life and livelihoods of Australian citizens, the fabric of social life, as well as to the broader economy and all the stakeholders and interest affected, from small businesses and farmers to schoolchildren and individuals with mental health difficulties. In other times we might take such consensus for granted, but in some areas of the world the virus has been dismissed as a hoax (particularly the USA and Brazil where such narratives are promulgated by political leaders). Some fringe citizen activists in Australian society, particularly in the Victorian city of Melbourne have promulgated such theories, but they are not part of mainstream governmental thinking or the experts surrounding them.

Broad agreement on the key foundations of the response: i.e. social distancing, restrictions on public gatherings, sporting events and various welfare and employer/employee measure to support those affected. While there is certainly some disagreement (in the realms of experts and politicians) about the scale, timing and cost of what is needed, Australian experts remain in broad agreement. Again, in other times we might take such broad agreement for granted, but experiences in other countries indicate that different approaches do happen. For example, Australia did not go down the route of Sweden, where there is a tradition of allowing public health experts to lead the response, and in this case the adoption of a strategy based on allowing citizens to take substantial personal responsibility for their COVID-related behaviours (Kamerlin and Kasson 2020).

COVID-19 data/cases have not reached the point where they substantially undermine governments' broad approach. While there are certainly disputes and disagreement, the broad narrative of government(s) in Australia, are/is broadly in line with the results/outcomes achieved. While second/third waves and further spikes are possible, especially until an effective vaccine is available, the government's evidence-informed approach has proved sustainable. One reason for such sustainability, which is studied in the field of narratives and drama surround crisis management ('t Hart 1993, Boin et al. 2017), is government use of symbols and metaphors to manage public fears, anxieties and collective stress. In Australia this is manifested in language such as 'flattening the curve', and 'summoning the spirit of the ANZACs (soldiers from Australia and New Zealand who fought in the First World War). The sustainability of government crisis narratives often depend on simple linguistic symbols and persuasion, rather persuasion based on 'hard facts'.

Such sustainability has also been possible because of a relatively high level of citizen trust in political leaders (while recognising some countervailing disconcertion). A study by Evans et al (2020) found that trust in Australian government (77 per cent) and indeed key public institutions generally, had increased significantly during COVID-19, and was considerably higher than the UK, US and Italy. A broad belief that Australian Commonwealth government politicians are mostly trust worthy and following 'the science', acts to alleviate public concerns – even if the decision-making process are much more complex.

Pragmatism: To date, the Australian response is broadly successful. In essence, this is precisely because it is pragmatic and informed by a range of experts and expertise, rather than despite it. Evidence and experts are multiple, complex, contested and not 'complete' in themselves. Pragmatic crisis decision-making drawing on experts from across the sciences, political and administrative arenas, has been a broadly effective way for Australia authorities to manage COVID-19.

Conclusion

Evidence-based policy making is almost a contradiction in terms, because it assumes a linear relationship between 'what experts say' and 'what politicians do'. Both sides of the coin (expertise and policy) are diverse, complex and multi-faceted. Australia's response, as with many other countries, has been informed by 'some' experts, 'some' of the time and to 'some degree', without being determined by it. Australia has managed to be relatively successful in

doing so and has not gone down the routes that some others have followed- such as the US where conspiracy theories and 'COVID is a hoax' have permeated significant portions of society and elements of the political class.

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