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Appendix C
Governing by looking back: learning from successes and failures

An ANZSOG research paper for the Australian Public Service Review Panel

March 2019

Jo Luetjens and Paul 't Hart

Australia & New Zealand School Of Government

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Successful Public Governance program
Utrecht University School of Governance
The Netherlands

ANZOG Expert Panel

This paper was prepared with the advice of an expert panel comprising:

- Chancellor Professor Tom Calma AO, University of Canberra
- Dr Nicholas Gruen, CEO, Lateral Economics
- Ms Robyn Kruk AO
- Professor Allan McConnell, Associate Dean Research, Faculty of Arts and Social Sciences, The University of Sydney
- Professor Patricia Rogers, Director, Evidence and Evaluation Hub, The Australia and New Zealand School of Government
- Chancellor Professor Peter Shergold AC, Western Sydney University
- Professor Helen Sullivan, Director Crawford School of Public Policy, Australian National University
- Mr David Tune AO PSM.

Our thanks for the useful contributions made by the panel members.

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EXECUTIVE SUMMARY

Governing by looking back examines how governments investigate and learn in a more ad-hoc fashion, from parts of their past that already have become labelled as a 'success' or a 'failure' in professional, public and political arenas. The imperative in learning from a problematic past ('failure') is to avoid its repetition, and to examine carefully whether a failure is due to implementation problems or inherent in an erroneous theory of change that underpins the design of the policy. Conversely, the rationale for looking back at successes is to learn positive lessons about designs and practices that can be emulated, reinforced and transplanted, whilst not ignoring the role played by incidental highly conducive circumstances which are impossible to replicate.

The main argument of the paper is that there is a structural imbalance in how the political system and the APS are tuned to detect and attend to government 'failures' (intensely so, and mostly in terms of accountability and blame) as opposed to 'successes' (much more sporadically, and when it occurs mostly in the form of unreflective desires to 'copy' and 'roll out'). This imbalance manifests itself both at the 'supply side' (the provision of performance information and the operation of accountability mechanisms) and at the 'reception side' (APS attitudes and practices in anticipating and responding to such feedback).

The first section of the paper conceptualizes 'success' and 'failure' in public policy and describes the distinctive opportunities and challenges that each presents for institutional learning. Inevitably reputational and political considerations, power relations and ingrained organizational cultures and routines shape the ways in which public agencies interrogate their pasts and those of other agencies at home and abroad as well as their appetite for and styles of learning from this engagement with past practices.

In the second section we focus specifically on the feedback systems in and around the APS, and how they construe, diagnose and draw lessons from successes and failures. Reviewing both regular and ad-hoc forms of review – for example, royal commissions, senate inquiries, commissioned reviews – we call attention to the structural imbalance that exists between 'success-finding' and 'failure-finding' practices, as well as practices that are driven with an accountability focus as opposed to an institutional learning focus. Here, we find the deck is stacked towards episodic practices which tend focus on failure and treat it in terms of accountability and (risk of) blame. We consider the implications that this has for building and sustaining institutional learning cultures.

The final section offers a range of strategies, gleaned both from promising practices at home and abroad, to strengthen the APS's capacity to learn from its own successes and failures as well as those of others. On the supply side, there is a need to strengthen mechanisms and practices of 'success finding' (e.g. the use of 'positive evaluation' methodologies, awards and competitions). On the reception side the APS needs to institutionalise and safeguard learning-enhancing values of openness, curiosity, risk absorption, self-reflection and experimentation – going self-consciously against the Zeitgeist of failure finding, blame avoidance, reputation management and thus predominantly defensive responses to negative feedback. The final pages of the paper offer a smorgasbord of strategies for doing so, gleaned from reviews and research both at home and abroad

INTRODUCTION

A professional public service system has institutional learning capacity: embedded systems and routines for reviewing its own past performance as well as those of other systems and jurisdictions so as to improve its current and future performance.[1] This requires the will and resources to:

- continuously self-monitor and internally discuss past practices;
- generate and process multiple feedback streams from external sources;
- compare performances across time, contexts, sectors and jurisdictions;
- maintain a culture in which it is considered safe and valuable to expose errors and engage in critical self-examination;
- engage not just in technical-operational ('single loop') improvements of the status quo but also in deeper reflective and adaptive ('double loop') lesson-drawing that is prepared to question key tenets of the status quo; to transform lessons into practices;
- muster the patience and persistence to sustain these efforts over time even as the focus of public and political attention has already shifted away from the original agenda.

This paper is 'twinned' with Matthew Gray and J Rob Bray's examination of the institutionalisation of evaluation within the APS. The current paper examines how governments investigate and learn in a more ad-hoc fashion, from parts of their past that already have become labelled as a 'success' or a 'failure' in professional, public or political arenas. Clearly, the institutional imperative in learning from a problematic past ('failure') is to avoid its repetition, and to examine carefully whether a failure is due to implementation problems or inherent in an erroneous theory of change that underpins the design of the policy. Conversely, the rationale for looking back at successes is to learn positive lessons about designs and practices that can be emulated, reinforced and transplanted, whilst not ignoring the role played by 'luck' (highly conducive circumstances which are however hard if not impossible to replicate).

In this paper we look at both ends of the continuum. We consult the international literature on government successes and failures, policy learning and policy transfer. We also glean insights from recent Australian experiences with major reviews, inquiries and other forms of 'looking back' at instances of success and failure. We conclude by offering observations about this dimension of the APS's institutional learning capacity and raise questions about how it might be improved.

[1] We gratefully acknowledge the feedback provided by members of our review panel, consisting of Tom Calma, Nicholas Gruen, Robyn Kruk, Allan McConnell, Patricia Rogers, Peter Shergold, Helen Sullivan and David Tune, as well as ANZSOG's liaison to the Review, Subho Banerjee.

The *main argument* of the paper is that *there is a structural imbalance in how the political system and the APS are tuned to detect and attend to government 'failures' (a lot, and mostly in terms of accountability and blame) as opposed to 'successes' (hardly, but when it occurs mostly in terms of desires to copy and 'roll out')*. This imbalance manifests itself both at the 'supply side' (the provision of performance information and the operation of accountability mechanisms) and at the 'reception side' (APS attitudes and practices in anticipating and responding to such feedback). On the supply side, there is a need to strengthen mechanisms and practices of 'success finding' (e.g. the use of 'positive evaluation' methodologies, awards and competitions). On the reception side the APS needs to institutionalise and safeguard learning-enhancing values of openness, curiosity, risk absorption, self-reflection and experimentation – going self-consciously against the Zeitgeist of blame avoidance, reputation management and thus predominantly defensive responses to negative feedback. The paper offers a smorgasbord of strategies for doing so, gleaned from reviews and research both at home and abroad.

HOW GOVERNMENTS PROCESS THEIR PASTS

Major failures and successes at first sight appear to be prime candidates for institutional learning. There are several reasons why this should be so. They are – at least for some time – on the radar and on the agenda. They are better studied, scrutinised and debated than less conspicuous endeavours. Successes provide policymakers with strategic opportunities to champion consolidation, extension and adoption elsewhere of valuable policies and practices (McConnell, 2010; Rutter et al, 2012) Failures can trigger reputational incentives to take effective action to avoid their recurrence (Maor and Sulitzeanu-Kenan, 2015). The larger and the longer high-profile successes and failures loom in the public and political imagination, the more likely that they become condensed into set narratives of policy success and failure that become enshrined in institutional memory and can be retrieved as historical analogies when seemingly similar circumstances or policy scenarios present themselves (Brändström et al, 2004; Axelrod and Forster, 2017).

Empirical research on learning in public policy indicates that it is easy to overstate its scope and potential. In spite of the work of professional monitoring and evaluation to produce rigorous policy-relevant knowledge and balanced inferences, the degree to which this work gets taken up is often limited (Dunlop, 2009) or takes the form of bargaining about competition for scarce resources rather than learning reflexively (Dunlop and Radaelli, 2016). The inherently competitive and contestable nature of budgetary and policy design processes provides policy makers with strong imperatives to demonstrate that the programs and initiatives for which they bear responsibility 'work' and thus should be continued and expanded. Grace et al. (2017), for example, note the pressure on evaluators to demonstrate progress in the development of mental health policy strategies. This has the potential to incentivise the pursuit of 'quick wins' over attempts to tackle 'intractable' issues, perhaps exacerbated by the fact that this program sat in the PM's portfolio, resulting in 'a dilution and reduction in the depth of evaluations concerning the achievement of service delivery reform objectives.' Stewart and Jarvie (2015) echo this concern in their study of Indigenous policy trials, noting that the strong bureaucratic focus on achieving results quickly acted as a clear impediment to learning.

Political considerations, power relations and institutional routines shape the scope and the impact of performance feedback and policy learning. This is particularly evident when it comes to learning from parts of the past that are somehow problematic, but it is equally true in relation to how governments identify and process successes. Failure-finding occurs mainly through media scrutiny, political oppositions, complaints procedures and the court system. In contrast, mechanisms for success-finding are much less well developed and reside mainly in professional bodies – e.g. through rankings, ratings and awards competitions. In that sense, the deck is stacked: not just the public and the media but even the public service itself are collectively predisposed to notice government's failures more than its successes. It is not surprising therefore, that even long-time observers of public administration fall prey to despair or even cynicism about political dysfunction and bureaucratic incompetence (Schuck, 2014; Savoie, 2015).

It is important to keep realising that this is a biased view (Roberts, 2018). A more dispassionate, even-handed, evidence-driven, systemic and long-term look at the quality of government in countries like Australia suggest that its net contribution to societal prosperity, safety, and well-being has been overwhelmingly positive (Goderis, 2015; Pinker, 2018). 'Doing better, feeling worse' is the perennial paradox of democratic governments. They demonstrably do well on many fronts most of the time, but their successes are taken for granted or simply go unnoticed as a result of the skewed ways in which their performance is typically looked at, talked about and interpreted (Douglas et al, 2019).

Government 'successes' and 'failures' are not straightforward occurrences. Rather, they are judgemental labels that are being applied to certain government policies, programs, projects, decisions and reforms (Bovens et al, 2001). These labelling processes are informed by the monitorial and evaluative work of professional bodies and think tanks (think of the OECD's rankings or the PISA scores), government regulators, auditors and evaluators (i.e. ANAO, Ombudsman, ACCC, Productivity Commission), and ad-hoc reviews (inquiries, royal commissions), but only up to a point. Ultimately the reputations of programs, agencies and office-holders are shaped in ongoing professional, public and political debates (Kay and Boxall, 2015). Once they have been embraced by a dominant coalition, 'success' and 'failure' frames act as a prism through which public policymakers are required to take stock of and interpret their past and present activities (Van Assche et al, 2011). At the same time, they also articulate what policymakers might learn from. They affect the reputations of the people and organisations involved in them and as such can have significant political and institutional consequences (Maor and Wæraas, 2015). Labelling a particular instance or episode as an outright failure entails a sharp form of negative feedback, a repudiation of a now compromised past. It sets in motion institutional rituals in which account-giving is demanded, blame will be apportioned, and learning must be shown take to place so as to avoid repetition (Boin et al, 2008, 2016). This raises the question whether and how governments can and should learn from their own 'failures' and 'successes'.

Patterns of failure in US government

Renowned US political scientist and Brookings fellow Paul Light studied 41 cases of public policy that were covered as 'failures' in the Pew Research Center's nonpartisan 'News Interest Index' in the period between 2001 and 2014. Digging into what caused these failures, Light (2014: 11), observes that 'government' [authors' note: when Light uses this term, he actually refers to the executive branch within the US separation of powers system] can fail for many reasons, including some that are well beyond its control. Poorly designed policies come from Congress and the president, for example, and may be impossible to implement regardless of bureaucratic commitment. Moreover, the public service cannot always do more with less, compensate for poor leadership, and manage the confusion created by duplication and overlap on Capitol Hill.' He then goes on to identify five common causes evident in his set of cases:

1. *Policy:* the executive might not have been given the policy, or any policy at all, by the legislature needed to solve the problem at hand; or the policy might have been either too difficult to deliver or delegated to a vulnerable or historically unreliable organization.
2. *Resources*: the public service might not have had enough funding, staff, or the "collateral capacity" such as information technology, oversight systems, or technical experience to deliver consistent policy impact.
3. *Structure*: the public service might have been unable to move information up and down its over-layered chain of command, select and supervise its contractors, or resolve the confusion associated with duplication and overlap.
4. *Leadership:* Government's top political appointees [note: in their 'spoils system'] might have been unqualified to lead; could have made poor decisions before, during, and after the failures appeared; or might have taken their posts after long delays created by the presidential appointments process.
5. *Culture:* the executive branch might have created confusing missions that could not be communicated and embraced, were easily undermined by rank corruption and unethical conduct, or were beyond careful monitoring through performance measurement and management.

In the event of high-profile incidents, disasters and alleged government blunders there are strong pressures to construct authoritative accounts of the 'who, what, when and how' of the policies and organisations under scrutiny (Boin et al, 2008, 2009; Perche, 2011; O'Donovan, 2017). During and following such inquiries there tends to be a flurry of activity in the initial aftermath as ministers and agencies must demonstrate that they are willing to heed the recommendations prescribed. For that impulse to translate into robust institutional learning, however, a clear vision or strategy is needed. This needs to be carefully, forcefully, and continually articulated so that it is understood by

those whose behaviour it intends to change (Pettigrew et al, 1992; Dunlop, 2017). Strategic direction by politicians may influence learning processes positively, *if* they commit to structural solutions and encourage the institutionalisation of organisational lessons, (Dekker and Hansén, 2004).

Yet even with such a strategy in place and the political commitment to see it through, drawing general lessons from in-depth scrutiny of a single case is tricky. A major and contentious case has high signal value, but unless some form of broader comparative and contextual analysis takes place, the extent to which its conclusions and therefore its recommendations can be confidently applied more broadly is limited. Also, the sheer number and scope of the recommendations produced by such inquiries presents a challenge to the public service's institutional learning capacity. Diligently working one's way through a long list of inquiry recommendations is a poor form of institutional learning. It taxes the public service's resources as well as its capacity to ensure that the flurry of disparate changes big and small add up to a coherent whole across portfolios and over time. Moreover, as Eburn and Dovers (2015) note, 'faithfully implementing all the recommendations from the last inquiry may prevent *that* event occurring again, but the next fire or flood will never be quite the same.' Research suggests that vivid historical analogies can become so dominant that the system unwittingly gears itself up to fight the last war – *only* the last war, and only a particular version of it (Khong, 1992; Brändström et al, 2004; Blandford and Sagan, 2016).

The public mood and the political dynamics of crisis inquiries can further complicate the learning process. When negative events become widely reported in the media, go viral on social media and are fought over in parliament, the public takes notice. Who to believe, what to think, who to hold accountable, and what must be done in the way of redress and to prevent repetition: it is all up in the air. The dramas of public inquiries that ensue may further feed the sense of shock, puzzlement, concern, indignation, outrage that segments of the public feel as they struggle to make sense of it all. This public sensemaking is at once a major function of crisis inquiries and a political battleground for stakeholders who have a lot riding on its findings and recommendations. In this volatile setting, crisis inquiries may evolve into rituals of mourning, redemption and reassurance that end up reaffirming the status quo; but they are equally if not more likely to become theatres of fault-finding, blame assignment and calls for 'root and branch' overhauls of current systems ('t Hart, 1993; Donaghue, 2001; Boin et al, 2008; Hood, 2010; Stark, 2018).

Crisis inquiries, in other words, are part and parcel of broader 'framing contests' in which the futures of ministers, officials, agencies and policy are at stake (Boin et al, 2009; Olsson, 2014). This is not an environment that is conducive to double-loop learning. Argyris, (1982: 86-88) notes that when learning becomes more about maintaining control and self-protection, which then encourages attempts to manage information and its interpretations, individuals act defensively and competitively, often lack autonomy and may become overconcerned with group power dynamics. There are strong impulses is to 'stand and defend', 'run and deflect' or 'weaken and exploit' – much more so than to 'reflect and improve'. Simply put: if the dominant imperative is that the minister and the agency must survive the 'war for meaning' (Müller-Seitz and Macpherson, 2014) that is the inquiry process, defensive reflexes are likely to crowd out the appetite for institutional learning or severely curtail its depth and scope. The challenge for the public service is to be politically astute in engaging with the political dynamics of processing 'failures' without becoming swept away by both self-preservation instincts. It is a fine line to walk.

The following page provides an at-a-glance overview of the main insights from the various strands of academic research on institutional learning from success and failure examined thus far. The next section examines how the APS's experiences of processing the past fit into this picture.

Learning from success and failure: opportunities and challenges

Learning from success

Opportunities and levers

- **Professional pride:** Mobilisation of energy to capitalize on own achievements and 'do even better' (for clients, in rankings etc.)
- **Vicarious learning:** Building upon from others' achievements without the opportunity costs of getting to that point
- **Epistemic communities:** Production and propagation of positive lessons and 'best practices' through professional forums and international platforms

Challenges and blockages

- **Hasty learning:** Overenthusiastic 'rolling out' of programs and practices that have proved successful in the past or elsewhere
- **Mindless learning:** Copying of whatever is 'hot' among traditional reference groups (e.g. the UK civil service, and 'epistemic communities' such as OECD working groups) without due attention to context and conditions
- **Not-invented-here syndrome:** Professional jealousy or institutional rivalry preventing due consideration and adoption of successful practices of other units, agencies or jurisdictions

Learning from failure

Opportunities and levers

- **Rich feedback streams:** Incidents and crises generate systematic ad-hoc scrutiny of systems and processes
- **Momentum to avoid repetition:** Temporary 'unfreezing' of otherwise taken for granted features of the status quo, pressure to demonstrate government is 'doing something' to improve
- **Mature professionalism:** in many professions/sectors (e.g. civil aviation), negative feedback is valued, even sought, as key to self-improvement
- **Institutional patience:** 'Bureaucratic' rhythms and pace enable methodical research, trialling and piecemeal institutionalisation of 'lessons learned'

Challenges and blockages

- **Defensive learning:** Self-justification and self-preservation instincts crowd out space for double-loop lessons
- **Aborted learning:** Momentum fades once political accountabilities are settled, public spotlight shifts, and chief sponsors move on
- **Shopping-list learning:** Disjointed implementation of multi-item 'shopping lists' provided by inquiries
- **Opportunistic learning:** Cherry-picking inquiry recommendations to implement only those lessons that are institutionally convenient or politically palatable at the time

INTERROGATING THE PAST IN AND AROUND THE APS

We now turn the focus on the APS. What do we know about how its processes feedback about its past performance in relation to policies, programs or projects that have become hailed as successes or branded failures? While there is no firm evidence base upon which to found a comprehensive and authoritative answer to this question, a good place to start is to keep in mind that there are roughly two important design dimensions along which we can broadly map out the various institutional forms of review and inquiry that exist in and around the APS:

- *Continuous* (i.e. ongoing, often with fixed rhythms tied to e.g. the budget cycle) vs episodic (i.e. ad-hoc, triggered by particular incidents or political momentum) forms of looking back
- Looking back through a lens of accountability (i.e. who are/were responsible for the structures, processes and outcomes under examination and what if any consequences for their offices, roles and powers should be drawn) vs *institutional learning* (i.e. what does this examination reveal about the make-up, values and performance of the system under scrutiny, and how can this knowledge be put to use in order to improve it?

If we apply this – admittedly stylised, in reality the lines are of course less clear cut – distinction to the 'supply side' of government performance, we can map the various review mechanisms according to their operative logics (see Table 1 for an illustrative, non-exhaustive overview). This suggests that potentially all the bases are covered: there are provisions for ongoing and repeated performance monitoring, and there is an array of mechanisms for ad-hoc inquiry; likewise, there are multiple format for accountability-focused reviewing as well as learning-focused reviewing. In practice, of course, much depends upon how a particular review entity takes up its role, how well it is resourced, and in what political climate it happens to be working. It is here that the deck tends to be stacked in favour of 'failure-finding' and against 'success-finding', in favour of 'accountability' processes (who is responsible) and against 'learning' processes (how can we improve).

Table 1: Interrogating the past in and around the APS: the supply side

	Focus	
Design	**Accountability**	**Institutional learning**
Episodic	'Investigatory' Royal Commissions Senate Select Committees, temporary committees established by the Senate to deal with particular issues APSC's Capability Reviews of Commonwealth Agencies ANAO Performance Audits	'Advisory' Royal Commissions Expert commissioned reviews, such as the Garnaut Climate Change Review, Gonski education review, *Ahead of the Game*
Continuous	Government Department Annual Reports Joint Committee on Public Accounts and Audit, the committee initiates its own inquiries into public administration matters Productivity Commission's *Report on Government Services* series	Certain Senate select committees (e.g. on Superannuation) Communities of practice, such as thematic interagency, interjurisdictional, international working groups in e.g. COAG, OECD, ILO, IOM, EU settings Productivity Commission's report series *Overcoming Indigenous Disadvantage*

We cannot cover the full range within this paper, but from the perspective of processing 'successes' and 'failures', some of the mechanisms presented in Table 2 are clearly more conspicuous than others. We begin with the most conspicuous one, Royal Commissions, and subsequently look at some other potentially significant 'learning-oriented' review mechanisms.

LEARNING FROM ROYAL COMMISSIONS

Since federation, 135 royal commissions have been established at the Commonwealth level. Collectively, these inquiries have probed a broad range of government functions, catastrophic events, corruption, maladministration and allegations of impropriety, resulting in countless recommendations, insights, understandings and potentials for learning. Ideally, the rich performance feedback and suggested lessons that these high-profile review bodies produce find their way into policy changes and organisational adaptations that are underpinned by a cognitive adjustment that aligns with the thrust of the inquiry (Stark, 2019).

This process, however, complicated by the nature of the inquiry undertaken as well as its rationale. As hinted at in Table 2, royal commissions (hereafter: RCs) are broadly of two kinds. Some are explicitly investigatory-inquisitorial, created to uncover the 'truth' about an allegation or an incident. Others serve more of an agenda-setting – or agenda-shifting – function in that their stated purpose is to examine the past and present of a particular policy issue or domain and make recommendations for the future.

Of these two core functions, the former has become much more prominent than the latter: over the last three decades more than 90% of RCs have been set up to investigate an alleged failure or major incident (Prasser, 2006, 2012). The creation of a RC itself thus usually signals that a program or policy has become the target of such significant negative publicity, public dissatisfaction and political contestation that the government is cornered into setting up this high profile, well-endowed form of public inquiry. This type of RC performs a balancing act between a wide range of functions that various stakeholders expect it to perform: providing an authoritative and public account of what happened, what went wrong and why; providing a platform for what may otherwise remain 'soft voices' in the policy conversation, e.g. those of victims and from within affected communities; establishing accountabilities and apportioning blame; providing evidence-based pathways for remedying shortcoming and more generally improving the performance of the system under scrutiny.

Individual RCs differ markedly in the emphasis they give to these various functions. Both the impetus for establishing a RC as well as decisions about its design (mandate, composition, rules of engagement and budget) set the scene for both the extent and kind of lesson-drawing that is likely to ensue (Weller, 1994; Prasser, 2006; Stark, 2018). Given the high stakes involved, it has often been claimed that the form and functioning of inquiries is prone to manipulation by political elites (Stone, 1994; Rowe and McAllister, 2006). RC's tend to be equipped with resources beyond those that are traditionally available within a ministry (Inwood, 2005) and/or legislative process (Salter, 2003). The public, formal, quasi-legal orientation of most RCs, combined with the strong expectations that it will pinpoint wrongdoing and establish culpability, is conducive to an adversarial climate. RC's accordingly have been described as 'trials in disguise' (Salter, 1989, p. 185), and ministers and agencies are typically wary of RCs as they wonder both 'what will we be blamed for' and 'who will be blamed' (Eburn and Dovers, 2015). There are however also instances when a (incoming) government pro-actively installs a RC to soften up the policy environment for reforms it seeks to make, skewing proceedings in ways that compromise lesson-learning (Eburn and Dovers, 2015).

Critics of current RC practices not just in Australia but across the Westminster world point to an inherent tension between the search for 'truth' and accountability privileged by such an orientation, and the constructive search for policy lessons. These criticisms are to be taken seriously. They raise important questions about Australia's reliance of RC's as a key mechanism for processing problematic pasts. Their traditional reputation for thoroughness can only survive if politicisation of their design is kept at bay. Their court-like rules of engagement may be seen to be a help to truth-finding, but undeniably also mobilise defensive reflexes among those scrutinised. There are more

reflective and discursive ways of running inquiries into problematic pasts, as e.g. as many truth and reconciliation commissions in post-conflict societies have demonstrated. But it is equally important to learn from instances where RC's have played an important role in provoking productive and sustained institutional learning (see Stark, 2018). We briefly examine two examples of relatively recent RC's. One markedly contributed to productive institutional learning: The Royal Commission into the collapse of HIH Insurance (2003). In the other case, the Inquiry into the Outbreak of Equine Influenza (2008), robust learning proved much more elusive.

The *HIH Insurance RC* investigated the 2001 collapse of insurance giant HiH. It issued several key recommendations related specifically to the functioning and regulatory style of the Australian Prudential Regulatory Authority (APRA). As a relatively new regulatory authority, APRA adopted the supervisory approach of its predecessor agency. The Commission, while clearing APRA of culpability, encouraged the authority to adopt 'a more sceptical, questioning and, where necessary, aggressive' regulatory approach. Before the Commissioner's report had been completed, APRA, in recognition of its shortfalls, began to radically re-examine not only the adequacy of its prudential framework but also the premise upon which it was based. The approach was developed in-house, led by an experienced international banker recruited outside APRA, and overseen by a group of people who had significant analytical experience in the domains of APRA's remit.

The revised supervisory philosophy became to intervene early, but in a more graduated way. The move to a more proactive strategy marks a significant shift not just in its attitude to large institutions, but in APRA's interpretation of its statutory powers. This shift, among other things, has been credited with playing an important role in Australia's weathering of the global financial crisis (Bell and Hindmoor, 2015, 2019). The revised approach was further supported with the reconfiguration of APRA's governance model. At the time, APRA's non-executive board structure reflected a 'governance board' rather than a previously intended 'advisory board'. Post-HIH, concerns were raised regarding the position of the governance board relative to the chief executive and Treasury. The fear was that this position could potentially blur the lines of accountability. In an effort to restore public confidence, the government agreed to overhaul APRA's governance structure. The reorientation of APRA in the wake of the Royal Commission into HIH Insurance is illustrative of the capacity to engage in double-loop learning, that is, to question its governance model, its existence, and the values underpinning its work.

The *Equine Influenza RC* was established following Australia's first-ever outbreak of a highly infectious disease of horses. Several factors played a part in the outbreak and spread of the disease, however the response resulted in successful eradication within a matter of months. After agreeing to the 38 recommendations, the Ministry of Agriculture, Fisheries and Forestry took the important step of enlisting the assistance of the former head of the APS Dr Peter Shergold to oversee the implementation process. The outbreak triggered an additional independent inquiry into the broader issue of biosecurity. Here, it appears that the Ministry initially retained a narrow focus on horses, rather than taking into consideration the interacting components of the broader quarantine and biosecurity systems. In his first report, Shergold commented, 'The important thing is to implement the substance of the Government's response to the [Callinan] Inquiry, rather than to treat each specific action as a biblical truth carved in stone.'

The EI Inquiry highlighted a critical need to address policy, operational and cultural failures throughout the quarantine system from pre-border, at the border, to post-border. This needs all elements of the broader biosecurity and quarantine systems, and each of the States and Territories working together. While these reports carefully the document the administrative effort undertaken to implement the recommendations, EI represents only one of hundreds of biosecurity threats to Australia. In the final report Shergold noted, 'the lessons of EI have broad applicability and it is important that the response to them be set within a wider context of quarantine control.'

These two illustrative cases offer useful insights into the APS's capacity to draw lessons from RCs. Although wrongdoings and capacity shortfalls were recognised in the HIH case, the recommendations moved beyond apportioning blame. Instead, the understandings which emerged enabled APRA to question the values

underpinning its approach as well as its capacity to deal with similar events in the future. In the EI case, the Australian Quarantine Inspection Service (AQIS) drew heavy criticism for the occurrence of the outbreak. Its strong motivation to ensure that a similar event would not happen again may account for the way in which the recommendations were diligently observed and implemented. And yet a 2011 assessment of biosecurity and Australia's level of preparedness to handle a medium-to-large outbreak of foot-and-mouth disease found evidence of capacity shortfalls that had been identified well prior to the equine influenza outbreak (Matthews, 2011). The RC's diagnosis had not been taken up to ask more reflexive and strategic questions about broader systemic issues and the interconnections between AQIS's regulatory stance and the actions of other players in the system.

In many ways, the easy option is to be sceptical about royal commission processes and about their policy impacts. But it is important to note Stark's (2018) much more positive conclusions at the end of an in-depth examination of the impact of four RC's in the risk and emergency domain in four Westminster countries, which echo those of the HiH case. He notes that in each of the four instances studied, 'post-crisis inquiries have propelled policy reforms that have been tested in subsequent emergencies and found to have improved the crisis management capacity of governments. These improvements have occurred primarily through policy learning which has enhanced coordination and inter-connectivity (…) and policy learning which has upgraded the effectiveness of crisis management tools (…). These findings tell us that we need to re-evaluate the body of ideas and explanations that surround our judgements about the inquiry. Those revaluations need to consider the strong likelihood that post-crisis inquiries are much more influential than we think and the possibility, yet to be explored properly, that inquiries more generally might be more effective than our current knowledge insinuates.'

LEARNING FROM OTHER FORMS OF REVIEW

The *Senate committee system* provides a potentially influential platform for ongoing review. It has a long-standing reputation as the key instrument of accountability within the Australian Parliament (Halligan, 2008). Its scope is broad as a committee can address virtually any issue within its overall remit. The potential policy coverage is far wider than can be addressed through infrequent inquiries, such as RCs. Clearly, the political dynamics of the committee influence the choice of inquiry subjects as well as their intent and tone, but it would be a mistake to simply assume that they are all only and relentlessly about accountability and political point-scoring. There are intriguing examples of committees that serve as platforms for more reflective dialogue and joint learning.

One such example concerns the Senate Select Committee on Superannuation, which was established in 1991. This ostensibly temporary Committee persisted for 13 years and proved instrumental in both the initial passage of legislation and the policy's ongoing development. Shortly after its establishment, the Committee embarked on a strategic orientation exercise to determine how it would take up its role. The Committee first reviewed previous Senate committees for 'model precedents or practices', and consciously identified and drew lessons. Early on, the Committee recognised that it was important not just to collect information, but also to disseminate it to promote understanding and debate. The Committee's focus was deliberately broad, aiming to improve and build on the existing regime. Over its 13 years, the Committee's achievements include significant capacity building through the development of in-house expertise, extensive outreach through public education and awareness programs, as well as an 'encyclopedia of superannuation' policy knowledge for industry, government and consumers (Hooper, 2006). This example suggests that it is worth asking what the operative elements are in creating this type of productive role-taking by Senate Committees, and what kind of rules of engagement between Committee and APS agencies help sustain it.

Since 2005, the *Australian National Audit Office* has distilled and distributed key lessons and learnings from its audit work that are deemed relevant for the broader functioning of the APS. The incorporation of a specific 'lessons learned' component in every ANAO publication is motivated by the desire to draw out pertinent generic messages of importance for all agencies, even though the audit may be directed to a single program. Notwithstanding that, Auditor-General Grant Hehir (2018) notes that it is not uncommon for agencies to downplay the value of an ANAO review by suggesting that they had already been aware of the issues identified in the ANAO audit. Perhaps somewhat exasperated by experiencing this type of engagement with the ANAO, Hehir warns that such responses can drive a culture of complacency. That may be so. In Australia as in other jurisdictions, research suggests that there can be considerable tension between the contents and intent of performance information and its reception and use by its intended audience (Taylor, 2011). But when the institutional learning that results from 'looking back' at past performance – notably when that looking back concerns major incidents and points towards major problems of conduct, judgement, process and/or systems design – is considered to be poor, perhaps the mechanisms that produce this are not just on the receiving end of review process, but also on the supply side.

The APS also reviews its own performance in various ways. There are the annual *State of the Service reports* of the Australian Public Service Commission, for example, which predominantly focus on HRM, capacity and professional ethics issues. For our purposes, the most important mechanisms are the occasional *system-wide public service reviews*. As the IPAA (2018) documents in its submission to the current review, there are marked differences in the perceived impact of the 19 public service reviews that have been held at the federal level since 1976. The 1976 Coombs review – the only one to have had the status of a Royal Commission – tops the list, which was compiled through a Delphi-style consultation of 31 academic and public service experts. More than three quarters consider it impactful, many credit it with leaving a legacy that endures today. None of the other reviews

were rated impactful by even a simple majority of the experts (though the 1986 Hawke reforms came close at 47%), and a handful were nearly universally deemed to have been largely ineffectual.

IPAA's submission should be food for thought for the current review and similar exercises in state jurisdictions. What is it that makes some reviews carry weight and have substantive impact over time, and others to have come and gone without much of a residue of learning? Clearly timing and political context always matter. But so does the quality of the review's thought leadership: the strength of its evidence-base; the methodological rigour with which this evidence is not just mustered but used to interpret, evaluate and craft recommendations; its ability to articulate a compelling storyline that conveys the overall message and hits a nerve not just in the political system of the day but among the APS's leading cadres (Lindquist, 2010; 't Hart, 2010).

LEARNING FROM ABROAD

To improve and learn, policymakers are encouraged to cast their attention to instances of success so as to first identify and then apply 'what works' in their own professional domains or to import acclaimed 'best practice' from other professions and jurisdictions both at home and abroad. In ideal typical form, this process of policy transfer, as it has been dubbed in the literature, is expected to follow a certain sequence. First, policymakers identify a policy or program area within their own jurisdiction they want to make progress on. Solutions are then sought based on successful experiences elsewhere, often leveraged by 'epistemic communities' (expert committees, international organisations, think tanks). Finally, a suitable solution is imported and applied to the issue at hand.

Policy transfer can be more precisely defined as 'a process in which knowledge about policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political setting' (Dolowitz and Marsh, 2000, p. 5). There is nothing in this definition to suggest that the learnings must stem from perceived instances of success or 'what works'. However, a tendency exists to cast one's eye abroad in pursuit of success. Research on policy transfer covers a broad spectrum: from the convergence of public management practices across the Anglophone countries (Legrand, 2016; Moynihan, 2006), the diffusion of public sector innovations (Rogers, 1962), to specific policies and programs (Cairney, 2009; Peck and Theodore, 2010).

Channels and processes of policy transfer – whether borrowing, imitation, or imposition – have been well established, especially between Australia and the United Kingdom (Rose, 1991). In the early 2000s, the UK moved to strengthen its procurement policies with the development of a quality assurance process to assess and manage risk. Termed Gateway Reviews, this process introduced six key decision-making points along the lifecycle of a project, a peer review process, and a traffic light system to signal potential problems. Perceived as a resounding programmatic success (Marsh and Fawcett, 2012), the Reviews were introduced first into Victoria, and then to the Commonwealth, NSW, Queensland and WA. Despite being broadly adopted, there is a risk in equating policy transfer success with intended and actual outcomes. Research on policy transfer rarely links the idea with its outcome (Evans, 2009). In the case of Gateway Reviews, however, the approach was iterative, with Victoria first engaging policymakers in the UK and seeking to learn from their experiences. This process allowed other Australian jurisdictions to learn not only from the UK, but also from the Victorian experience. In addition, there has been lesson-sharing back from Australia to the UK, 'so the jurisdiction that created the system is now learning from the borrowers' (Fawcett and Marsh, 2012).

In 2003, a think-tank in the US introduced the idea of justice reinvestment as a potential approach to counter incarceration rates and enhance public safety. The idea and its various manifestations have spread throughout 35 US states. In 2009, former Social Justice Commissioner Tom Calma discussed its potential in light of the over-representation of Indigenous children and adults in the Australian criminal justice system. The approach is currently being developed in a number of trial sites around Australia – with some promising results (Willis and Kapira, 2018). The experience across individual US states has been mixed, but cumulatively, these initiatives have contributed to a change in the political climate whereby lowering imprisonment rates can be seriously entertained by public officials (Austin et al, 2013). With trials running in NSW, SA, and NT, the challenge lies in maintaining the integrity of the process and its original principles but also understanding that it's not a cookie cutter (Brown et al, 2016). Policies, programs and instruments from other jurisdictions cannot be taken 'off the shelf' and adopted without translation and adaptation (McCann and Ward, 2012). The common political, media and public discourse of 'rolling out' policies profoundly misrepresents the processes of policy formulation and the difficulties of transforming

intentions into on-the ground processes in widely varying localities. The ‘roll out’ metaphor draws its strength from the desire to seize on a proven successful program which can be picked up and imported into a new context.

Yet when the keenness to implant trumps the discipline to first translate, experiment and adapt in the new context, policy transfer may end in disappointment rather than triumph. In 2015, the Reference Group on Welfare Reform recommended that the Commonwealth government emulate New Zealand’s practice of treating social services as investments. Inspired by actuarial practices in the insurance industry, the aim of the investment approach is to identify people at high risk of becoming major welfare recipients over their lifetime and heed off the problems before they occur (Mintrom and Luetjens, 2018). The objectives are threefold: to get people back into work, reduce poverty, and increase living standards. The motivation to emulate this approach is likely triggered by its potential cost savings which are argued to emerge *if* the intervention steps are successful. The ideas underpinning this approach – to intervene early, to save over the long-term, to reduce welfare dependency – are politically appealing. However, recent research has criticised both the approach and its perhaps overly enthusiastic adoption into the Australian context. NZ welfare experts argue the original approach was developed solely as a response to welfare dependency – rather than the broader benefits that it touts (Fletcher, 2015; Chapple, 2018).

Enthusiasm and opportunism may thus overcome prudence in searching abroad for lessons. Studies show that a tendency exists to ‘overlook the negative experiential learning that contradicts the desired policy doctrine’ (Moynihan, 2006, p. 1029), whereas it is clearly critical to be fully cognisant of precisely *what* is being transferred (Howlett and Cashore, 2009) from where (De Francesco, 2016; Legrand, 2016), on what grounds and for what reasons. Particular examples, experts and evidence-bases may gain currency not because of their substantive merits but as a result of their ideological leanings or political expediency in the context of the adopting system: ‘instead of truth speaking to power, power decides what is true’ (Stone, 2017, p. 63).

Still, there is much to be said for building the public service’s capacity to engage in policy transfer more systematically (and, we add, more widely, beyond its cherished Anglosphere) than it does at present. Pathways for doing so include:

- commissioning targeted comparative research into successful programs and reforms (see Compton and ’t Hart, 2019; Luetjens et al, 2019);
- purposefully leveraging the natural laboratories that federal systems and subnational levels of government constitute;
- investing in and exploiting the work of international epistemic communities.

That said, research on policy transfer offers several important caveats that should be taken into account when doing so. Ignoring the importance of context in policy design and delivery comes at a price (Sharman, 2010; Rose, 1991). Furthermore, ideas from abroad may be introduced merely to persuade policymakers to put an item on the agenda, without an examination of how well the idea will work or what adaptations are needed. In other words, policies may spread as fads – but their applicability to localised challenges may be more limited than the hard sell with which they have been introduced has let on (Mossberger and Wolman, 2003).

Principles for prudent policy transfer

1. Learn the key concepts: what a programme is, and what a lesson is and is not
2. Catch the attention of policymakers
3. Scan alternatives and decide where to look for lessons
4. Learn by going abroad
5. Abstract from what you observe: build a generalised model of how a foreign programme works
6. Turn the model into a lesson fitting your own national context
7. Decide whether the lesson should be adopted
8. Decide whether the lesson can be applied
9. Simplify the means and ends of a lesson to increase its chances of success
10. Evaluate a lesson's outcome prospectively and, if it is adopted, as it evolves over time

Source: Rose (2004), *10 steps in lesson-drawing* <https://paulcairney.wordpress.com/tag/lesson-drawing/>

PRODUCTIVE LEARNING FROM SUCCESS AND FAILURE: EXAMPLES AND GUIDELINES

How to strengthen the APS's institutional learning capacity in relation to both its own experiences of success and failure as well as those of other governments? Our review suggests that it may be helpful to approach this question by looking at both sides of the learning equation. On the *supply side*, the core challenge is that of generating rich and usable feedback streams about complex and contentious as well as celebrated or taken for granted instances of public programs, projects, reforms, collaborations and innovations. We can question whether the current feedback regime for spotting, analysing and drawing inferences from government failures and successes in and around the APS is up to the task. On the *reception side*, the core challenge is that of creating institutional cultures and practices that are both responsive and astute in processing and utilising such feedback streams. Here, we can question whether both as a system and as individual agencies the APS harbours such learning systems.

Promising leads about what both that might look like have begun to appear in other jurisdictions as well as in academia. On the 'supply side', there are green shoots of less exclusively incident-driven, failure-oriented, n=1, accountability and blame focused modes processing the past that are needed to create a richer, more versatile evidence base and feedback environment than is presently the case. The UK's Institute for Government (2012, 2016) has sought to actively create rich accounts of both failures and successes within British government, involving key actors in the cases studied in the process of fashioning, validating and reflecting upon the implications of those experiences. In the wake of the RC on the Home Insulation program and a number of other recent inquiries into program failures in the Australian federal government, Peter Shergold (2015) was asked to take a step back and digest broader lessons from these experiences (see box below). Almost ten years earlier, in 2006, the Australian National Audit Office released a 'better practice guide', *Implementation of Programme and Policy Initiatives: Making Implementation Matter.* The parallels between these guidelines and the lessons emerging from *Learning from Failure* are stark. Both highlight the need to understand appropriate lines of responsibility, the time required for project planning, procurement and contract management, broad stakeholder consultation and inclusion, and the practical knowledge required to ensure a policy works on the ground.

Meanwhile, important leads for improving key feedback mechanisms such as royal commissions can be found in the concluding chapter of Stark's (2018) cross-national study of RCs. He concludes that if these types of review processes are to be effective levers for institutional learning, they would do well to:

- Always contain seasoned public administrators who have experience of the policy implementation process and that they are allowed to influence the crafting of reports and recommendations.
- Develop any operational level recommendations with some cognisance of the capacities of street-level actors and, where possible, recommend ways in which those capacities might be enabled.
- Anticipate the ways in which their recommendations will be 'translated' and 'refined' in the receiving system and determine what is and what is not acceptable in this regard.
- Be led by chairs and commissioners with a mix of skills and a capacity to see beyond their own professional logics and employ staff who have the capacity to talk across and connect different professional logics for action.
- Think about innovative ways in which the tool of public hearings can be modified or supplemented to better facilitate policy learning outcomes.
- Always recommend the means of oversight through which the implementation of their reforms can be audited across the long-term.
- Empower or create specific offices to act as reform champions and knowledge recall agents.

On the ‘reception’ side, positive evidence that active and open learning cultures can actually be created and sustained comes from world-wide research on so-called ‘high-reliability organisations’: systems and networks responsible for the management of high-risk technical systems in turbulent operating environments that have achieved remarkable levels of reliability in their performance (Hopkins, 2009). Actively seeking (and internally encouraging and empowering) negative feedback early on – before deviations and errors accumulate and cause major performance failures – is a core feature of these systems.

Principles of high-reliability organising

A. Capacity for early detection through mindful awareness of risk

1. Preoccupation with failure.

   Attention on close calls and near misses (“being lucky vs. being good”); focus more on failures rather than successes.

2. Reluctance to simplify interpretations.

   Solid “root cause” analysis practices.

3. Sensitivity to operations.

   Situational awareness and carefully designed change management processes.

B. Capacity for keeping incidents small through smart corrective action

4. Commitment to resilience.

   Resources are continually devoted to corrective action plans and training.

5. Deference to expertise.

   Listen to your experts on the front lines (ex. authority follows expertise).

Source: adapted from Weick and Sutcliffe (2011)

No doubt, such disciplined attention to the possibility of failure is helped by the fact that everyone operating these systems is deeply aware of the catastrophic nature of failure in systems like civil aviation, nuclear facilities. Indeed, many including the operators themselves – pilots and cabin crews, submarine personnel, nuclear power station staff, emergency first responders – may well die in the event of catastrophic failure, and even single incident may severely dent their organisation’s reputation (and solvability). The operating environment for most policy officers and service delivery staff is less unforgiving, though arguably the obsession with political and reputational risk in Canberra and the rawness of the blame games can ensue in cases of politicised policy failure can create similarly high stakes. This has no doubt negatively affected risk appetite across the APS and has blurred the distinction between failures as experiential data points conducive to learning and failures as reputational catastrophes for individuals and organisations.

From our perspective of institutional learning this presents a two-fold challenge of strategic leadership and cultural stewardship within the APS.

A culture of curiosity and experimentation

Challenge 1: To institutionalise and safeguard learning-enhancing values of openness, curiosity, risk absorption, self-reflection and experimentation within the APS even as the political Zeitgeist is one of blame avoidance, reputation management and consequently defensive responses to negative feedback.

Three major recent reviews of government failures in the US, Australia and the UK each offer sets of recommendations for improving the quality of policy design, decision making and delivery, as well as of the organisations involved. Each speaks to a specific context and audience, but there is a striking degree of complementarity between them. They are noted in summary form here; each source reference can be clicked on for further details and contextualisation.

Learning from failure: Insights from recent reviews

Light, Cascade of Failures (2014)
<https://wagner.nyu.edu/files/faculty/publications/Light_Cascade_of_Failures_Why_Govt_Fails.pdf>

1. Think about policy effectiveness from the start
2. Provide the funding, staff, and collateral capacity to succeed
3. Flatten the chain of command and cut the bloat
4. Select political appointees for their effectiveness, not connections
5. Sharpen the mission

Shergold, Learning from Failure (2015)
<http://apo.org.au/system/files/62938/apo-nid62938-72731.pdf>

1. Providing robust advice
2. Supporting decision-making
3. Creating a positive risk culture
4. Enhancing program management
5. Opening up the APS
6. Embracing adaptive government

UK Institute for Government 'Failing Well' (Wajzer et al. 2016)
<https://www.instituteforgovernment.org.uk/sites/default/files/publications/IFGJ4331_Failing-Well_25.07.16_WEBc.pdf>

1. Peer to peer support provides opportunities for earlier intervention – but it needs a trigger
2. Interventions may not need to remain in place until the turnaround is complete
3. Insularity is often a characteristic of failing organisations
4. Responses to failure can be over-reliant on structural reforms
5. Creating an open, no-blame culture helps to protect against future risk of failure
6. There is scope for more sector-wide learning from failure
7. Failure can (appear to) get worse before it gets better
8. Turnarounds should set the foundation for long-term improvement, as well as dealing with immediate problems

Identifying and debriefing successes

Challenge 2: To counterbalance the overemphasis on failure-finding in its authorising environment with internal routines and methodologies of success-finding (and reflective practices about learning from it) at both the agency and the systemic level.

Securing the ability to notice, remember, apply and learn is not just relevant in the context of processing problematic pasts, it is also a key principle at work in processing successful pasts. First of all, there needs to be an acknowledgement that many, in fact the bulk of, public policies, programs and projects run well, some even outstandingly so, and that this side of the performance coin provides a reservoir for institutional learning too. Once we turn that corner, the question becomes how to make success visible and study it with a view towards discovering its enabling conditions and operative mechanisms, and thus once again in a fashion that eschews reputational concerns, in this instance credit-claiming and moves beyond the more simplistic 'what works we copy' approach to policy transfer. A promising set of practices in this regard has been developed with the field of evaluation research under the banner of 'positive evaluation'.

Finding successful pasts

I. Methods of positive evaluation

Method: Appreciative Inquiry
Aim: Inquiring into, identifying, and developing the best practices and policies of organisations

Method: Success Case Method
Aim: Linking success and positive learning through identifying best practices or cases

Method: Most Significant Change
Aim: Facilitating program improvement by focusing on valued directions

Method: Positive Deviance
Aim: Finding existing solutions, assets, and strengths and mobilise improvement from within

Method: Developmental Evaluation
Aim: Supporting innovation while guiding adaptation to change in complex environments

Sources and case applications: Bohni Nielsen et al (2015), Van der Knaap (2017) and Better evaulation website <https://betterevaluation.org>

II. Leveraging learning through mobilising pride: awards and competitions

In Australia like in other nations and regions, professional bodies like IPAA run annual awards pageants. These are mainly designed to celebrate the achievements of individuals, teams and organisations, and rightly so. But they are also a great mechanism for 'digging up' narratives and data about programs, projects, reforms and innovations that public sector professionals that have demonstrably created public value, satisfied users and stakeholders and instilled professional pride. The potential for 'learning from successes' that this harbours currently is underused, but is easy to harness. The same goes for the use of the mechanism of (online) 'ideas competitions' to bring to bear the wisdom of the crowd on issues that require innovative solutions. This mechanism has produced some astonishing results in terms of the quality and speed of the solutions provided, and yet is simple and cheap to run (see for example Innovation Contests and Challenges webpage <https://www.ideaconnection.com/challenges/>).

Substantively, what can be learned from successes? The three studies highlighted in the next and final box all drew their evidence from high-performing organisations and/or government successes. The convergence between these three and the three meta-analyses of failures in the earlier box is striking. They all emphasise the importance of civil service professionalism that combines craftsmanship in policy design with openness to feedback and adaptation: a culture of curiosity, where there is space for doubt, that is comfortable with uncertainty, well aware of limitations, and one that seeks errors and failures as data points rather than as sources of professional embarrassment and political risk. They all emphasise the importance of rigour and robustness in analytical and advisory processes. They all eschew quick fixes and top-down solutions, and favour more adaptive and collaborative approaches to capacity-building. In short, at the level of first principles, the path is clear. The challenge is now to translate these principles into the APS's professional practices.

Learning from success: Insights from recent reviews

Harvard Business Review, Building a learning environment (2011)
<https://hbr.org/2011/04/strategies-for-learning-from-failure>

1. Frame the work accurately – people need shared understandings of the kinds of failures that can be expected to occur in a given work context
2. Embrace messengers – 'blameless' reporting
3. Acknowledge limits – being open about what you don't know
4. Invite participation – ask for observations and ideas and create opportunities for people to detect and analyse failures
5. Set boundaries and hold people accountable

UK Institute for Government, 'The S Factors' (Rutter et al. 2012)
<https://www.instituteforgovernment.org.uk/sites/default/files/publications/The%20S%20Factors.pdf>

1. Understand the past and learn from prior failures
2. Open up the policy process
3. Be rigorous in analysis and use of evidence
4. Take time and build in scope for iteration and adaptation
5. Recognise the importance of individual leadership and strong personal relationships
6. Create new institutions to overcome policy inertia
7. Build a wider constituency of support

Harvey et al. (2017). Fostering learning in large programmes and portfolios: Emerging lessons from climate change and sustainable development
<http://blogs.lse.ac.uk/impactofsocialsciences/2017/03/29/eight-lessons-on-fostering-learning-in-large-research-and-development-programmes/>

1. Don't assume a collaborative mindset
2. Understand and create incentives for participation
3. Set learning priorities and realistic outcomes
4. Engage early and intensively in setting up learning processes
5. Promote collective ownership of learning agendas
6. Invest in facilitated, face to face engagement
7. Identify and regularly revisit themes of shared interest
8. Iterate and adapt learning mechanisms

PRODDING QUESTIONS FOR THE APS REVIEW PANEL

Strengthening the institutional learning capacity of the APS should be a key priority for the current review. Our overview of current practices of 'governing by looking back' both within the APS and in other jurisdictions suggests the following questions might offer useful searchlights in taking up this task.

Q1: How can the APS be more mindful of and learn from its own successes? What systems or processes of 'success detection and dissection' are needed above and beyond existing performance measurement routines that do not yield the rich and reflective feedback required?

Q2: How can the design, operation, reporting and follow-up of internal and external inquiry or review processes be optimally calibrated to foster productive lesson-drawing?

Q3: If rapid prototyping – 'failing fast, failing cheap, failing forward' is the mantra of the design approach to public policymaking that is currently enjoying so much currency, how can this be given momentum and protection in an administrative culture where traditionally 'failure is not an option'?

Q4: Where should stewardship for a more broadly developed and institutionalised suite of methodologies for finding, analysing, comparing, crafting, disseminating and remembering lessons from successes and failures lie within the APS system?

Q5: Is it useful to invest in dedicated capacity for policy transfer, i.e. through the wide, robust and purposeful scanning of international governance environments and the translation, adaptation and experimentation work required to increase its effectiveness?

Q6: How is knowledge, including deep and tacit knowledge about major instances of success and failure, shared throughout the APS? What are the incentives to do so?

Q7: How can the development of professional habits and institutional repertoires for the mature and mindful processing of negative and positive feedback be stimulated?

Q8: How can the APS nurture its institutional memory – both the recall and use of 'lessons of the past – across time, portfolios and agency types?

Q9: How can public service leaders be empowered to prudently support their ministers in navigating the politics of credit and blame whilst at the same time fostering a non-defensive, blame-free learning culture within their agencies?

Q10: How might the APS leverage Australian's federal system's potential for cross-jurisdictional learning much more effectively than is currently the case?

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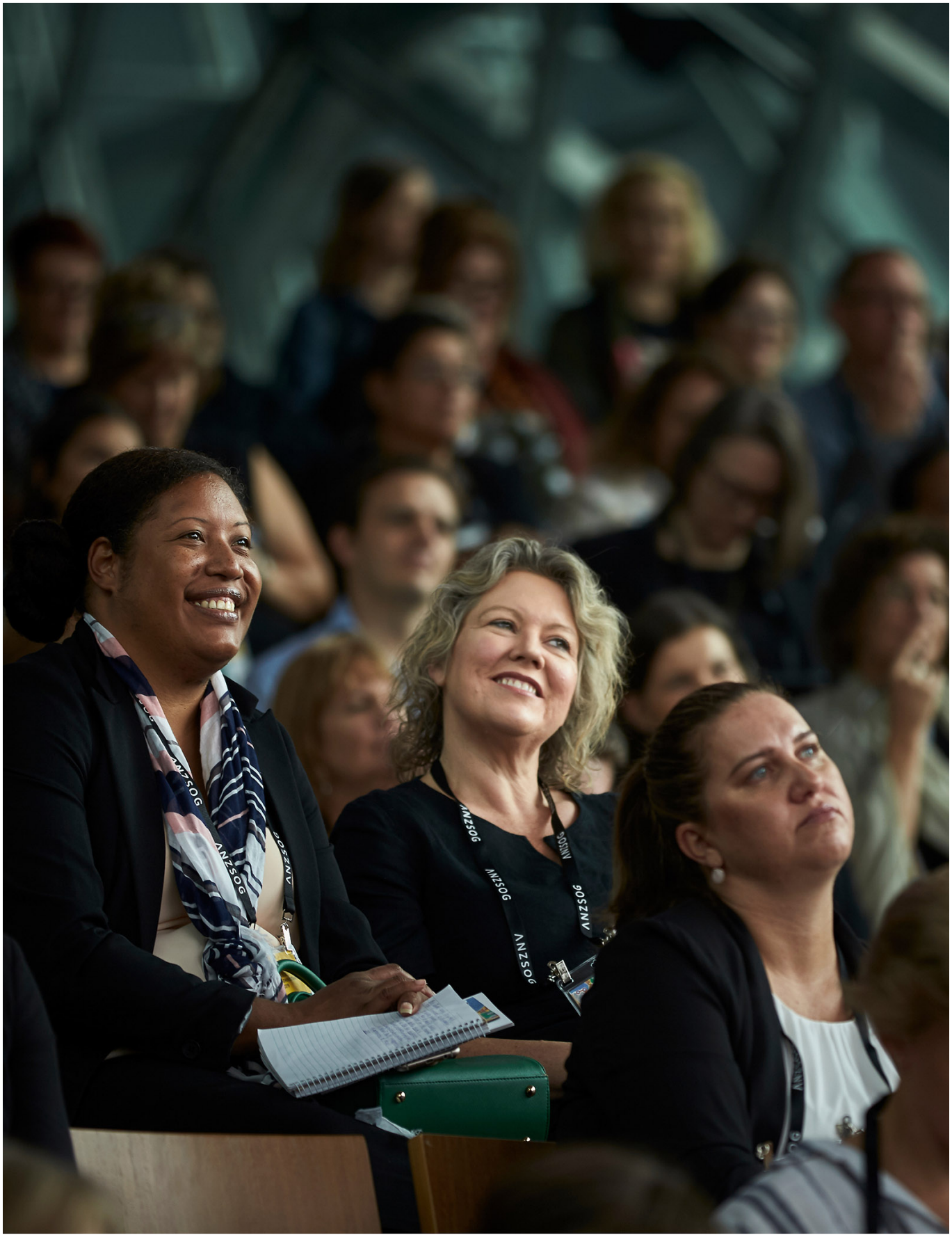
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