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Why Departments Need to be Regulatory Stewards

The latest Crown financial statements report that, at 30 June 2014, the New Zealand government held total assets valued at around \$256 billion (New Zealand Government, 2014). These included a diverse range of physical, financial and other assets, such as national parks, highways, state houses, electricity generation plant and equipment, Kiwibank mortgages, shares, deposits, and the National Library and Te Papa collections. But some of the most important assets that the New Zealand government develops and maintains are not recorded on the Crown's balance sheet. They are the

regulatory arrangements that have been developed, introduced and refined over many years to, among other things, protect the rights, safety, property and other interests of its citizens, residents and visitors, allocate responsibilities for various risks, and otherwise help them transact or engage with each other on fair and efficient terms.

Why do I suggest that regulatory arrangements are assets? Well, the definition of an asset, in the eyes of an accountant, is something within an entity's control from which future economic benefits are expected to flow. If we adopt a national perspective and include benefits beyond the merely economic, this corresponds pretty well

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with our expectations of any regulatory regime established by New Zealand legislation: namely, that it should deliver a future stream of benefits to New Zealanders that is greater than its costs. Leaving aside the measurement issues, the perceived legitimacy of regulation rests, at least in part, on satisfying this basic conceptual premise.

The response from some to this suggestion that regulation be viewed as an asset will be that they can think of many examples of regulation where the benefits do not exceed costs. And in some cases they are likely to be right. Regulatory regimes that the government intended to be an

'human errors' and 'system failures' that they argue have repeatedly produced major mistakes in policy design (King and Crewe, 2013). While their analysis is not specifically focused on regulation and is derived from UK cases, the human errors they have catalogued are likely to be found in a wide range of regulatory contexts. They include:

- cultural disconnect – where policy-makers unconsciously project onto others values, attitudes and even ways of life that are not remotely accurate;
- group-think – where there is such widespread agreement among a group, or such a desire to maintain

the strength of the narrative case for change, they are likely to be subject to ... judgements that are known to be subject to many important biases. (Hughes, 2013, p.38)

Some of the tools of policy or regulatory design, such as systematic impact analysis, consultation expectations, and other techniques for testing the robustness of regulatory proposals like regulatory pre-mortems (where you imagine a proposed regulation has failed and try to work out all the various ways that could have happened), are intended to help counter these risks.

Even without policy-maker biases, however, the design of effective regulation is an inherently challenging task. The essence of regulation is an attempt to alter the behaviour of others to meet a specified objective (Black, 2002). Since different people, through inclination or circumstances, will respond in different ways, a regulatory regime needs to be designed to be able to deal with a range of behavioural responses. The choice of regulatory approach (e.g. prescriptive, process-based or results-based regulation) must also take careful account of the potential for innovation or continuous improvement, the likely capability and resourcing of the regulator, and also differences in our inherent ability to observe or measure the regulated behaviour and outcomes.

To make matters even more difficult, regulation will frequently be applied within 'complex adaptive systems' (Dolphin and Nash, 2012; Eppel, Matheson and Walton, 2011). These are environments characterised by diverse, interdependent but self-organising actors, networks and institutions that continually influence, and in turn adapt to, each other's behaviour and the broader environment. The system's dynamics are typically non-linear and not geared toward equilibrium, making it inherently difficult or impossible to predict responses to and outcomes of regulatory policy change. Unanticipated and unintended consequences are therefore to be expected. In these circumstances, new regulation cannot be expected to be 'right first time', which means that many regulatory

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asset for New Zealanders can in practice turn out to be a liability. We might call these cases of regulatory failure.

What disasters tell us about regulatory failure

There are, unfortunately, many ways in which regulatory regimes can fail. The failures that will spring to mind most readily are those associated with disasters – those highly salient events or discoveries that have or reveal major negative outcomes. We know quite a bit about these types of regulatory failure because they are usually the subject of a subsequent public inquiry seeking to learn lessons from the disaster. Oft-cited recent New Zealand examples include leaky buildings, failed finance companies, and the Pike River mining tragedy (Searancke et al., 2014).

Mistakes in policy design

It seems that the seeds of a future disaster are frequently sown at the policy design stage. In their very readable book about UK government policy 'blunders', Anthony King and Ivor Crewe identify a range of

group cohesion, that no one expresses dissent;

- intellectual prejudice – an unquestioned belief that some kinds of institutions and some kinds of policies can be counted on to work better than others; and
- operational disconnect – the lack of communication between policy makers and implementers.

King and Crewe argue that steps can be taken to counteract these common errors, but also note that this will not occur without prior recognition of the danger. The same point could be made about the various cognitive biases described in the behavioural economics literature, to which policy advisers and policy decision-makers can be just as prone as those whose behaviour government policy is seeking to influence. Tim Hughes wrote about this in a previous *Policy Quarterly* article, noting that:

To the extent that advice is given or decisions are taken quickly, on partial information, on gut feel or

interventions are best treated as policy experiments. What this implies, as Peter Mumford has previously suggested, is that 'If we do accept ... the proposition that regulatory regimes are experiments, and novel regimes even more so, then constant monitoring and evaluation over time are critical' (Mumford, 2011, p.37).

Mistakes in regulatory operations

Poor (or unlucky) policy design, however, is not the only cause of regulatory disasters. The evidence suggests that operational factors within the control of regulators are also important contributors.

Learning from regulatory disasters was the theme of Julia Black's Sir Frank Holmes Memorial Lecture in Wellington in April 2014. She defined a regulatory disaster as one that results from 'the unintended and unforeseen consequences of the design and/or operation of a regulatory system and its interaction with other systems' (Black, 2014, p.4). From her analysis of the reports on several regulatory disasters, Black noted that:

While the political and legal context has a role to play in shaping organisational processes, cultures and decision-making, a striking feature of all the regulatory disasters analysed here is the central role played by failures of governance and leadership within organisations, in both regulators and regulated firms. (ibid., p.6)

Her analysis of the failings of these organisations led her to conclude that:

- organisational culture matters;
- the training, skills and expertise of its personnel matters;
- organisational failures usually come from the top;
- organisations often take the path of least resistance, and as a result can fail to manage risks strategically; and
- where multiple regulators are involved, they consistently fail to coordinate among themselves in the operation of the regulatory system.

As part of its recent inquiry into regulatory institutions and practices, the Productivity Commission extended Black's analysis to cover 18 reports

of major disasters, seeking to test her hypothesis that regulatory failures were often a contributing cause, and to identify what aspects of regulation were implicated (New Zealand Productivity Commission, 2014, p.23). The commission found that a number of regulatory factors were frequently implicated, including:

- the lack of clarity of the regulator's role;
- the complexity of regulatory regimes;
- weak governance and management of both regulator and regulated parties;
- weak regulator accountability, monitoring and oversight;

regulatory failures due to the chronic underperformance of regulatory regimes ... have been called the 'silent killers', and should be considered a significant risk ...

- the capacity and resourcing of the regulator;
- failures of compliance and enforcement;
- failure to understand and assess risk;
- poor engagement and communication about regulatory requirements;
- the culture and leadership of both regulators and regulated parties; and
- out-of-date regulation or lack of review of regulation.

While Black and the Productivity Commission sought to draw attention to the frequency with which some factors are linked to regulatory disasters, their findings also serve to highlight the wide range of factors that can contribute to those disasters. If there were just one or two specific factors strongly linked to almost all regulatory disasters, it would be relatively straightforward either to design a regime to significantly limit those particular risks, or to identify indicators to enable periodic monitoring of risk levels at modest cost. But with so many factors potentially in play, that significantly increases the difficulty of

being able to design around, or spot the emergence of, possible future problems.

Disasters are not the only form that regulatory failures can take

Major disasters are a particularly visible form of regulatory failure, due to the terrible harm they cause to those directly affected. The attention this also creates means that very significant amounts of ministerial and public servant time are then diverted to support urgent inquiries and reviews and to develop and implement an inevitable government response. But while the risk of regulatory overreaction is very real in these

circumstances, there is at least a reasonable prospect that action will be taken that will improve the performance of the regulatory regime concerned.

By contrast, regulatory failures due to the chronic underperformance of a regulatory regime are far less likely to attract policy-maker attention. In the absence of a systematic approach to regime monitoring and review, it is possible for unnecessary, ineffective and excessively costly regulation to persist for a very long time without any action being taken. Regulations of this nature have been called the 'silent killers', and should be considered a significant risk because the review of New Zealand's regulatory regimes has been largely 'built around "alarms going off" rather than "regular routine patrols"' (Gill and Frankel, 2014, p.60).

Managing regulation as an asset

With so many different sources of potential regulatory failure, what should we be doing to ensure that New Zealand's regulatory regimes function as assets rather than liabilities?

Box 1: Cabinet's Initial Expectations for Regulatory Stewardship (March 2013)

Cabinet expects that departments, in exercising their stewardship role over government regulation, will:

- monitor, and thoroughly assess at appropriate intervals, the performance and condition of their regulatory regimes to ensure they are, and will remain, fit for purpose
- be able to clearly articulate what those regimes are trying to achieve, what types of costs and other impacts they may impose, and what factors pose the greatest risks to good regulatory performance
- have processes to use this information to identify and evaluate, and where appropriate report or act on, problems, vulnerabilities and opportunities for improvement in the design and operation of those regimes
- for the above purposes, maintain an up-to-date database of the legislative instruments for which they have policy responsibility, with oversight roles clearly assigned within the department
- not propose regulatory change without:
 - clearly identifying the policy or operational problem it needs to address, and undertaking impact analysis to provide assurance that the case for the proposed change is robust
 - careful implementation planning, including ensuring that implementation needs inform policy, and providing for appropriate review arrangements
- maintain a transparent, risk-based compliance and enforcement strategy, including providing accessible, timely information and support to help regulated entities understand and meet their regulatory requirements
- ensure that where regulatory functions are undertaken outside departments, appropriate monitoring and accountability arrangements are maintained, which reflect the above expectations.

Clearly it needs to start with good policy design, built around processes and tools that recognise and seek to counter the danger presented by common human decision-making errors and biases. While it is true that the practice rarely matches the rhetoric in any country, this is a key reason why governments in almost all OECD countries, and increasingly elsewhere, have introduced requirements for regulatory impact analysis and for consultation on regulatory proposals, in one form or another. Beyond these familiar requirements, the Treasury is considering whether there are simple ways to prompt policy advisers to, for instance, make appropriate allowance for unintended consequences and better identify the implementation challenges that need to inform the policy design stage.

But good policy design, even if that could be assured, is not enough to ensure

that regulation continues to deliver a flow of future benefits. Even if a particular regulatory environment of interest is very stable, with limited technical innovation or change in the strategies of regulated parties over time, a 'set and forget' approach to regulation is still quite a risky one. We never have full knowledge of the existing regulatory situation, and cannot reasonably anticipate all potential consequences of a regulatory change or all future opportunities for improvement. Consequently, it does not make sense to rely solely on regulatory processes and tools that operate only during the policy and legislative design stage. Once a regulatory regime is operational, we should also monitor, evaluate and then, if feasible and appropriate, seek to fix, maintain and improve the regime over time.

This is, after all, what we do with our other important assets. George Tanner,

the former chief parliamentary counsel and law commissioner, made just that point when he said, 'we paint our houses and service our cars, but we don't look after our laws in the same way' (Gill, 2011, p.195). Organisations routinely employ a range of asset management techniques to help get the best performance out of their assets. So why has the state sector not systematically sought out and implemented the regulatory equivalents of those techniques in order to reduce the frequency and scale of regulatory failures, or maintain and improve the performance of regulation that can or does provide benefits in excess of costs?

Regulatory stewardship

If the answer to that question is that state agencies did not think that this was one of their core responsibilities, then recent developments within the New Zealand state services should be starting to change that point of view. One low-profile but important change made as part of the government's Better Public Services initiative was to introduce the notion of 'stewardship' as a key responsibility of departmental chief executives. In particular, section 32 of the State Sector Act has been amended to provide that, among other things, the departmental chief executive is responsible for the stewardship of:

- the department itself, including its medium- and long-term sustainability, organisational health, capability, and capacity to offer free and frank advice to successive governments; *but also*
- the assets and liabilities that the department administers on behalf of the Crown; and
- the legislation administered by the department.

In support of this, the state services commissioner is also charged with 'promoting a culture of stewardship in the state services'. The Act defines stewardship as the 'active planning and management of medium- and long-term interests, along with associated advice'.

Much of the discussion of this new stewardship responsibility to date has highlighted that it requires departments to adopt a longer-term perspective on

their operations. At its core, however, being a steward simply means having a proactive duty of care for a resource that belongs to, or exists for the benefit of, others. The introduction of the stewardship responsibility sends a signal that departments can no longer just be passive, working only on those matters that their minister has deemed to be of interest or priority. They have a duty to systematically and proactively monitor, review and advise the minister on what can or should be done by the government to ensure New Zealanders obtain the best long-term benefit from the resources or assets for which they are steward.

Concerning regulation more specifically, the key point to note is that a department's statutory stewardship responsibility extends to the legislation administered by that department. To give departments a little more direction as to what this might mean, in March 2013 Cabinet agreed to a set of 'Initial Expectations for Regulatory Stewardship' (see Box 1).

Naturally enough, these regulatory stewardship expectations promote the ongoing monitoring, evaluation and

regulatory maintenance activities that I have suggested are essential if we wish to reduce the scope for and size of future regulatory failures, whether in the form of disasters or of the chronic underperformance of a regulatory regime. The prominence given to regulatory regimes in the expectations seeks to shift attention from a narrow focus on the 'flow' of proposed regulatory changes to a broader focus on the performance and condition of the underlying 'stock' of regulation. Lifting the attention level to regimes is also intended to help departments focus on the ultimate policy outcomes sought by the government, and encourage them to bring a systems perspective to their monitoring and analysis (i.e. looking at how related instruments and their associated institutional actors interact in pursuit of those key outcomes), which a focus on individual acts or regulations would be less likely to do.

The expectations for regulatory stewardship, therefore, seek to encourage better management of New Zealand's important regulatory assets. Indeed, the initial set of expectations agreed by

ministers can be viewed as introducing some very basic asset management concepts to the regulatory environment.

There is a long way to go, however, before we will be able to say that the techniques we have for managing New Zealand's regulatory arrangements are as good as those currently applied to the management of other assets important to New Zealanders. That is why these were deliberately described as a set of initial expectations. It is hoped that they will be further developed and refined as we all learn more about the range of practices that different departments introduce and find helpful in discharging their regulatory stewardship responsibilities. They may even need to be tailored for different agency roles, since the current expectations were developed primarily for departments with regulatory policy responsibilities, rather than agencies that primarily exercise regulatory powers. The development of regulatory stewardship practice, just as with some regulatory policy interventions, is a bit of an experiment, and so ongoing monitoring, evaluation and adjustment is likely to be required.

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